

## Chapter 2

# Enforcing Medical Treatment to Keep a Person Alive: The Problematic Case of Anorexia Nervosa

### 2.1 Introduction

In order to introduce the main problems present in debates over the [mis]use of enforced medical treatment, I will begin my specific analysis of controversial cases involving this issue by focusing on Anorexia Nervosa. The particularly controversial nature of the current way of dealing with Anorexia Nervosa stems from the question of whether or not we should consider anorexics autonomous enough to refuse medical treatment, given that Anorexia Nervosa is generally classified as a mental disorder. In this chapter I will more closely consider this approach, attempting to establish whether or not Anorexia Nervosa can be classified as a mental illness. Further, that being the case, I will ask to what extent this aspect can undermine the patient's competence when reaching decisions over the acceptance or refusal of naso-gastric treatment. Before moving into the philosophical sphere of the discussion, however, a more accurate examination must be carried out of how and in which ways this epidemic condition affects its sufferers.

### 2.2 Anorexia Nervosa: An Insight to a Contemporary Drama

In his book *Psychopolitics*, Peter Sedgwick<sup>1</sup> relates his dismay when, as a young, left-wing “active partisan” he discovered that from a leftist point of view issues related to mental illness were virtually non-existent, as it was the fashion

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<sup>1</sup>Sedgwick (1982), p. 4.

of the time to deny the very fact that people do suffer from various mental disorders.<sup>2</sup>

Similarly, I have come to observe an inconsistency in the application of the principle of autonomy and respect for individual choice in cases of refusal of treatment in Anorexia Nervosa as well as in other mental disorders. By inconsistency, I mean the irregularity of the implementation of the principle of autonomy. This inconsistency in applying the same notion to relatively similar cases in extremely different ways is frequently evident in liberal societies such as the UK, the US and—to a certain extent—Italy, where individual choice and autonomous decision are vehemently defended under “normal circumstances”. I think it is time for us to make the same mature step and understand an inconvenient truth about the processes currently at work in cases of refusal of treatment. But first we need better to understand what Anorexia Nervosa is.

Anorexia Nervosa is a specific version of those recently emergent illnesses,<sup>3</sup> namely Eating Disorders, that have increasingly come to affect Western and Westernised countries. In the past 30 years all kinds of Eating Disorders have seen sufficient incremental growth as to suggest a need for urgent attention to this problem. Without wanting to underplay the importance of problems such as Obesity, Binge Eating and Bulimia Nervosa,<sup>4</sup> this work will focus on Anorexia Nervosa alone.

Before describing the symptoms of Anorexia Nervosa in more scientific terms, it is important to underline one aspect of this condition that might easily go unnoticed and thus reduce the quality of the current analysis. By acknowledging the rise of Eating Disorders, and more specifically Anorexia Nervosa, in Western contexts, we immediately begin to prepare the ground for a linear critique of the illness not in medical terms but rather in socio-historical ones. A valuable contribution to this analysis can be achieved by reference to Daniel Callahan’s *False Hopes*,<sup>5</sup> which details the undeniable truth that the Hippocratic Oath is in fact applied differently in similar cases. As Callahan explains, medicine cannot be considered to be value-free: its applications, priorities and taboos are deeply embedded in the governing power.<sup>6</sup>

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<sup>2</sup>Certainly the Anti-psychiatric movement led by Thomas Szasz was very much in line with this idea, even though the bottom line was perhaps not to deny entirely the existence of some kind of dysfunction in the mind of certain people, the core revolution that the movement wanted to provoke was to stress the “mechanical” aspect of brain malfunction; i.e. it was curable with appropriate medicines rather than through the reassessment of the values of the individual.

<sup>3</sup>A definitive assessment of when Eating Disorders emerged is not the remit of this work, and for reasons of simplicity I will accept the standard date of the 17th Century as the beginning of these kind illnesses. To understand the impact of such illnesses see: Kelly et al. (2009), pp. 97–103.

<sup>4</sup>Not everyone agrees that Obesity is an Eating Disorder, but for a closer look at the current debate over this and other aspects of Eating Disorders see, amongst others: Fairburn and Brownell (2002); Palmer (2003), pp. 1–10.

<sup>5</sup>Callahan (1998).

<sup>6</sup>Di Paola and Garasic (2013), pp. 59–81.

