

Title: “Autonomy integrity”: another way to understand autonomy in psychiatry?

Short title: consent, autonomy, psychiatry.

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Short author biography:

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ABSTRACT:

The decision to involuntarily hospitalize a patient underlines an inherent contradiction in psychiatry between the need for care and the lack of consent to care. The growing importance of respect for individual liberties in our society fosters the renewal of questions about the best way to respect patients' autonomy in psychiatry. As a clinical ethics support service, we carried out a prospective and qualitative study on involuntary hospitalization in psychiatry in 3 psychiatric wards. The goal was to understand the stakeholders' perceptions and ethical arguments about involuntary hospitalization (42 cases, 161 semi-structured interviews: with 35 patients, 30 relatives, 37 psychiatrists and 19 nurses). It seems that the solutions provided by the law, as well as the development of tools for the defense of patients' rights, do not exhaust the questioning on the respect for patients' autonomy in psychiatry. Beyond the conflict between need for care and respect for freedoms, we understood from the patients' discourse in the study that their priority is to be respected in their integrity. It therefore seems necessary to think and develop ways to respect what will be called the patients' "autonomy-integrity".

BACKGROUND:

It is common knowledge in medicine today that patients' consent must be obtained before they can be treated. However, it is not unusual to see this basic principle flouted in psychiatry [1]. In order to care for mentally ill patients who can be considered unable to make reasonable decisions for themselves [2], psychiatrists resort to involuntary hospitalization. As a clinical ethics support service¹, we have witnessed many questions raised by the specific field of psychiatry and the breach of consent it allows. Healthcare professionals have for instance come to us with their questions on what decision to make when a patient refuses treatment or what would the benefit of a surrogate in these cases be. Their questioning meets the prevalent quandary in psychiatry between the "right to health" and respecting the patients' civil rights, or in other words the dilemma between restoring the patients' "psychic autonomy" in the name of respecting a right not to suffer from a "dehumanizing" condition [3], or instead guaranteeing their right to come and go as they please, thus respecting them as citizens first. Society in general is also divided on this matter. On one hand, the social representations of mental health as potentially dangerous and the will to keep treating those suffering from it justifies involuntary hospitalizations for the best interest of the patients and the community. Recent reports on this point show that the number of involuntary hospitalizations in psychiatry keeps increasing [4]. On the other hand, a movement in favor of more rights for people with disabilities rises, thus promoting more respect of the patients' freedoms and less coercion in general [5].

In France, the law updated in 2011/2013² regarding involuntary hospitalizations in psychiatry tries to find the right balance between respect of patients' rights, their best medical interests and the best interest of the community. It includes new tools in favor of patients' civil rights such as an obligation to refer to the liberty and custody judge within less than 12 days after patients are involuntarily hospitalized; all the while distinguishing three forms of involuntary hospitalization, one of which authorizes doctors to make the decision to involuntarily hospitalize a patient without a close one's signature (until then forbidden by

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² Loi n° 2011-803 du 5 juillet 2011 et Loi n° 2013-869 du 27 septembre 2013

the law in France) in case of an “imminent danger” [péril imminent] which makes it potentially easier.

Respect for patient autonomy in this context raises questions only a few ethical studies have been conducted on, especially in France [6]. The ones that do exist are mostly retrospective [7,8], or focusing on coercion and the relationship between patients and the medical staff [9,10]. The objective of this clinical ethics study was to understand the perceptions and ethical arguments about involuntary hospitalization of patients, their relatives, as well as doctors and nurses.

METHOD:

The study was qualitative and prospective. The main purpose was to get to know each person’s arguments on the matter, as well as to discuss the possible advantages of tools known to promote patient autonomy in other fields such as surrogate or advanced directives in these cases.

