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The role of broad and narrow definitions of capacity in treating anorexic patients

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Summary

Anorexia nervosa is a dangerous and difficult-to-treat illness, but the most common problems may result from the lack of a clear distinction between competence and incompetence. There are a lot of studies which, on the one hand, suggest compulsory treatment of eating disorders; but on the other they underline the difference between "resistance" and "refusal" in the context of anorexia nervosa treatment. According to more flexible authors, anorexia nervosa is not included in the category of illnesses with psychotic symptoms and can't be treated under compulsory order, but when a person is in grave danger of dying it seems to be useful to treat such patients without consent. The main aim of the article is to present state of art literature about compulsory treatment, especially that concerning ethics and efficacy of such treatment. Additionally, the article presents modern attitudes to anorexic patients' treatment such as a new – narrow definition of capacity and a guardianship resolution.

K*ey words*: anorexia nervosa, compulsory treatment/compulsory order, incompetence/incapacity

Introduction

According to many authors, treatment programs for anorexia nervosa generally combine nutritional therapy (which involves refeeding to reverse the biological consequences of starvation) with pharmacotherapy and psychotherapy aimed at understanding the underlying sources of the problem. Unfortunately, clinical efforts to treat anorexia nervosa are constantly rejected by patients. Even in the face of impending death, they seemingly block all attempts to help them. Such behaviour may manifest itself in several ways, among which such tactics as refusal to eat the medically prescribed quantity of food, intensive exercises, removal of nasogastric tubes or consumption of laxatives or emetics (in an attempt to counter the effects of nutrition) are not rare. Such behaviour contributes to the common perception that patients with anorexia nervosa are difficult [1, 2, 3]. According to Harris and others [4], eating disorders seem to have earned the reputation for difficult if not impossible to treat among the general public as well as the medical and psychiatric communities. The validity of this opinion is most apparent when applied to anorexia nervosa which is described as a refractory illness.

But it must be underlined that clinicians should be particularly careful about differentiation between two terms: "to resist" and "to refuse", especially because this difference and the ethical challenges in anorexia nervosa treatment resulting from it, is a neglected area of research.

According to the Longman Dictionary of Contemporary English, "refusal is an act of saying or showing that you will not do something that someone has asked you to do or an act of not accepting something that is being offered to you" [5, p. 1193 – 1194]. On the other hand, "resistance is an act of preventing change or preventing yourself being forced to do something" [5, p. 1211]. In simpler terms, refusal may be considered to be an outright categorical resistance.

MacDonald [3] points out that the existing literature on food rejection in anorexia nervosa patients focuses on rather rare cases of food refusal while there are no studies of quite common treatment resistance. Similarly in articles which describe psychology of hunger-strikes among prisoners, the word "resistance" is omitted, for example according to Brockman [6] self-starvation behaviours among prisoners may be considered to be food refusal. MacDonald [3] concludes that a lack of a term "food resistance" is somewhat surprising in this exhaustive state of the art analysis and little attention has been given to the ethical aspects of food resistance in treating anorexic patients. Furthermore, the ethics literature on anorexia nervosa focuses generally on cases of compulsory treatment.

It should be noted that only food refusal (contrary to food resistance) in anorexia nervosa leads to very serious two serious dilemmas:

- when the patient's physical condition has deteriorated to the point where her life is in grave danger,
- whether to respect the patient's autonomy or to impose tube-feeding [3].

In this context, a suggestion of Griffith's and others that "In the event of treatment refusal, which is common, compulsory treatment may be deemed necessary" [1, p. 526] should not be surprising, especially in the light of MacDonald's words "attention has focused on the question of what circumstances may justify clinicians' forcing treatment upon a patient who categorically refuses to cooperate" [3, p. 3].

Undoubtedly, the above statements warrant increased discussion, especially because in very frequent cases of food resistance, clinicians not only engage in various forms of persuasion, but probably unnecessarily resort to such strict behavioural regimes as: restricting the patient's movement within the hospital, demanding that a patient eat 100 % of her/his meal, forbidding patients to exercise. According to some authors, in the case of just food resistance, such practices must be perceived as unethical and inhumane [7, 8].