Hence we should consider his critique towards Western medicine, which he finds to be too aggressive and too dependant upon the demands of a capitalist market that wants to solve its problems through the exacerbation of the conflicts of principles that it was responsible for in the first instance.<sup>7</sup>

Capitalism needs autonomous agents to be “free” to make their decisions, particularly regarding what to buy and consume. So too do certain medical professionals. In line with the idea that the market decides provision, we have ended up with surgeons suggesting morally dubious aesthetic operations. However, as long as we can say that the autonomous, competent citizen should be allowed to choose freely amongst the available options, little can be done to prevent or even to dilute this profit-based understanding of medicine.<sup>8</sup>

What creates problems with the possibility of revising such an attitude is that it constitutes a pillar of most societies that have attained a certain level of development; any such internally directed critique could spread to other areas of the same system, ultimately threatening to destabilise the very foundations of the consumerist society in which we live and in which the cases considered were able to take place.

The need for autonomy to be so prominent in bioethical contexts results from its political value. Once the role of autonomy as the leading principle in bioethics is understood—an understanding to which this work aims to contribute—we will be able to embrace a new vision of autonomy that will help us to deal with relatively similar cases in the most appropriate manner without resorting to a patently biased interpretation of this notion. For the time being, suffice it to say that, given the internal readjustment that Western society has undergone in recent times—giving rise to greater self-criticism with regard to past actions and inactions—the analysis of Anorexia Nervosa (and other Eating Disorders) began from a contested position, making it impossible from the outset to claim objectivity for any “scientific” analysis.

### **2.3 The Conceptualization of Anorexia Nervosa by Medicine, the Law and the Sufferers**

Despite being the psychiatric illness with the highest mortality rates,<sup>9</sup> Anorexia Nervosa remains paradoxically the one condition that has managed to produce the least effective countermeasures to its impact. One of the main reasons for this peculiar situation lies in the crucial factor that makes Anorexia Nervosa unique: the vast majority of anorexics do not commit themselves to escape the illness. On the

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<sup>7</sup>Whether intentionally or not, it seems that a common critique of extreme consumerism is shared by Daniel Callahan and Michel Foucault. For reason of spaces the present investigation will not develop this connection any further, but for the purposes of this work, it will suffice to underline the role that consumerism has in medicine in contemporary Western society.

<sup>8</sup>This is particularly true in the US, while not so evident in Europe—especially in Northern European countries such as Norway for example.

<sup>9</sup>Ramsay et al. (1999), pp. 147–153; Franko et al. (2004), pp. 99–103.

contrary, their embracing of the condition as a vital part of their identity results in an additional layer of ethical dilemmas that all those concerned with Anorexia Nervosa have to face. As highlighted in one study carried out by Jacinta Tan, Tony Hope and Anne Stewart: “the decision to accept treatment can become heavily loaded with the implication of giving up a part of themselves, which can affect their decision.”<sup>10</sup>

From an historical perspective, the term Anorexia Nervosa—the most common way of referring to this condition both in English and in the international debate—was first introduced in 1873. Even though it remains unclear who first coined this term,<sup>11</sup> it is widely accepted that Charles Lasègue did carry out numerous studies on this Eating Disorder, defining it most commonly as “anorexie hystérique”<sup>12</sup> (hysterical anorexia) with all the sexist implications that such a definition entails. It is perhaps also for this reason that Mara Selvini Palazzoli would prefer the term “anoressia mentale”<sup>13</sup> (mental anorexia), because, on top of avoiding scientific confusion, it would also detach Anorexia Nervosa from a common inclination to link the illness only to women. We can see quite easily that this reading is erroneous as in the last decade the percentage of males affected by Anorexia Nervosa in Western countries has increased to 8 % of the overall cases,<sup>14</sup> a figure which continues to rise.<sup>15</sup> All of the definitions listed above, however, have as their key word anorexia—etymologically meaning “lack of appetite”—which also constitutes the most common popular and media referent. However, as Simona Giordano points out, the illness does not express itself through the absence of appetite in the sufferer: the individual does have the “normal” input of feeling hungry—the presence of appetite—but she will force herself to resist it as proof of her self-discipline. She will become obsessed with food and, at the same time, with exercising her capability to resist the temptation of eating.

In this light, it should not come as a surprise to the reader that, in the vast majority of cases, the sufferer represents the prototype of a “successful individual”. She would be first in class, a hard worker, striving for perfection. This “psychological identikit” is obviously limited, and it does not pretend to achieve the unachievable by defining in scientific terms the average anorexic profile. However, I believe that it is important to highlight certain common characteristics of sufferers—also in broad non-medical terms—to include a wider group of people in the analysis in which this work intends to engage.

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<sup>10</sup>Tan et al. (2003), p. 546.

<sup>11</sup>Simona Giordano suggests in her book that this might instead have been William Gull. Giordano, *Op.Cit.*, p.18.

<sup>12</sup>Lasègue et al. (1873), pp. 265–266 and 367–369.

<sup>13</sup>Selvini Palazzoli (1998).

<sup>14</sup>Fichter and Krenn (2003), p. 369–383.