Sample

We were foremost interested in involuntary hospitalized patients’ testimonies. We chose to meet them as soon as possible following their admission into the hospital. The other stakeholders we met were the patients’ relatives and the psychiatrists who hospitalized the patients and/or who were in charge of them in the hospital, and a nurse of the team working the day we were present. Nurses do not take part in decisions of involuntary hospitalization, but it seemed appropriate to meet with them, as we assumed their ethical arguments on the subject could differ from doctors’. Three different sites were selected for their specificities: 1) a classic hospital service, with a large and multi-sectorial recruitment; 2) a hospital service that promotes home care and avoids constraint and therefore involuntary hospitalization; 3) an “emergency service” where patients can stay three days in observation before being involuntarily hospitalized. Patients were randomly selected.

Data collection

Clinical ethics’ interviews were conducted. They were led by two people, a physician and a non-physician. The second researcher was either a journalist, a psychologist, an occupational therapist in psychiatry, a philosopher or a jurist. Participants were interviewed preferably alone. Time was given to them to speak as freely as possible in a narrative mode and to develop their arguments on the subject under consideration. The researchers were only guided by an interview grid which was validated after a few test interviews (cf. table 1). The goal was to investigate the issues in their ethical dimension rather than strictly factual, using Beauchamp and Childress principles of respect for autonomy, beneficence, non-maleficence and justice [11]. In summary, we tried to understand: what is the role of the person’s autonomy and his or her consent when a disease casts a doubt on them? What does the person expect from medicine and what does medicine owe her in return? What is the part played by relatives, society, the law or patients’ rights tools?

- Beneficence/non-maleficence, disease, risks, support, treatments
- Person's autonomy, advanced directives, surrogate, consent, information
- Hospitalization and forced treatments
- Coercion, security, public order, law, judge, lawyer
- Patients' rights, freedom, empowerment
- Decision making, doctor-patient relationship, confidence, medical power
- Follow up care, care organization, social security
- Role of medicine, professional integrity
- Relatives, family, legal representative

Table 1: keywords chosen as guideline for the interviews

Data analysis

The research method used is the "grounded theory" [12]. Contrary to a hypothetico-deductive approach, the study was not intended to test a hypothesis previously identified, but to bring out data collected from the explanatory tracks. Regarding data analysis no software was used. In accordance with the method of "sequential thematic" analysis [13], the interviews were analyzed and coded using recurrent keywords. The coding highlighted themes, which were then grouped into thematic trees and linked to the original questions.

Ethical aspects

The written consent of the interviewees was asked before each of the interviews, and after having been informed orally and by a letter of the study's subject. The confidentiality of all data collected was rigorously insured, and participants were notified once the results were available. Regarding the patients, knowing that their free and informed consent could be questioned, we made every effort to make it as authentic as possible (oral presentation of the study, delivery of the letter with the Clinical ethics center's information and contact details, discussion of their written consent at the time of the interview). Ethical approval for the study was obtained from an ethical research' committee (Paris Descartes) on the 10th of June 2014 (IRB: 20141100001072).

RESULTS:

Participants

In total, 161 semi-structured interviews were conducted. Patients and proxies' characteristics are detailed in table 2. We also met one local psychiatrist in each case and 19 local nurses, as well as 18 psychiatrists having signed a first certificate of hospitalization (which means who didn't work at the local site). In terms of diagnosis, the sample may be defined as "classical" in current psychiatry: 31 patients suffered from psychotic pathologies (schizophrenia, delusional melancholy, acute delusional blast, etc.) and 11 from non-psychotic disorders (psychotic mood disorders, etc.). Thirteen used toxic substances (alcohol, cannabis, or other drugs). We identified 3 types of "typical profiles" that justified the hospitalizations: 1) 28 patients had a psychiatric history and had already been hospitalized without their consent. Of these, 22 were known from the site where we met them and 6 were unknown to the inclusion site and without recent follow-up; 2) 4 patients had a "psycho-social" history (former inmate and/or social exclusion without obvious psychiatric diagnosis); 3) 10 were young people who had an acute episode or elderly people

with a suicidal gesture, without any psychiatric history. The study took place between September 2014 and June 2016.