Fortunately, in some cases, treating a patient even despite resistance might be justified on the basis of consent. Most patients in eating disorders programs are there more or less voluntarily. That is, most patients want clinical intervention, even though they may disagree with clinicians over the specific goals of that intervention (for example, they usually don't want to gain weight). When a patient has voluntarily entered a treatment program and knows what such treatment will entail, she is in effect consenting

to a certain amount of infringement upon her autonomy. But in this context, some questions must be raised, namely: "Just how voluntary is the patient's participation in treatment?", "Has her family (perhaps feeling exhausted and helpless) exerted undue pressure?", "Has she been threatened with civil commitment if she does not enter treatment voluntarily?". There are no simple answers to such questions, but it should be noted that the amount that can be justified based on consent is proportional to the freedom with which that consent was given [3, p. 4].

Mental illness and mental incapacity as criteria for compulsory order: a broad model of incapacity in the case of anorexia nervosa

Tan and others claim that "They are differing views among mental health professionals over the use of the mental health legislation or other means of compulsory treatment" [17, p. 697]. There remains a great deal of controversy among professionals, with "some supporting the rights of such patients to refuse treatment, while others oppose this view" [9, p. 625].

There is little doubt that anorexia nervosa can be described as a "'challenge' of psychiatric terminology" [10, p. 826). On the one hand for many clinicians anorexia nervosa is an intriguing, poorly understood illness and its cause and cure are unknown [3, 11, 12]. In this vein Dresser argues "Anorexia nervosa exemplifies the arbitrariness inherent in labelling individuals mentally ill" [13, p. 6]. Similarly, Guntrip [14, p. 26] defines anorexia as "hardly so much a symptom as a guiding principle of life". This problem is presented in Crisp's textbook "Anorexia nervosa: Let me be": "Crisp – widely recognised as an international expert on eating disorders – claims in the first chapter that in his opinion the condition is an illness (...). Nevertheless, he almost invariably puts 'illness' in inverted commas when referring to anorexia" [15, p. 129). It is little doubt that according to the above authors, treatment (especially compulsory treatment) of anorexia nervosa may be unreasonable.

On the other hand, more and more authors underline that anorexia nervosa is a grave mental disorder which raises questions concerning the use of compulsory treatment [16, 17, 18]. Moreover, it seems to be very important to underline that according to Griffiths and others [1, p. 530], although treating (especially compulsory treating) anorexia nervosa patients is particularly time consuming, and these patients invariably resist weight gain even after treatment has been implemented; recovered patients who survive their illness are often "deeply grateful that the clinician has persevered throughout the process". Conversely, "When a patient who has been diagnosed with anorexia nervosa dies, the grieving family often claims that they had wanted to hospitalize the patient – commonly, in cases where the patient had refused treatment and could not be coerced" [9, p. 617]. Finally, Melamed and others ask "Why is a patient with anorexia nervosa permitted to starve to death while patients diagnosed with schizophrenia are protected from self-inflicted harm?" [9, p. 622].

But question of compulsory treatment of anorexic patients needs further discussion. According to Tan and others, about 10% of inpatient admissions for anorexia nervosa involve compulsory treatment [18]. According to Günther [19], the limited research