<sup>15</sup>For example, in their report “*Treatment Decision-Making in Anorexia Nervosa*”, Jacinta Tan, Anne Stewart and Tony Hope reported an increase in the figure of male anorexics to 10 %. (p. 3) available at : <http://www.psychiatricethics.org.uk/ANwebreport/report.pdf> [accessed on 4 January 2015].

I am well aware that the present exploration of the clinical dimension will necessarily prove severely limited but, both for lack of space and of professional competence, this work cannot investigate the medical dimension of mental illnesses—Anorexia Nervosa more specifically—in great depth. I am confident, however, that many interesting and valuable works have been produced in recent years that allow a particularly interested reader to expand their knowledge on the topic.<sup>16</sup>

In the most recent version of the International Classification of Diseases (ICD) produced by the WHO, Anorexia Nervosa can be found under “*mental and behavioural disorders*” (Chap. 5), and more specifically within the section covering behavioural syndromes associated with psychological disturbances and physical factors. The definition as presented reads:

A disorder characterized by deliberate weight loss, induced and sustained by the patient. It occurs most commonly in adolescent girls and young women, adolescent boys and young men may also be affected, as may children approaching puberty and older women up to the menopause. The disorder is associated with a specific psychopathology whereby a dread of fatness and flabbiness of body contour persists as an intrusive *overvalued* idea, and the patients impose a low weight threshold on themselves. There is usually undernutrition of varying severity with secondary endocrine and metabolic changes and disturbances of bodily function. The symptoms include restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics.<sup>17</sup>

Even though the clinical criteria highlighted by the ICD have a measure of undeniable scientific accuracy—insomuch as is possible in medicine—it would be to offend the reader’s intellectual ability not to acknowledge that in this description there are present numerous value judgements that I opt not to emphasise. I am certainly not claiming that the idea of thinness in anorexia is not *overvalued* by those individuals suffering from it, but it is unclear where we should draw the line between a noxious attitude towards life and a situation in which we can begin to speak of mental illness. For example, tobacco and alcohol abuse also figure within the “mental and behavioural disorders due to psychoactive substance use” section of Chap. 5, but there is no mention of the value that these substances are guaranteed in terms of socio-cultural acceptability and common usage. In other words, an alcoholic is presented in this description as a sane person who becomes sporadically “insane” due to the use of alcohol, or in more technical terms, he enters a phase of chronic alcoholism, but there is no direct attack on the value of alcohol itself. As a result, while on the one hand the value of thinness (strongly present in our society, tolerated and encouraged most of the time) is deemed to be “overvalued”, on the other hand the same does not occur with the value of more damaging phenomena such as drunkenness and/or alcoholism. The reason behind such a discrepancy in relatively similar cases has to do with the fact that alcohol remains central to so many cultures and countries around the world that a full-scale attack on it would be too destabilising to a number of other institutional certainties that authorities do not

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<sup>16</sup>See amongst others: Kaplan and Woodside (1987), pp. 645–653, Carney et al. (2008), pp. 199–206, Tureka et al. (2000), pp. 1806–1810.

<sup>17</sup>WHO (2015a). My emphasis.

want to see called into question. This statement should not come as a surprise to the reader as it has already been affirmed that the intention of this book is to reveal that such inconsistent dynamics are particularly strong in cases concerning the application of the notion of autonomy. It follows that, differently from widespread diseases such as alcoholism, Anorexia Nervosa can be expressly attacked because it affects a relatively low number of people and, most importantly, any attempt to save the lives of its sufferers does not jar with modern values. It is important to notice, however, that even accepting this reading as valid a clash would still exist. That would be the inconsistent use of terminology, serving to preserve that stability that authorities desire but that has to do with power rather than with the real nature of the illness.

In this light, two aspects of the WHO's account of Anorexia Nervosa deserve attention. The first point I want to raise is a provocative one. It is interesting to underline that, following a logic of exclusion often used in schematic and relatively scientific methods, there exist grounds to affirm that, when moving from the more general group of disorders towards the more specific one, the "mental dimension" of the disorder has been cast aside to leave the focus on the "behavioural dimension". Of course, this should be seen as a clinical categorisation of mental illnesses that aims to describe the disorder, hence behaviour—intended in the broadest sense—emerges as the main feature of Anorexia Nervosa.

However, the same logic could well prove the opposite: the definition has to focus on—and negatively emphasise—the anorexic [mis]behaviour in order to legitimise its reading of this very particular mental state as a mental disorder. Obviously, though, the fact that society does not consider a certain behaviour as rational, or even virtuous, does not function as a justification for classifying that particular state of mind as a threat to an individual's competence and autonomy. Otherwise, by parity of reasoning we should also stop drinkers and smokers from continuing in their "behavioural disturbances"! The overall perception evident in this description raises additional questions regarding the current situation which find their echo in other unconvincing contributions, leading to a more technical second point.

