# St Luke's Ethics Essay competition 2013: Essay Topic 2

## Ethical considerations during invasive treatment in Anorexia Nervosa patients

The ethics around treating patients with anorexia nervosa has always brought about much debate. Anorexia nervosa is a mental disorder classified in the DSM IV as a condition characterized by an individual's: refusal to gain/maintain a proper healthy weight, fear of gaining weight, severe distortions of the perception on their own body shape/size.[1] These characteristics generally manifest in their behavior as extreme diet restrictions or binge eating and then purging.[1] This condition is predominately found in late adolescents, particularly in females. Patients suffering from this disorder endanger their lives via their laxative use, extreme exercise, or extreme diet restrictions, which can result in severe malnutrition and dehydration, as well as other complications.[1] However, these patients often show good understanding of the disorder, as well as the risks and benefits of refusing treatment. Yet, they still refuse. This refusal, along with their apparent mental competence, leads to an ethical dilemma for physicians who place a value on patient autonomy. The major ethical considerations in these cases are: whether or not the benefits are significant enough to justify compulsory treatment, a patient's competence and capacity, and setting a boundary as to when treatment refusal is ethically allowable.

The three major ethical principles that govern patient care are beneficence, non-maleficence and autonomy.[2] In this particular case, the suggestion of putting a 15 year old boy with anorexia nervosa, who has been non-compliant with his oral diet, on an

invasive tube feeding regimen is brought up. If the boy's life were in immediate danger, acting upon only the first 2 principles, there would be no debate as to how the boy would be treated. He would be started on nutritional rehabilitation, in this case, tube feeding, with close monitoring to prevent re-feeding syndrome.[3] At the same time, psychosocial interventions would also be initiated to address the mental health issues.[3] However, by acting upon only these two principles without the boy's consent would violate the third principle of autonomy. As a physician, we are required to "Respect the right of a competent patient to accept or reject any medical care recommended".[4] In order to act in accordance to all 3 ethical principles, we must consider the patient's right of informed consent, and their right of refusing treatment after being informed.

In a study by Tan et al. (2003), the researchers elicited opinions from anorexia nervosa patients and parents. Their results showed that patients felt compulsory treatment, such as invasive tube feeding, are only justifiable if the patient was at a significant risk of death.[5] In non-life-threatening cases, parents/patients felt that the benefits from compulsory treatment were not significant enough to justify a violation of a patient's autonomy.[5] Their arguments were that the weight gain in these cases are only short-term, and do not address the psychological components of the disease.[5] In addition, the study showed that although the parents/patients viewed compulsory treatment as often necessary, they still found it traumatic and likened it to imprisonment or punishment.[5]

In this example, there are two factors that play a part in respects to the patient's autonomy. These are: the patient's age, and the patient's competency. In this case, the

boy, who is 15 years old, is legally a minor. In Canada, most provinces have adopted the doctrine of "mature minor". This is where competence to give informed consent is not based on age, but upon the minor's physical, mental and emotional development.[6] Because of the precedence set by these legislations, age no longer becomes an issue. Based on these principles, as long as the patient is deemed competent enough to understand their condition and the consequences of treatment/non-treatment, then their wishes should be followed.

A patient suffering from severe starvation would most definitely lack the mental capacity to make an informed decision.[3] However, as I noted before, patients with anorexia nervosa that aren't right on the verge of death often understand their disorder and the consequences of treatment refusal. Yet they still paradoxically refuse treatment. It is important to note that when judging competence, one should not make the error of judging purely on the irrationality of the decision. We must remember that irrationality is not equivalent to incompetence. To the health care provider, their decision to forgo treatment may seem irrational. However, they may still be competent. Case in point, many feel that Jehovah's Witnesses' are irrational in their refusal of blood products due to their beliefs. However, just because we do not agree with a certain rationalization, in this case-religion, does not make it wrong, or deem that individual incompetent.[7] This makes it extremely difficult to judge competency, especially in an anorexia nervosa patient, who often are still competent at making other decisions not related to their disease.