record on compulsory treatment in anorexia nervosa calls for a critical evaluation. The most difficult problem is that many patients refusing treatment appear to possess the capacity to refuse treatment and at the same time they are often at immediate risk of death [17]. Melamed and others [9, p. 617] ask: "Since complications of malnutrition can become life threatening, should compulsory hospitalization be exercised when there is an imminent risk of death for a patient diagnosed with anorexia nervosa?" According to the authors "The legal question then arises as to whether anorexia nervosa may be classified as a psychotic illness." [9, p. 617]. Anorexia nervosa is listed in the Diagnostic and Statistical Manual of Mental Disorders. Text Revision (DSM-IV-TR) [20] places it under the heading of eating disorders rather than under that of psychotic disorders (or, at least disorders with "with psychotic equivalence" or "containing psychotic features") [9, p. 622]. Thus, "Although it is a serious mental condition and may be life-threatening, anorexia nervosa is not a psychotic illness. The term psychosis is defined in the Comprehensive Textbook of Psychiatry, 3rd Edition as 'a mental disorder in which a person's thoughts, affective response, ability to recognize reality, and ability to communicate and relate to others is sufficiently impaired to grossly interfere with his capacity to deal with reality. The classical characteristics of psychosis are: impaired reality testing, hallucinations, delusions, illusions'. Confusion arises when the term psychotic is used to indicate a level of severity of the mental illness" [10, p. 823). The anorexic patient's compulsory admission to hospital is sanctioned under the Mental Health Act of 1983, i.e. when there is a possible threat to the individual's life [2]. Anorexic patients were able to be detained involuntarily under the Mental Health Act 1958. However the 1990 Mental Health Act specified that mental illness be defined by the presence of psychiatric symptoms [1]. Since anorexia nervosa does not fulfil the criteria of psychosis under the Act (although it is generally considered to be a serious psychiatric disorder), if anorexic patients are temporarily disturbed or pose a risk to themselves, the Act allows for detention to facilitate emergency treatment as "mentally disordered persons" for a maximum of 3 days [1]. But it is very important at this point to call to mind the following commentary of Griffiths and colleagues "the law has little application in the long-term management of anorexia nervosa" [1, p. 526]. This statement suggests that anorexia nervosa patients are usually detained involuntarily for more than the 3 days mentioned. On the other hand, according to Beumont and Carney "psychiatric terminology is quite fluid and flexible" and "In practice, however, mental health admissions and tribunal reviews of clinical decisions about involuntary admission do adopt the more capacious and fluid terminology favoured by the practice of psychiatry" [10, p. 829].

It seems to be very important to specify in this article whether patients with anorexia nervosa are competent (capacitated) to decide about their treatment, because forcible feeding generally appears in the context of compulsory order. The criteria for compulsory treatment are defined in the Mental Health Act [21] and are shown in Table 1.

Table 1

The criteria for compulsory treatment are defined in Review of the Mental Health Act (1999) (the author of the table M. Starzomska)

According to Review of the Mental Health Act 1983 (Report of the Expert Committee; November 1999) [21, p. 70].

"5.95. Before confirming a compulsory order the tribunal would have to be satisfied as to the following:

i. the presence of mental disorder which is of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services;

and

ii. that the care and treatment proposed for, and consequent upon, the mental disorder is the least restrictive and invasive alternative available consistent with safe and effective care;

and

iii. that the proposed care and treatment is in the patient's best interests;

and, either

iv. that, in the case of a patient who lacks capacity to consent to care and treatment for mental disorder, it is necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled under this section;

or

v. that, in the case of a patient who has capacity to consent to the proposed care and treatment for her/his mental disorder, there is a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if s/he remains untreated, and there are positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or to secure an improvement in the patient's mental condition." (p. 70 - 71).

According to Brockman [6], "Any patient assessed for compulsory treatment must satisfy the psychiatrist and social worker that he not only suffers from a mental disorder, but also that the disorder is of a nature and degree which allows compulsory intervention[1]. Finally, the crucial decision about compulsory treatment is made on the basis of the incompetence assessment. Because competence is the clinical equivalent of capacity, the comparable legal term to the term "incompetence" is "incapacity"; thus a patient who is judged to be unable to make decisions about his care is said to be incapacitated [6, p. 453; 17]. According to the authors of the Review of the Mental Health Act, "7.5. (…) a broad model of incapacity which accepts that a person may lack capacity where, although intellectually able to understand and apply the information, that person nonetheless reaches a judgment which s/he would not have reached in the absence of the disorder. Such a judgment can be said to be primarily the product of the disorder and not to reflect the person's true preferences (…)." [21, p. 88 - 89]. In short, an individual is described as being incompetent if he does not have the ability to make informed decisions. In other words, behaviour of such a person cannot be considered

[1] It is important to underline that presence of a mental disorder does not always imply "incapacity". Many people suffer from a mental disorder, have a disability, but still remain competent [6]. Tan and others claim "If we treat patients who do possess the ability to make their own treatment decisions but suffer from a mental disorder in a more paternalistic fashion than other patients simply because they have a mental disorder, we discriminate against them as a group" [18, p. 629].

as rational and self-directed [2]. Unfortunately, factors relevant to the consideration of competence are poorly defined [17].