When reading more carefully the ICD's section on Anorexia Nervosa, there is a peculiarity not immediately evident on first reading: the definition does not apply to all cases of Anorexia Nervosa. In the very beginning of section F50 (concerning Eating Disorders) there is a list of which variants of these disorders are excluded, within which figures Anorexia NOS.<sup>18</sup> NOS stands for Not Otherwise Specified and is normally used for more general Eating Disorders,<sup>19</sup> a puzzling definition when considered alongside Anorexia. More precisely, if there are insufficient grounds to state with relative certainty that the disorder fits the definition of Anorexia Nervosa, how can it be then approximated to Anorexia NOS?

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<sup>18</sup>WHO, *International Classification of Diseases (ICD)*, *ibid.*

<sup>19</sup>See, amongst others: Fairburn and Harrison (2003), pp. 407–416; *Eating Disorders: Anorexia, Bulimia & Eating Disorder NOS* (2015).

The answer to this question comes also from the WHO's ICD schema, which in its subsequent blocks on "disorders of adult personality and behaviour", provides some material valuable to the sceptical reading developed here:

This block includes a variety of conditions and behaviour patterns of clinical significance which tend to be persistent and appear to be the expression of the individual's characteristics. [...] They represent extreme or significant *deviations* from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others.<sup>20</sup>

It seems sufficiently clear that here the superiority of the authorities in charge—in contradiction of the [mis]judgement of the individual— is not explicitly affirmed. It follows therefore that there is a reluctance to state clearly that certain choices are not the expression of the individual, but rather that they appear to be so. This ambiguity contributes to the undermining of the respect for the clinical data analysed and supports the aim of this work in demanding a more coherent and credible way of dealing with controversial cases that revolve around the issue of autonomy.

In relation to this unconvincing use of psychiatry to justify enforced treatment—but more generally to legitimise its own authority— in her influential book *Understanding Eating Disorders*, Simona Giordano has a very interesting section in her book that examines what she calls "the Fallacy of Psychiatric' Explanations"; this notion deserves to be considered in greater depth. Interestingly enough, the focus of her discussion is schizophrenia, the very same mental illness that will be considered in the next chapter's exploration of the Singleton case. Giordano's argument is both very simple and also very strong: in its explanation of the symptoms and effects of a mental illness psychiatry often uses an approach that fails to be logically acceptable. The logical error comes from the tautological justification given in contexts where instead the authorities involved should have the courage to accept—and publicly admit— their limits. Giordano's scheme (Fig. 2.1) allows us to understand the logical fallacy applied to Eating Disorders.

Giordano's interesting conclusion in this section of her important work, points out that, if we accept and establish that—in the vast majority of cases—<sup>21</sup> psychiatry can only give a descriptive picture of the mental illness, it follows that such mental disorders (including of course Anorexia Nervosa) do not compromise the autonomy of the person in question.

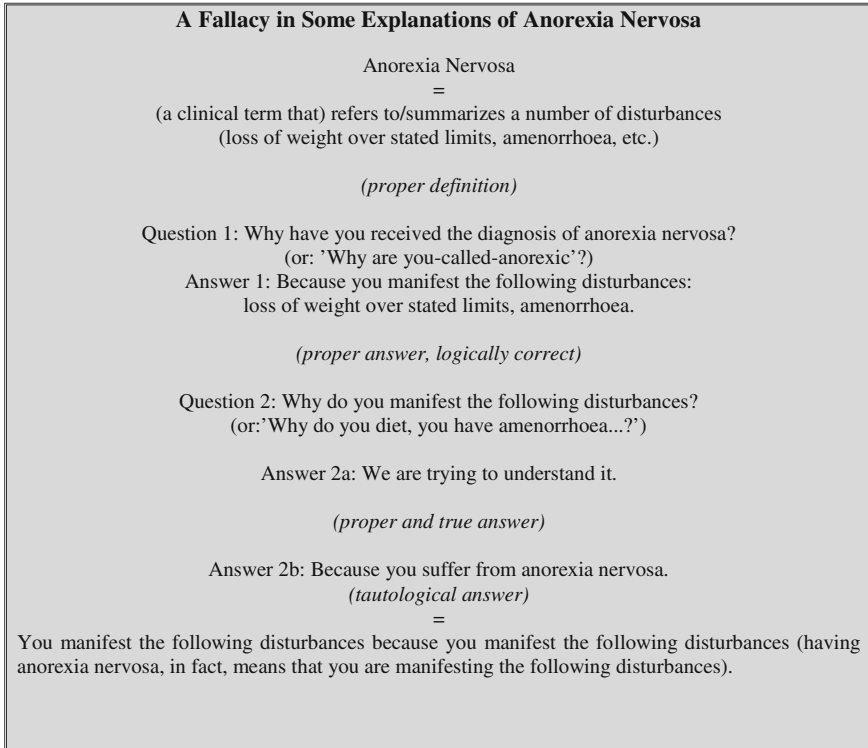
As she writes:

In the majority of cases when it is said that a person has a mental illness, what is meant is that she manifests some disturbances. In most cases the psychiatric diagnosis is only a short cut to describe a pattern of disturbances: it has no explanatory value. In all cases in which the diagnosis merely has a descriptive value (and this is the majority) it is simply not true that 'mental illness' jeopardizes people's autonomy. Mental illness is a 'description of events', and as such it does not and cannot jeopardize 'autonomy'.<sup>22</sup>

<sup>20</sup>WHO, International Classification of Diseases (ICD), Op. Cit. My emphasis.

<sup>21</sup>Giordano (2005), pp. 68–69.

<sup>22</sup>Giordano, S., Op.Cit., p.70.



**Fig. 2.1** A Fallacy in Some Explanations of Anorexia Nervosa

Given the sceptical nature of this consideration, in the next section we will focus more closely on the definition of mental illness. We will then apply it to Anorexia Nervosa in order to criticise the justifications used to define Anorexia Nervosa as a mental illness, implying also a consideration of the consequences of this general consensus.

## **2.4 The Tension Between Competence and Mental Illness in Anorexics**

Although not directly defining mental illness, the WHO constitution describes a person as in good mental health not only because of the mere absence of mental disorder. As an extension of this approach, the WHO website reads:

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to

make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.<sup>23</sup>

By the vocabulary used, it seems evident that the definition above points out two implicit aspects of mental illness (the absence of mental health). First, the capability to produce (a central notion in a capitalist society) is a crucial factor in establishing whether or not a person can be considered sane. Second, the actions of the individual must also be functional to the community. These variables, however, appear to be more political than medical.

Continuing with this deconstructive approach, and being provocative for the sake of the argument, one could even attempt to defend the idea that Anorexia Nervosa needs to be seen as a mental illness in order to avoid uncomfortable situations of biased judgements over relatively similar cases. After all, as Giordano rightly points out:

The person with an eating disorder is far removed from the common idea of the ‘insane’ and may be a skilled and competent person in virtually all areas of her life. [...] If people are normally entitled to choose their lifestyle, however dangerous or irrational it may appear to others, why should not people be able to choose what and how they want to eat?<sup>24</sup>

Even more so, the fact of having Anorexia Nervosa outside of the standard ways of classifying a mental illness can surely be argued to be convenient for a certain project. In fact, having Anorexia Nervosa as non-classifiable “normal” case of refusal of treatment could be seen as a very useful way out for the judicial system in situations where the role of mental illness, competence and autonomy can be used in inconsistent ways to favour the prevailing political trends.

Without wanting to enter into a deep technical debate on the definition of mental illness, I will now aim at highlighting the main implications for decisional processes of suffering from such an illness. In other words, I will take Anorexia Nervosa to be a mental illness, but I will question the meaning of precisely this definition.

The key aspect of this consideration will be to establish whether or not a mentally ill patient can still be deemed competent. In this respect we should consider the view of Thomas Szasz,<sup>25</sup> amongst others. According to this view, if we were to consider mental illness an actual illness, it would be one of the brain, not of the mind. With such an approach towards cases of Anorexia Nervosa, for instance, it should become clear that once the incapability of the doctors to improve the situation, or more simply to cure the illness, is accepted, the decisional power should return to the competent patient. This idea will be analysed in greater depth in the next section of this chapter, but, before taking that path, we shall consider an additional aspect relevant to a full understanding of Anorexia Nervosa. In relation to the evaluation of Anorexia Nervosa as a pathology particularly linked to female characteristics, we must understand these as gender-specific limits shaped by historical injustices. Helen

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<sup>23</sup>WHO (2015b).

<sup>24</sup>Giordano, S., *Op.Cit.*, pp. 30–31.

<sup>25</sup>Szasz (1972).