Thus, instead of competence, the capacity of the patient should be determined. Capacity is concept that is specific to one particular decision. It is the ability to reasonably appreciate the foreseeable consequences of that decision.[8] In this example, the patient here may be competent enough to make decisions about what kind of medications he receives, but incapable in regards to decisions on diet and feeding. Therefore, to fully respect this patient's autonomy, the physician must gauge the boy's capacity in regards to nutritional therapy. There are many tools that can help determine a patient's capacity. One such tool is the "Aid to Capacity Evaluation". This evaluation would judge a patient's ability to: understand the medical problem, treatments/alternatives, understand their option of refusing treatment and why this may be withheld, appreciate the reasonably foreseeable consequences of accepting or refusing treatment, as well as making a decision free of delusion or depression.[8]

Two scenarios can develop from capacity determination. If a physician finds that the boy's capacity in regards to nutritional therapy is lacking, and the boys life is in danger, I believe that a forced tube feeding can be justified, as the patients often have control issues or a distorted perception of their body image, which can be the reason for treatment refusal. However, there are cases where the patient is deemed capable, and their competent refusal of care is informed. It can be argued that patients who suffered from anorexia past the expected normal cycle, have been previously treated and force-fed, and are capable of making informed decisions on their quality of life, are actually capable of making decisions on their nutritional treatment.[7] Additionally, their requests for refusal of care could be viewed as equivalent to palliative care requests from patients with chronic

terminal diseases.[7] Much caution should be taken, as such a decisions should not be made lightly. The physician must be confident that the patient is not deluded by their disease, but rather, feels the burden from the treatment negatively impacts their quality of life, so much so that they are willing to forgo treatment. Only in these limited cases should the patient have full autonomy of their treatment.

In conclusion, when determining the appropriateness of invasive tube feeding in anorexia nervosa patients, physicians should consider: whether or not the patient is critical and if care provided will provide significant long-term benefit, the capacity of the patient, and whether or not the patient could be viewed as palliative. In the case example given, the physician should determine the stability of the patient, and then assess his capacity. If the patient is deemed incapable, or is in critical condition, then invasive treatment is required. However, if the patient is relatively stable and is capable, then the tube feeding should not be done. Instead, the physician should approach patient care from other routes, eliciting the help of occupational therapists, pediatric psychiatrists, dieticians and etc. Anorexia Nervosa is a complex mental disorder that requires a multidisciplinary approach. Oral nutrition and tube feeding are only small components of the treatment, and should not be initiated exclusively without managing the psychological component. In addition, a patient's autonomy should be respected at all times. Through this multidiscipline approach, we can ensure that our treatment and approaches are ethical.

# References:


1. American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders, 4 Edition. Washington, DC.: American Psychiatric Association.

2. Dickey S, Deatrick J. Autonomy and decision making for health promotion in adolescents. Pediatric Nursing Sep/Oct 2000; 26 (5): 461-467.

3. Norrington A, Stanley R, Tremlett M, Birrell G. Medical management of acute severe anorexia nervosa. Arch Dis Child Educ Pract Ed 2012: 97: 48-54.

4. CMA Code of Ethics (Update 2004) [Internet] 2004 [Updated 2011 Mar; cited 2013 Jan 29]. Available from: http://policybase.cma.ca/PolicyPDF/PD04-06.pdf

5. Tan JOA, Hope T, Stewart A, Fitzpatrick R. Control and compulsory treatment in anorexia nervosa: The views of patients and parents. International Journal of Law and Psychiatry 2003; 26: 627–645.

6. Consent for minor patients [Internet] 2011 [cited: 2013 Jan 29]. Available from: http://www.cpsa.ab.ca/Libraries/Res/Consent_for_Minor_Patients.pdf

7. Draper H. Anorexia Nervosa and respecting a refusal of life-prolonging therapy: A limited justification.Bioethics ISSN 0269-9702 Nov 2000; (14): 120-133.

8. Etchels E, Sharpe G, Elliot C, Singer PA. Bioethics for Clinicians: 3. Capacity. CMAJ Sept 15 1996; 155(6): 657-661.