There have been few studies examining capacity to consent to treatment in psychiatric patients and no studies generating empirical analyses of capacity or competence in the patients diagnosed with anorexia nervosa [17, 18]. These studies have employed quantitative methodology and they have used instruments based on the legal criteria of capacity, with the focus on understanding and reasoning [17, 18], but this legal concept of capacity may fail to capture the more global difficulties that patients with anorexia nervosa may experience in making treatment decisions [18]. Because of the excellent understanding and relatively intact reasoning abilities that the majority of anorexia nervosa patients appear to exhibit[2], we need careful analyses of capacity or competence in these patients [17]. Although, the MacCAT-T is the most fully developed standardised method of assessing competence; results of the study conducted by Tan and others [16, 17, 18] reveal that the standard concept of capacity to consent to treatment, as being one of understanding and reasoning which is captured well by the MacCAT-T, may not be relevant to the difficulties that anorexic patients may experience in their decision making[3] and "the current legal criteria of capacity, applied by the MacCAT-T test, failed to capture difficulties that were relevant to competence to refuse treatment in anorexia nervosa" [17, p. 706]. The authors claim that the assessment of competence to refuse treatment in anorexia nervosa should be based on an assessment that includes "a wider range of beliefs and values" [17, p. 705]. It is well known that problems with the capacity-based approach in the case of anorexia nervosa result from the fact that an account of capacity based on understanding and reasoning does not capture the difficulties in decision making that these patients experience and the clinicians and other participants themselves do not find capacity a useful concept in justifying compulsory treatment [18]. Melamed and others [9] suggest that during treatment of patients with anorexia nervosa, it is necessary to concentrate on actual behaviour rather than thought content, which usually does not contain delusions or perceptual disorders aside from those related to weight. In cases of anorexia nervosa, behaviour often presents evidence of self-inflicted bodily danger.

[2] According to Melamed and others "hard-core patients are even capable, after months or years of hospitalizations, of intellectualizing that they are too thin and of quoting which exact dietary regimes they should follow. Thus, in competency testing procedures, they often score normally, while in reality, their daily behaviour regarding nutrition is inappropriate." [9, p. 622].

[3] For example, the qualitative analysis revealed very specific attitudes to death and disability among anorexic patients: treatment refusal may occur, not because the patient wishes to die, but because of relative unimportance of death and disability or because of the particular meaning death and disability may acquire in the context of anorexia nervosa. Also the results of the study conducted by Tan and others [17] reveal that "the aspect of anorexia nervosa as part of personal identity is an important one with respect to how the patients themselves view the prospects of treatment for the disorder. The participants' views suggest that anorexia nervosa can change their personality and sense of identity; and that independent of an understanding of the benefits of having treatment and the risks of continuing to have the disorder, the decision to accept treatment can become heavily loaded with the implication of giving up a part of themselves, which can affect their decision. These above problems are not addressed by the MacCAT-T. Thus, the assessment of competence to refuse treatment in anorexia nervosa should be based on an assessment that includes a wider range of beliefs and values.

To sum up, although "there has been little attempt to study nature of competence to make treatment decisions in general and of the problems in treatment decision making, which may occur in anorexia nervosa in particular" [18, p. 629], more and more "developments suggest that to develop a better understanding of the nature of difficulties with competence to consent to treatment in anorexia nervosa, an approach more fruitful than conducting research purely based on the criteria of capacity would be also to explore the different factors of competence not included in the definition of capacity" [18, p. 630].

Existential discussions on competence among anorexic patients as an avenue to a modified definition of capacity

Even if we assume that anorexia nervosa patients do not possess capacity to make decision concerning their treatment, we must face a lot of opposite arguments. For example, Wright [2] claims that there are a number of "decisions" that people make in their lives, or behaviours that people engage in, which have the potential to be life-threatening; according to Brockman [6] sometimes these behaviours are "foolish", but not all of them can lead to the individual being compulsory admitted to a hospital to receive treatment against their will. For instance, excessive alcohol consumption can lead to death. However, someone who is known to drink excessively over a period of years will not be compulsorily detained to help them recover from their alcohol addiction. So why does one individual seemingly have the "right" to kill themselves and another is considered to be irrational and not in a position to make her own decision about her life? Such inconsistencies are clearly worrying.