Malson's very interesting work, *The Thin Woman*, provides an analysis of the "genealogy of anorexia", pointing out that, despite recent improvements in the relationship between genders that have given more respect to women, there is still an acceptance of the intrinsically masculine concept of "healthiness".<sup>26</sup>

Such an acknowledgement is certainly worthy of attention, but, despite supporting Malson's application of Foucault to the current analysis of Anorexia Nervosa—and the resultant belief that to understand it fully we cannot limit ourselves only to the result of a historic-medical discourse- I believe that certain characteristics of Anorexia Nervosa are objective realities that signify illness regardless of their links to a specific gender. As proof of its "intergenderness" it would be worthwhile to consider once again that in recent years the number of males affected by Anorexia Nervosa has drastically increased and can sometimes even produce more problems related to the specific biological structure of male sufferers.<sup>27</sup>

This recognition leaves us with two considerations to take into account: the first is that, if we had to accept the conservative male-centred view of Anorexia Nervosa, this would be perhaps a good occasion to understand that if the illness is "transmittable" between genders, the problem lies in the external factors that produce the precondition for Anorexia Nervosa to develop (obsession with body image, need to prove one's will power). This accepted, the conservative view would be knocked off its chauvinist pedestal. The second consideration that deserves attention is that, as for Szasz, the mere awareness of the fact that something was abused in the course of history in order to prolong the continuation of an injustice is not sufficient reason to refute the scientific validity of those data that we currently have. As a matter of fact, Szasz himself did not claim that psychiatry does not exist, but only that we should reshape its use.<sup>28</sup>

We have already explained in the previous chapter the definition of competence vis-à-vis the notion of autonomy and its legal and medical status. Here, we will look at this definition in closer relation to Anorexia Nervosa. To evaluate the impact of Anorexia Nervosa on the competence of those refusing naso-gastric treatment, it has been accepted that Anorexia Nervosa is a mental illness. In arriving at this acceptance, however, the question that we have raised focused on affirming that even given such a scenario there is no clear evidence that the incapability to judge competently in decisions related to food would necessarily jeopardise the competence of the anorexic in any given context.

As we have seen above, it is not entirely clear whether or not the anorexic sufferer can be claimed to be incompetent in every context. In truth, it appears well accepted that they are indeed competent in most cases. They are perhaps incompetent when it comes to food, but not when asked about their quality of life. This is

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<sup>26</sup>Malson (1998), pp. 47–48.

<sup>27</sup>In this respect it is interesting to note the different reaction that females and males have towards involuntary treatment. A good example of this distinction is Silber et al. (2004), pp. 415–418.

<sup>28</sup>Szasz, T., *The Myth of Mental Illness*, Op. Cit.

clearly the main problem to deal with: if they are competent, can we still override their will and force-feed them?

Some positions would argue that there are cases, even if very small in number, where such refusals should be heeded, and the reason for such an affirmation is that in these given instances the patients would be in a position to make a competent decision. One very common position would then argue that patients suffering from Anorexia Nervosa are not capable of making any competent decisions regarding feeding or, more generally, any issue relating to food. These views accept this position but highlight that in cases of naso-gastric treatment concerning “experienced” and relatively “stable” patients (persons that have already been through such therapy and that are in no immediate danger of death) the issue to consider relates not to food but rather to concerns over quality of life. These patients would be able to make competent decisions, because these decisions would not be related in any direct way to food. Critiques of this point are based on the further development that affirms that if we recognise anorexics as competent, we should be ready to affirm their autonomy as well. Such critiques and their counterarguments shall be addressed through the analysis of the key concepts of competence and autonomy. As Heather Draper suggests in her paper:

What needs to be established, and what is very difficult to establish in the case of anorexia nervosa, is whether the person with anorexia nervosa is an autonomous agent who is incompetent to make some judgements, or a non-autonomous agent who is competent to make some judgements.<sup>29</sup>

Yet, it is important to take into account another crucial factor: in the cases considered, doctors are not expecting the situation to improve, their intention is only to postpone death insomuch as possible. Under these conditions, however, it seems obvious that the moving principle behind the decision not to interrupt a treatment or switch off a vital machine has to do with the moral view of the doctor on the matter. But should it be so? Should the will of the patient not be respected if the actual consequences of the most extreme decision would only result in the acceleration of a process otherwise incredibly painful? After all, the Anglo-American norm in medical contexts it is to accept the decision of the competent patient as decisive, including when their decision would result in death.

## 2.5 Are We to Enforce Medical Treatment in Cases of Anorexia Nervosa?

The recent 2012 ruling in the UK where it was affirmed that an anorexic woman should have been force-fed against her will<sup>30</sup> has revived the debate over the permissibility of such procedure in cases of Anorexia Nervosa. As a moral

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<sup>29</sup>Draper (2003), p. 4.