	Site 1 (classic unit)	Site 2 (promoting home care)	Site 3 (emergency unit)	Total
Cases	15	15	12	42
Patients we met	12	13	10	35
- Men	11	7	6	24
- Women	4	8	6	18
- Middle age	44	38	36	39
- < 15 days of hospitalization	9	12	7	28
- > 15 days of hospitalization	3	1	3 (2 after exit)	7
- Classical involuntary hospitalization (with proxies' signature)	7	11	11	29
- Imminent danger (only one psychiatrist certificate)	8	4	0	12
- Refusal	1	1	1	3
- Out of sight	2	1	1	4
Cases where we met proxies (n=30)	3	13	8	24
- < 15 days of hospitalization	2	11	5	18
- > 15 days of hospitalization	1	2 (after exit)	3 (2 after exit)	6
- Not seen because :	-	-	-	-
o Patient refused	4	1	0	5
o Proxies refused	1 (too hard)	0	1 (didn't come)	2
o Patient not seen/no response	7	1	3	11

Table 2: patients and proxies characteristics

Patients spoke more about integrity and their need for human interactions than their lack of consent

Consent was not the patients' first concern although nearly every one of them knew they had been involuntarily hospitalized. We noticed patients reacted in different ways to their involuntary hospitalization, hence three groups. The first one was "living with it": consent was not seen as an issue; quite the opposite, they agreed with their hospitalization because they admitted they could benefit from it in terms of health. *"It was very logical decision. I wasn't able to think, I wasn't aware of my actions... They asked if I agreed. I talked about it with my brother-in-law. I didn't suffer from it... I gave my consent, I don't see it as something forced on me."* (7). Some of these patients believed their involuntary hospitalization to be right for them and helpful for the future. *"At first I didn't know I had a disease. The involuntary hospitalization made things more serious and I realized it... Being under constraint really encouraged me to get better. It truly helped me. It gave me strength to go back to voluntary hospitalization"*. (37). The second group included those who had "resigned" themselves to it, even though they were theoretically against the idea of being involuntarily hospitalized. They mostly dismissed the question about consent and said that they did not regret it in the end, but what they needed now was to move on from it. *"It wasn't really on board with it; but I understand that she (his mother) worries because she can't always keep an eye on me. I understood and agreed with it. (...) I wasn't given any choice. I am very cooperative in general."* (29). The third group included those who disagreed

and could show anger. It was either due to a difficult relationship with the proxy that had signed the consent form, or to a strong claim that their freedom had been denied. *“(My relatives) came and kidnapped me on Monday to lock me up. (My boyfriend) will pay dearly for this, he had no right. He thought I had mental problems, but my only problem is with them. I lose it when I see them.” (11). “It wasn’t easy for me. I am 41 and I’m an adult... I take care of all my bills... It’s a bad memory.” (8).*

A large majority of patients denounced the harsh living conditions during their hospitalization in psychiatry. They emphasized the feeling of not being respected as persons or human beings. Even though some patients valued the way the medical staff received them or special relationships they occasionally developed with caregivers or other patients, many described the daily atmosphere as boring and rough, and sometimes violent. They added the struggle of living with a chronic mental condition that is more or less disabling and almost always stigmatizing. *“There should be more dialogs with the patients, more activities here. There is nothing going on here. We can only smoke. People should be more involved in patients’ lives.” (18). “I’m considered as a mad man. It doesn’t make much of a difference. I’m only asking them to let me breathe a little and make me somewhat comfortable.” (29).* They particularly condemned the day-to-day restrictions of freedom (such as having to wear pajamas, restrictions on smoking, phones and visits), and the coercive measures. Many insisted they felt pressured into taking pills to be freer. *“I was afraid it would be even worse then, that they wouldn’t let me out. I felt like they gave me a pill for me to shut up.” (41).* They were even more virulent towards restrictive measures, and more specifically towards isolation rooms or physical restraint. *“Being physically restrained although you’re of sound mind... Your hands, your feet and your stomach squashed in for four days, it’s unbearable... Seeing myself tied up haunts me. I will never forget the grip. They would only free one arm to let you eat something.” (41)*

Patients had not made the law theirs at all. Many were unaware of the very existence of the legislative text or the different ways of involuntary hospitalization. The part played by relatives in the legal system (especially their signature on the hospitalization’s consent form), or by the judge, were not at all obvious to them. However, most of them were interested in the surrogate tool as they understood it as someone who could stand up for them. As we’ve previously said, patients spoke to a great extent about bounds and relationships with other people and were sorry there were not more of them.