It should be noted that according to the Mental Health Act "Imprudence does not on its own amount to lack of capacity" [21, p. 90]. Draper also tries to discuss above problem and claims: "Patients can refuse therapy for a variety of reasons. They may have religious objections to some procedures which are life saving (like Jehovah's Witnesses do, to blood transfusions); they may have moral objections (perhaps a strongly held view that it is wrong to terminate the life of the unborn even to save one's own life); they may hold the personal belief (whether or not well founded) that they have become too much of a burden upon their family (...)" [15, p. 125]. None of these reasons requires us to be convinced that it is in the patient's best interests to be dead – but any of these reasons given by a competent patient would be sufficient to suppose that the patient's decision should be respected. We might argue that, for example, it is irrational to put religious beliefs before life itself – particularly when the religious belief is based on a literal interpretation of the Bible and that it is irrational to prefer to save the life of an unborn child to one's own, particularly if the unborn child may die anyway as a result of one's own death. But we should avoid confusing irrationality, strong disagreement and competence. "Although it is recognised that irrationality may be a symptom of incompetence, it is not by itself a sign of incompetence" [15, p. 126].

It should be noted that according to Draper [15, p. 127] "a competent decision to refuse therapy can be made on rational or irrational grounds or even no grounds at all". According to Melamed and others, there is a clear border between anorexia nervosa and others forms of dieting, the authors say: "Body piercing is presently a socially

accepted practice; however, if one would decide to amputate rather than pierce body parts, it is likely that society would intervene. There is an essential difference between the life-threatening weight loss of a patient diagnosed with anorexia nervosa and the normal weight-reducing diet that might be considered even desirable for an overweight person" [9, p. 623].

Anorexia nervosa seems to differ from under-eating which is done for the sake of current fashion and in conformity with current trends about body image in two important respects. First, the diagnosis is usually only made once the under-eating threatens life and health (but the same could be said of at least some of those who over-eat and put their lives in jeopardy). Second, it is believed that the compulsion not to eat is somehow involuntary or beyond the control of the sufferer so this sufferer who has low self-esteem and other psychological problems with her identity is not competent (but the same could be said about women who refuse to undergo radical breast surgery and they are considered to be competent) [15, p. 131]. It is useful to cite the words of Draper, who says "(...) We are generally considered free to (...) engage in gluttony as we like – however immoral or imprudent it is to do so (...). It is unlikely, however, that people who are either on the way to eating themselves to death, or who are likely not to receive the therapy they need to survive unless they stop overeating; would or ought to be compelled by physical force to reduce their food intake (...)" [15, p. 128]. Undoubtedly, it would be unacceptable for clinicians to forcibly prevent from eating those for whom over-eating was life-threatening; one reason for this is that over-eating is not considered to be a mental disorder. But over-eating could be a symptom of an under-lying mental disorder [15]. Thus it may be wrong, as well as unlawful, to force patients to comply with therapy simply because they are anorexic, because many sufferers from anorexia are not broadly incompetent [15, p. 133].

According to Draper, anorexia nervosa is the condition which challenges distinctions between irrational and incompetent decisions and in the case of this disorder, food is refused because the patient is completely obsessed with the idea of weight loss and maintains weight at a level incompatible with active life or even any life at all [15]. Although it seems to be two justifications for associating irrationality with incompetence in the case of anorexia nervosa patients (One is that the desire not to eat undermines an even stronger desire not to die. Another is that the desire not to eat might itself be an involuntary one, grounded in some other deeply held, but false, belief about their body image – usually that they are 'fat') [15, p. 129], but this incompetence is not a typical, classical, "perfect" incompetence and needs a new, more specific definition. It is tempting to say in this place that also capacity to consent is best considered as different from the purely rational, or "perfect" cognitive consent" [10].

Towards a new (more specific, narrow) definition of capacity?

According to Tan [22], the understanding of competence to refuse treatment in anorexia nervosa needs to be specified beyond the current legal criteria of capacity. Thus "anorexia nervosa clearly presents a challenge to the notion of capacity and highlights the fact that patients can struggle with decision making in ways that are not

captured in a conceptualisation of capacity, which does not extend beyond the realms of understanding and reasoning" [18, p. 643].