<sup>30</sup>Dyer (2012), p. e4232.

justification for refraining from artificially feeding a patient suffering from Anorexia Nervosa, it could be argued that it would be a practical form of the doctrine of double effect. In fact, this interesting argument is pursued by Fiona Randall and Robin Downie in their book *Palliative Care Ethics*:

the doctrine of double effect which relies on a moral distinction between intended and foreseen events allows the use of measures to relieve suffering even though they carry a significant risk of shortening life.<sup>31</sup>

I shall argue that adapting this approach to the interruption of naso-gastric treatment would produce the effect of defending this option as functional to the reduction of the patient's suffering with the unintended result of letting the self-same patient die. For the sake of the argument, it might be claimed that from a utilitarian point of view it could even be justifiable to force treatment on anorexic patients because their internal suffering would still produce less "moral" damage to the consciences of the persons around them (family, friends, and doctors) than would their death. This approach, however, would deny the centrality of ensuring that the patient's autonomous decisional power be defended in all cases where the patient's competence has been established.

In fact, I want to suggest that one of the justifications for the disparity of strictness in accepting the will of the patient as morally permissible and based on competence may well be linked to the possible consequences of denying such freedom to translate choices into actions. The reason is self-evident: while in the case of terminally ill patients the hope for recovery has completely disappeared and nothing will prevent the patient from dying, in the case of Anorexia Nervosa the hope may always exist, including for the patient herself. To not accept any refusal is often seen as a way of gaining time in which the patient might "come to her senses" and move away from a condition of extreme Anorexia Nervosa towards a less extreme stage of the illness at least. However, it is through the acceptance of such a strategy (that may often be rooted in noble intentions) that I hope to have highlighted what does not satisfy me about the present discrepancy between different types of treatment refusal, all of which would eventually result in death. For the situation just considered would imply a level of paternalism on the part of the doctors that we claim to be unjustified when the patient has the capability to make a competent decision. In other words, if the patient is found to be competent, we must allow her to pursue her destiny despite our concerns over the "chances of success" were any refusal of treatment to be accepted. We should be ready, as Giordano says, to make the "brave claim".<sup>32</sup> Admittedly, this is not a decision to be made light-heartedly and for this reason in the next section of this chapter we will shift our attention on to the unique complexity of the problems surrounding Anorexia Nervosa.

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<sup>31</sup>Randall (1999), p. 127.

<sup>32</sup>Giordano, S., *Op.Cit.*, pp. 246–250.

## 2.6 The Biopolitical Reasoning for Keeping Anorexics Alive

The deep-rooted dilemma in Anorexia Nervosa is that it is a very peculiar condition which, in developing as early as the age of twelve (this figure falls each year as the pressure on youngsters grows), makes it extremely difficult to ascertain precisely when the patient has recovered from the mental illness, because in most cases the mental illness itself has evolved as part of their own personality and way of being. We could say that in some ways abruptly breaking this link with a part of their selves could prove seriously destabilising, a point that should probably be given greater consideration than is usually the case. A metaphorical representation of what it means to develop Anorexia Nervosa might be the science-fiction-type situation where some children grow up with tinted glasses fixed to their eyes. In time, their particular way of seeing the world (through green-tinted lenses, say) will become their only accessible and conceivable reality. With this simple yet hopefully valuable scheme in mind, two considerations arise in relation to Anorexia Nervosa.

The first consideration concerns the potential damage done by removing the sunglasses too abruptly from the eyes of the patient. As the reader might know from personal experience, such an action is always followed by a moment of temporary blindness. In the imaginary scenario portrayed above, the situation entails an exponential increase both of the time of exposure to the sun and the time in which the eyes adapt to seeing the world through green filters. As a result, it should be easily understandable that a precipitous choice—aiming to show the true colours of the world to the patient through sudden removal of the “anorexic sunglasses”—might result in a more damage than benefit, at least in the short term.

The second aspect to consider—and the one more closely linked to the purposes of this work—relates to the value that we assign to the role of the green-filtered sunglasses when establishing the level of competence of the individual in question. More specifically, crucial is the certainty with which we can affirm that this distortion of reality impairs the person’s ability to analyse competently important features other than colour; to deny respect for general competence on the grounds of possible incompetence in a certain domain would hardly be justifiable. Continuing with our metaphor, then, we could say that, on the one hand, it would be reasonable to accept that in the condition described it would be unrealistic to expect the person with sunglasses to be able to distinguish between two objectively distinct shirts (one green and one white) that to her green-filtered eyes will result undistinguishable.

On the other hand, however, would it not be unreasonable to claim instead that due to her sunglasses, if put in the condition of having to do so, the person in question would not at least try to dodge a (grey) stone thrown at her? Instinctively, no one would deny that the absence of competence in regard to the (partial) colour-blindness of the person would not still represent a sufficient impediment substantially undermining the self-preservative nature of the individual who will do anything in her power to avoid the potential pain caused by the stone. Though simplistic, this example could well function as a launch pad to enter into a more

sophisticated discussion of this peculiar—and controversial—aspect of Anorexia Nervosa: the shaky ground on which rests the assessment of partial incompetence.