Relatives wanted to help the patient to recover his “normal” life

For all of the relatives we met with, their close one’s hospitalization was considered as a relief after straining and lonely times, when they would have a hard time getting medical help to prevent the coming acute crisis. For them, the question was not consent but the need to get care for their close one and to keep them safe from danger for themselves and for others. They clearly criticized the lack of anticipation and the difficulty of having their loved one hospitalized to help him. *“We’d negotiated with him, we said it’d be very quick, but we ended up waiting 4^{1/2} hours... I understand a psychiatrist can be unavailable, but it should at least be possible to let him in the building to trap him, instead of having us wait on the parking lot... We got lucky he agreed to wait, because we weren’t going to knock him out... It’s pretty unhealthy. It’s like we have to push him to the limit for someone to intervene.” (34)*

It should be noted that, unlike patients, relatives did not talk about the living conditions in the hospital or about coercion.

Proxies criticized the lack of information during the hospitalization and complained of being excluded from care, even if they had good relations with the health teams. They believed they could stay closer to the patient and finally be recognized as the medical staff's first interlocutors by signing the hospitalization request, and as a matter of fact, that is why they wanted to sign the hospitalization's consent form (in half of the cases) in the first place. The law and the procedure were not at all what concerned them in the first place at that time. In addition, that is why they all rejected the surrogate tool; they wanted to be the first ones concerned anyway.

Healthcare professionals were guided by a position of principle on consent and constraint

To justify involuntary hospitalization, healthcare professionals – both doctors and nurses – mainly referred to medical arguments, speaking of the danger for the patient such as the vital or social risks aggravated by the disease. They didn't refer to the potential danger for the family or the public order. It was the psychic state, or even the physical state, of the patient, which worried them (delirium, anxiety, behavioral disorders, carelessness, agitation, incurability with possible repercussions on physical health, undernourishment, abandonment on the streets), especially if the patient had a psychiatric history already or if he had stopped his treatments abruptly. They said that they could not take into account consent at that time, because of the patients' inability to consent, their refusal to be hospitalized, or incidentally for organizational reasons (easier on a Friday evening for example). Contrary to our first intuition, there was no difference in reasoning between doctors and nurses.

Every healthcare professional thought that involuntary hospitalization was unavoidable, but the ways of apprehending coercion in general differed according to various ways of practicing psychiatry. Some could emphasize on the need to restore the patient's psychic abilities above everything else, which implied distancing themselves from the questioning on coercion, and considering for instance isolation rooms to have therapeutic virtues. *"Physical restraint is often seen as barbaric, but it allowed him to lay down and rest for a moment."* (1). *"Coercion is a part of care in general. (...) It protects the patients, and without it his only way out is death."* (7). Conversely, some sought to respect the person as a citizen before seeing him as a patient to promote better long-term follow-up, hence a rejection of coercion, sometimes in its entirety. Forced treatment was also avoided, among other things, even if it could have improved the psychic state of the person. *"I feel like I'm in a horror movie if I have to make someone do something. I'd rather have him discharged, because there're not many arguments to keep him against his will. It's a gamble on the future, so that he knows he can trust us."* (14). For others, the need to restore the patients' psychic abilities, using coercion if necessary, coexisted with the need to respect their freedom. For example, on one of the sites, the local administrative organization prevented the use of "imminent danger". *"We don't use coercion unless it is absolutely necessary. It is care that guides us, when coercion can benefit the patient."* (37)