According to Treasure and Ramsay, [7], anorexia nervosa is a severe mental illness and at times, some patients may not be competent to make a decision about their welfare. Similarly according to MacDonald [3], clinicians are often justified in pursuing particular interventions despite anorexia nervosa patients' resistance, given the reduced competency of them.

As was mentioned, many authors underline that sufferers from anorexia nervosa are not competent to make any decisions that relate to food because they are not competent because of uncontrollable non-eating behaviour and a completely distorted body image; for example Melamed and others [9, p. 621] claim that while patients with anorexia nervosa may be able to make valid judgments and function normally, with regard to such matters as employment and education, they are often unable to make rational decisions concerning body weight, diet, and acceptance of medical care. According to many authors, competence of anorexia nervosa patients is seriously diminished, because thoughts which are called overvalued ideas can quickly develop into delusions [9, 23, 24], thus "If one domain of the ability to maintain reality testing is impaired, then all functions of reality testing are likely to be affected" [9, p. 622]. According to Gans and Gunn [25, p. 681], the competence of patients with anorexia nervosa is inherently suspect in the narrow area of self-nutrition but this is the essence and defining feature of the disease and "this argument is often used to declare anorexics incompetent a priori on the basis of their anorexia". It is also well known that among anorexics the choice to starve is experienced existentially as the choice to be and at least for some experts, this particular paradox renders the anorexic person a priori incompetent.

But according to Draper such an assertion "assumes that incompetence is a description of an individual (broad or global incompetence) rather than an assessment of the capacity of the individual to make a specific decision (narrow incompetence)" [15, p. 122]. This author claims that only "Some anorexics may indeed be incompetent as individuals (be broadly incompetent): for example, those on the point of starving to death. Others are certainly not broadly incompetent; they are studying for school leaving exams, or degrees, or are running their own financial affairs, others are professionals working in demanding jobs." [15, p. 122]. Also according to MacDonald [3], patients with anorexia nervosa serve as a reminder that autonomy and competency, properly understood, are issue-specific rather than global. That is, patients ought not to be characterized as either "competent and autonomous" or "incompetent and non-autonomous", but rather as more or less competent (or autonomous) with regard to particular kinds of choices. The clinician should be aware that the patient may be competent to make some decisions but not others, depending upon both the degree of disability and the gravity of the decision, because competence is not a concrete entity, and can vary within an individual over time [6].

In a similar vein, Gutheil and Bursztajn describe the anorexic as "globally competent", with a "subtle" or "focal" incompetence in one area. According to these authors the competence of patients with anorexia nervosa is inherently suspect in the narrow area of self-nutrition (that is the essence and defining feature of the disease) [25].

Noteworthy, the distinction between broad and narrow incompetence is consistent with two approaches to the problem of autonomy of the patient in modern psychiatry: consistent to this autonomy and pragmatic. According to the first approach to patient autonomy, "it would be inappropriate to intervene compulsorily in the face of a capable refusal whatever the risk to the patient and the only justification for overriding the principles of non-discrimination and patient autonomy would be the need to protect others from a substantial risk of serious harm. In cases, where a patient maintained a capable refusal of care and treatment, compulsory intervention would not be justified solely to protect the patient" [21, p. 71]. On the other hand, the pragmatic approach to autonomy "would allow intervention for the protection of the patient in cases of severe risk." [21, p. 71]. Also the terms "unchallenged paternalism" versus "weak paternalism" and "libertarianism" are worthy further discussion in this context. According to the principle of weak (contrary to unchallenged) paternalism, an agent may intervene on grounds of beneficence or non-maleficence only to prevent substantially non-voluntary conducts that is, to protect persons against their own substantially non-autonomous actions [3]. It should be stressed that those clinicians who accepted such a pure approach are "in a small minority" [21, p. 19] and "few if any would wish to return to unchallenged paternalism" [21, p. 20). It is not strange since the primacy of respect for the patient's autonomy is a cornerstone of modern medical ethics [26, 27].

Do anorexia nervosa patients benefit from compulsory treatment?