To avoid a serious confrontation on this topic, with all its potential consequences in the biopolitical sphere, many proposals have been touted. For example, the possibility of using nocturnal naso-gastric treatment<sup>33</sup> is significant and worthy of particular attention as it attempts to reduce the clash between the medical obligation to treatment and the explicit overriding of the patient's will. But while it might succeed in making this contrast less violent, it still fails to provide a satisfactory solution.

We might feel entitled to feed the patient while she is asleep without asking her permission, perhaps without even informing her of the treatment in order to avoid problems related to standard naso-gastric treatment. To do so, however, would entail the sidelining of the question of whether or not the patient is competent or not, the patient being left bereft of any possibility to decide how to deal with her situation. As such—aside from the purely technical aspects—the nocturnal naso-gastric treatment does not differ in any significant way from a standard paternalistic approach that would naturally presume the incompetence of the anorexic patient.<sup>34</sup>

The brief analysis produced in this chapter will lead us back to the initial question that haunts those attempting to find an acceptable solution to the ethico-legal problems associated with Anorexia Nervosa: what should authorities do when faced with such cases? How should we, as a society, behave in such an ambiguous situation? Where to draw the line of respect for freedom of choice and for life?

In her article 'Anorexia: a Role for Law in Therapy?'<sup>35</sup> Terry Carney focused on a very practical way of dealing with the issue, namely ensuring that law would guarantee the preservation of life in so much as possible. She writes:

It (is) hard to reject a role for law in the authorisation of the use of coercion in some form in the case of emergency or life-saving interventions for severe anorexia nervosa. But [...] it is equally difficult not to accept that a guardianship-type order/jurisdiction<sup>36</sup> has a legitimate role as well, and indeed should serve as the preferred initial measure when legal intervention is required.<sup>37</sup>

Thus, despite having an intuitive leaning towards the preservation of life as the ultimate duty, the law should first respect its own limits, and accept that at this stage in the majority of Anglo-American legal systems the principle of autonomy resists any attempt to be diluted.

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<sup>33</sup>See footnote 27 above and Robb et al. (2002), pp. 1347–1353.

<sup>34</sup>Halse et al. (2005), pp. 264–272.

<sup>35</sup>Carney (2009), pp. 41–59.

<sup>36</sup>Here Carney refers to a specific term used in Australian contexts in relation to a third person (a guardian/tutor) deciding on behalf of the patient in question. Obviously, if the anorexic is found to be competent enough to make a decision, the guardianship remains with her.

<sup>37</sup>Carney, T., *Op.Cit.*, pp. 41–59.

This awareness, combined with the commonsense intuition that it would be morally wrong to allow the loss of life of certain anorexics (many of whom will later prove grateful for having received enforced treatment) for the sake of respecting this self-imposed predominance of autonomy, should lead us to ask if this system based on an individualistic version of autonomy is indeed as suitable as we currently believe it to be.

## 2.7 Conclusion

In the course of this second chapter we have moved the analysis of the notion of autonomy in bioethical cases from a more theoretical discussion towards a more empirical, fact-based approach. More specifically, our focus has turned to controversial cases of enforced naso-gastric treatment in Anorexia Nervosa, developing further—and in greater contextual depth—the concepts of competence, autonomy and mental illness relevant to all of the cases considered in this work. Through an investigation that has brought to the fore the medical peculiarity of Eating Disorders—and more specifically Anorexia Nervosa—when evaluated in terms of autonomy and competence, it has been pointed out that patients suffering from Anorexia Nervosa cannot be so easily separated from their illness as can those undergoing most other medical procedures. As shown with the arguments sustained and convincingly articulated by Giordano, we have shifted the debate over the legitimacy of enforced treatment in Anorexia Nervosa into a field that questioned more vigorously the limits that authority can (or should) have in relation to the values of individual. In doing so, we have reinforced the conviction that, while Anorexia Nervosa might not jeopardise the level of the patient's competence to such an extent that enforced treatment can take place under current legal and moral standards, the unacceptability of the refusal of treatment in Anorexia Nervosa is related to the impact that such an acknowledgement would have on wider societal values. By referring extensively to previous researches and perspectives, it was not the intention of this chapter to be particularly original in its content. Rather, its function was to introduce the reader to the multilayered problems related to enforced medical treatment through an in-depth analysis of cases of Anorexia Nervosa—as they represent a unique example of the tension between respect for patient's autonomy (especially if assessed to be competent in all but one field), medical concerns and political choices. The way in which these three aspects interact in different cases is the central theme of the book and Anorexia Nervosa represented the best way to highlight the limits of the conflicts that patients, doctors and political authorities need to face when dealing with any kind of enforced medical treatment. The inconsistent use of autonomy as a function of its political context will be further analysed in the next chapter.

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