All health professionals agreed the law is protective of patients and that it is a sign of respect for the person. According to them and although they could fear an over-legalization of the practice or feel the potential maleficence for the patient of meeting with a judge, they recognized the law could facilitate their work seeing as they are no longer the only ones to decide. The decisions were more legitimate for the patient, and collegiality was respected more easily. *"It's good for him to see a judge because then, he stays in because the law said so. We value this decision."* (7). Regarding the signature of relatives, they told us it was a

good representation of the legal system protecting the patient. In these situations, the signature of relatives firstly showed that the patient really needed help, secondly involved directly the relatives, and thirdly favored the therapeutic alliance – all of this improving patient's care. *"It's often the third party that warns us. It's a guarantee that someone outside the hospital sees it like we do... We can't act without the relatives. Where would we be going?"* (23). Unlike the law, the surrogate tool was not widely valued. They thought that the time of an involuntary hospitalization was not ideal to involve a surrogate, as there were already many people involved around the patients to take decisions for him. It could only aggravate the feeling of incomprehension and rejection of the patient. They were not either very interested in advance directives in psychiatry.

DISCUSSION:

The clinical ethics study on the decision to involuntarily hospitalize underlines the constant opposition between the need for care - in the name of a "right to health" - and lack of consent to treatment - to the detriment of respect for individual freedoms, or more specifically of patients' rights in medicine. Meeting the protagonists in the field made it possible to highlight the disparities of professional approaches regarding consent and constraint, thus giving a great importance to culture of service in general, and maybe even to each psychiatric service's culture in particular. Meeting with patients sheds some new light on the issue of respect for autonomy in the context of involuntary hospitalizations. Without denying the possible use of the services rendered by psychiatry and without focusing their discourse on their consent, but by stressing the importance of respect for their integrity, the patients lead us to think beyond "psychic autonomy" or "freedom autonomy", towards an autonomy that will be called here "autonomy-integrity".

Limitations

The timing of the interviews in relation to the time of hospitalization can be discussed. The fact that patients did not openly criticize the procedure of involuntary hospitalization may indicate that they were perhaps lessened by it, or not as free to talk as we could have hoped at the time we interviewed them. We can nevertheless note that we met 2 patients after their hospitalization who had similar speeches as the other patients. Moreover, the patients were able to be scandalized about many other things (they stressed even more the lack of respect for the person). Furthermore, Anglo-Saxon publications show the same results, both at the beginning and at one year of involuntary hospitalization [7,8,14,15].

We are also aware that the populations were different according to the sites in terms of recruitment (home monitoring, emergencies). For example, none of the 10 inclusions for which the patient had no psychiatric history or follow-up took place in the 1st site. No patient was unknown to the teams in the 2nd site, and there was only one in this situation in the 3rd. This suggests that the indications for hospitalization are not the same depending on the sites. For example, on site 2, patients were hospitalized after everything has been tried at home which means they could be considered as more complicated patients.

Regarding the recruitment of relatives, we can ask ourselves if we only met with relatives eager to be heard; still only 2 relatives refused to see us. In 5 cases, it was patients that refused we meet them. In 11 other situations, there were no relatives, or they did not respond.

The law and patient advocacy tools, while necessary, are not enough to restore some autonomy to involuntary hospitalized patients.