Infringement of autonomy is always ethically worrisome, but in the case of anorexia nervosa, autonomy of patients is already seriously compromised. Autonomy of the anorexic person is seriously limited, because "To become anorexic is to create and inhabit a nightmarish world within which basic human needs cannot and will not be met – an ascetic prison[4] with ever narrowing boundaries" [2, p. 54]. Thus, clinicians should be particularly careful about infringing upon the already-limited autonomy of patients with anorexia nervosa. Thus psychiatric wards provide fertile territory for examining ethical challenges of autonomy, especially in the case of self-starvation which is quite common among anorexic patients. Currently, in the age of respect for autonomy, the main issue for debate which appears in this context is: "Should autonomy be sacrificed if life of the low weight patient is threatened?", "When are we justified in interfering with a patient's autonomy, and how far are we justified in doing so?", "Is intervention justified only as far as we know what will help?" or "Is our intention to help sufficient justification: But above all the following question appears: What is really good for this one patient? How do we know it? These questions appear especially in the context of anorexia nervosa, because the anorexic person may sometimes be competent, incompetent or partly competent (see above); the last category is the most difficult to recognize.

[4] Thus there are very evident distinctions between compulsory treatment of an anorexic person and intervention with a self-starving prisoner [13]. According to Keywood [13], the law's engagement with the anorexic body is stronger than in the case of prisoners on hunger strike.

MacDonald [3] points out that the treatment of anorexia nervosa constitutes merely a particularly clear example of an ethical decision within the context of the clinical practice. According to MacDonald [3], clinicians probably must decide 100 times a day whether a certain treatment, limitation, or requirement constitutes a justified infringement upon the patient's right to autonomy [3].

On the one hand, according to some authors, it is quite likely that the anorexic patient's autonomy will itself be enhanced by even compulsory interventions, because if psychiatric treatment is successful, the patient may come to be governed less by her compulsions [3].

On the other hand, the use of compulsory treatment is problematic, because it is experienced by some patients as painful and difficult; descriptions of the experience of compulsory treatment as imprisonment, punishment, helplessness, and marginalisation, raise the issue of whether compulsory treatment, however well meant, could be considered degrading and an "infringement of human rights and dignity" [18, p. 642]. Parents of the patients are not satisfied, Tan and others cite the following words of one mother of an anorexic girl: "I don't think treatment should be given without consent, if you can understand what I mean. But as a mother, I wouldn't want that. I would want to be able to intervene. So I have two conflicting opinions" [18, p. 636]. Additionally, for the anorexia nervosa patients, the struggle to be in control is a core issue and attempts by professionals to exert control over these patients lead to strong resistance against them [18, p. 642, 643; 19]. According to Tan and others [16, p. 535], compulsory treatment in adults with anorexia nervosa may not be effective in achieving good long term outcomes, although it appears that it can yield short term weight gain. Admission of adolescent patients with anorexia nervosa seems to be a predictor of poor subsequent outcome; "Involuntary treatment may evoke resistance and may ultimately deter the patient from seeking treatment, so that while the patient's life may have been saved in the short term, the long-term risk may increase." [9, p. 623]. According to Gans and Gunn, "If the focus on weight gain takes precedence over patient autonomy and choice, it can result in therapeutic rupture and setbacks" [25, p. 678]. Hearnden [28] underlines that compulsory treatment may only be successful in the short term. In the long term it does nothing to reduce the fear of food, weight and hospital felt by the patient and it is a barrier to treatment. Suicide accounts for 27% of anorexia deaths. Compulsory treatment may make the patient more depressed and at greater risk from harm; not to mention many cases of drop-out from treatment; research suggests that approximately 50% of the patients with anorexia nervosa drop out prematurely from therapy [29, 30, 31, 32, 33, 34]. Noteworthy, in the case of anorexic patients, the overall rate of relapse was 35% and the mean survival time was 18 months; the highest risk period was from 6 to 17 months after discharge [35]. Others studies confirmed these results [36, 37]. It is useful to cite words of Melamed and others [9, p. 624] "While we may be compelled to discharge a patient who was involuntarily hospitalized after the patient gained weight over and above the danger line, we know there are cases, such as the case described above, where the weight loss following discharge is even more serious." According to Ramsay and others [38], compulsory versus voluntary hospitalization represented a risk factor for death. Sometimes the most tragic decisions

to commit suicide among these patients arise out of deep anguish and despair after a compulsory order[5].