Despite the evolution of the law and the introduction of new tools for the defense of patients' rights, the ethical dilemma between the defense of the patient's best medical interest and the respect of his freedoms when he is hospitalized without consent remains. In light of the various functioning of the three inclusion sites in the study, it appears that involuntary hospitalization decisions and those of coercion were mainly related to different cultures and care practices, and not to recommendations of the law. When the emphasis is put on the rapid restoration of the patient's psychic autonomy, the use of medication and coercion is justified by the urgent need for care and is not necessarily questioned; consent becoming secondary. If the emphasis is on respect for human freedoms, considering that it is also the most effective way of doing psychiatry, the therapeutic alliance is put forward, the constraint is most often rejected, and the patient's consent is more easily questioned. These approaches to psychiatry can each have advantages and limitations. Resort to involuntary hospitalization may entail greater risks of less overall respect for the patient's autonomy, being less vigilant regarding his potential competence for other care or his choices in general. Conversely, too much respect for freedom can lead to a loss of medical opportunity. It also appeared in the study that it is not because the law is respected by health professionals that the decision to involuntarily hospitalize is ethical. For example, the signature of the relatives is thought by the doctors (and by the law) as a tool of defense of the rights of the patients, as it is supposed to prevent abusive hospitalization decisions. A doctor told us in this sense: "*The judge will look if we did things by the book, if we did not go too far*". But firstly, while doctors said they favored the opinion of relatives in the decision to involuntarily hospitalize, they could make involuntary hospitalizations without relatives when they thought their opinion was deleterious or useless. Secondly, on the family side, those who told us that it was important for them to sign did so mainly to stay closer to the patient, and not actually to justify involuntary hospitalization. It is then questionable whether the signature of the relatives is a real tool for questioning patient autonomy and therefore better respecting it.

Finally, patients themselves have not shown any particular interest in questioning respect for the right to health versus respect for patients' rights. During this study, they appeared to be relatively unaffected by their rights in general and by the protection of their civil liberties in particular.

Then how to respect autonomy beyond consent to hospitalization?

In the clinical ethics study, neither patients nor professionals expressed an opinion on consent or its various facets, but it could be observed that when consent was cast aside in the decision to hospitalize a patient, patient's autonomy was less likely to be considered at all during the hospitalization. In other words, when consent is not questioned, neither is autonomy in general. It is therefore necessary to think about new ways to respect patient autonomy when informed consent is not respected. The principle of autonomy should be respected more in everything that concerns the rest of hospitalization, and not lead to more practices felt as humiliating by patients. Incidentally, the testimonies of the patients met in the study show the need to respect their integrity. It would be then possible to respect a form of autonomy qualified as "autonomy-integrity". To respect the integrity of a person means to consider her whole, or as an unimpaired human being.

Respect for “autonomy-integrity” as a new way to respect patient autonomy differs from the approaches that aim to broaden the concept of consent for more “vulnerable” people, that is, not necessarily recognized as competent to decide for themselves. Benoit Eyraud and Pierre A. Vidal-Naquet, for example, speak of “intimate” or “uncertain” consent to describe one aspect of consent (relating to self-determination and informed choice) of persons under guardianship, that is to say those whose capacities to consent have been legally disqualified [16]. It leaves room for a consent that would be less precise, or expressed in a less rational way, to better guarantee the dignity of the so-called “incapable” person and to promote her empowerment. Respect for “autonomy-integrity”, however, aims to broaden the concept of autonomy beyond consent.

Respect for “autonomy-integrity” is also not equivalent to adding the principle of integrity to the one of autonomy in the hope of better respecting a person in her entirety. It is for instance the goal of the advocates of the “European principles of bioethics” [17], who felt that the principles of respect for autonomy, beneficence, non-maleficence and justice according to Beauchamp and Childress [11] only valued respect for people's self-determination [18]. The integrity of the patient must, in this perspective, be taken into account as well as his autonomy, dignity and vulnerability so that when the patient is not considered autonomous because he is incapable of giving informed consent to care, this does not preclude the respect of his integrity, namely “the untouchable core, the private sphere of the human being who should not be subjected to outside intervention” [17]. In this perspective, autonomy is still reduced to consent, and respect for integrity is considered as another way than autonomy to respect the person.

Integrity and autonomy have already been linked by E. Pellegrino, who considers respect for autonomy as one way of respecting a person’s integrity [19]. The concept of integrity can overcome the inadequacy of autonomy when it is understood as informed consent, as it also includes respect for a person’s values and history. While respect for a person’s autonomy would refer strictly to respecting her rational choices, respecting her integrity leads to respecting her more widely through her values, referring to a universal feeling of being a separate and consistent entity.

This conception of autonomy is often used in clinical ethics, on a case-by-case basis, when a person’s authenticity and values are questioned in order to better respect her autonomy [20]. In psychiatry like in all medical specialties, this conception can help evaluating the necessity and specifying the quantity and nature of a patient’s long-term follow-up. However, it was observed in our study that once respect for consent has been breached, there is a risk for the principle of respect for autonomy to be forgotten altogether. The patients met in the study did not demand more respect in terms of values. Furthermore, it is possible that respecting a person’s values in this context (even though it is as important as elsewhere to do so), is not sufficient to lead to a respect for integrity of the person as a human being. For example, when a decision is made to put a patient in isolation or to confiscate his personal belongings and have him wear a pajama instead, the concern regarding his values can be overcome by health care professionals’ habits in complex and anxiety-inducing situations.

We choose to speak of integrity and not humanity because it can resonate more clearly in psychiatry: it calls for ways to respect the bodily integrity of the person and being careful not to damage it or to try to rebuild it if it has been harmed even though constraint can be used.

Linking integrity and autonomy aims to get closer to individual autonomy as self-determination even without informed consent for which authenticity may not be sufficient, for instance in the context of hospitalization without consent in psychiatry.

Respect for the autonomy of patients hospitalized without consent further by respecting their "autonomy-integrity".

"Autonomy-integrity" as a new way of respecting a patient's autonomy can also be defined in practice.

Studies on the violation of the integrity of patients hospitalized without consent thus far focus on how to be less maleficent towards patients [21] or how to better respect their consent. Anglo-Saxon studies have, for example, focused on the feelings of involuntary hospitalized patients [7]. Positive aspects are valued by patients: information, co-decision with professionals, compassion, trust, feeling recognized as an individual in its own right. Conversely, patients criticize negative aspects: not being able to decide on their treatment, being forced to respect the rules, the lack of humanity, the devaluation, the feeling of loss of control over their choices. A French survey interviewed psychiatric inpatients by questionnaire, 27% of whom were without consent [6]: the study suggested the patients be informed and take part in the decisions that concern them to reduce their feelings of helplessness, worthlessness and punitive experiences. The findings of these studies generally push caregivers to improve their care practices in the name of non-maleficence and beneficence for patients or to respect patient's consent the best they can.

In the clinical ethics study, various leads have been observed in the different sites we studied on how to respect patients' "autonomy-integrity", meaning how to respect their autonomy in spite of the absence of informed consent. There are many possibilities. Firstly, on an organizational level, approaching respect for autonomy as self-determination can be achieved by: 1) setting up mobile teams of care outside the hospital to better prevent crisis moments and to be able to manage them without resorting to hospitalization if possible; 2) setting up 72-hour treatment units where the pressure on the decision to involuntarily hospitalize is mitigated by the time and resources allocated to crisis management; 3) developing advance directives about involuntary hospitalization; 4) creating "morbidity reviews" in psychiatry in order to question the hospitalization of each patient in retrospect in a systematic way, as it is done in somatic medicine when a serious undesirable event has happened.

Secondly, on an individual level and in terms of human interactions, keeping in mind that discussing with the patient is relevant to better respect his autonomy-integrity can be achieved by 1) debriefings or discussions on daily prohibitions; 2) debriefings or discussions on constraint and forced treatment; 3) increasing opportunities for the patient and the medical staff to interact for the patient to understand that it has been decided without his consent that he had to be involuntarily hospitalized because there was no other option.

Setting up referents outside the service, maybe in the hospital, is another track: the referent could play a role of "surrogate" for the patient.

In the potentially harsh environment that is psychiatry – where many habits are implanted and where people may feel more easily stigmatized than elsewhere – it seems necessary to be more vigilant to consider patients as persons with whom it is possible to discuss the decisions and prohibitions of everyday life, or in other words to respect their "autonomy-integrity".

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