In this context the statement of Melamed and others [9, p. 624] "It is interesting to note that in studies that examined the results of involuntary hospitalization as opposed to voluntarily treated patients, no differences were found in body weight and other characteristics", sounds a bit surprising. But it is more understandable when we consider that not only compulsory treatment as a form of intervention, but "content" of this information, e.g. therapy is the most important for long-term outcomes, because it has been recognized that weight gain alone is not always a sign of recovery"; but on the contrary, "If involuntary treatment is imposed for a minimal but essential period of time and if it is strict but empathetic and transmits interest and concern for the patient, then it may be an expression of 'tough love' where the patient eventually appreciates the outcome" [9, p. 624].

There is no doubt that therapy of self-starving patients should address personality [16, 30], identity [16], spiritual well-being [39, 40, 41] and overall psychological functioning [32]. Therefore, intervention, however compulsory, must address psychological problems of self-starving patients, although it is useful to use various methods, which prevents poor outcomes of compulsory treatment, for example: checking readiness to change among anorexia nervosa patients [42, 43, 44], using "relapse management cards" [45], using motivational interviewing [46] or measuring of decisional balance [47].

Alternatives to anorexia nervosa compulsory hospitalization?

Undoubtedly, compulsory treatment infringes on the rights of patients and on their autonomy. Another option for invoking compulsory treatment, is in accordance with The Law for the Protection of Patients' Rights (however this law is not equipped to deal with prolonged treatment of patients diagnosed with anorexia nervosa) and the third possibility is appointment of legal guardian [9, p. 620]. "This possibility is the most common, the legal guardian (for the patient's body) can determine the need for compulsory hospitalization for a fixed period of time." [9, p. 620]. "In most cases, the guardian is a member of the immediate family, such as the parents of patients who are 18 years of age or above." [9, p. 620]. According to Disability Services and Guardianship Act 1987 which was established by the Australian Guardianship Board in 1989 "a person in need of a guardian" as "a person who has a disability and who, by virtue of the fact, is totally or partially incapable of managing his or her person". A person with a disability is defined as a person who is "intellectually, physically, psychologically or severely disabled; is of advanced age; is mentally ill within the meaning of the Mental Health Act 1990; or is otherwise disabled; and, who by virtue of the fact is restricted

[5] According to Review of the Mental Health Act [21, p. 95] "Those who would wish to give precedence to autonomy in the case of harm to self (as in anorexia nervosa) suggest that for many disorders of personality rather than mental illness, treatment under compulsion is likely to be counterproductive" (p.20). Furthermore "In the current state of knowledge most, if not all, such interventions in the case of personality disorder are those which require the co-operation of the patient. It is hard to envisage how they can be both forced on the patient and effective."

in one or more life activities to such an extent that he or she requires supervision or social rehabilitation" [1, p. 526].

In the case of anorexia nervosa patients applications for guardianship orders are usually made by health professionals and family members. The Guardianship Board calls an urgent hearing as soon as each application is lodged because the life of the anorexic person generally is in grave danger. At the hearing the Board receives evidence from the applicant, family members, health professionals and the person with anorexia nervosa. The Board must affirm that the person has a disability and an incapacity before an order is made. An order may then be made appointing a guardian (either a private person or public guardian) for a period of up to the year. The Board determines all functions of the guardian, which may be for accommodation, medical treatment and behavioural management [1].

It is noteworthy that with modern guardianship legislation the dichotomy between libertarianism and paternalism is outdated. It is a less stigmatising alternative than mental health legislation because it responds to the person's psychological incapacity, needs or disability rather than diagnostic classification. It is also a less coercive alternative because a guardian: negotiates consent to treatment on behalf of the patient; observes the patient throughout the treatment; and makes decisions as close as possible to the patient's own wishes [1]. According to Tan [18, p. 628] guardianship "is a move away from paternalism".

On the other hand, Melamed and others [9, p. 623] criticize the appointment of legal guardians: according to these authors, this arrangement is in fact inherently problematic. When a parent is appointed as a legal guardian and opts for hospitalization, they find themselves in a very difficult situation. The parent must decide on a procedure, which is, on the one hand, contrary to the wishes of their child, but which is also, on the other hand, necessary for their child's well-being. The option of guardianship is also problematic because it does not consider the discretion of the doctors who should have primary authority in cases of involuntary hospitalization. The patient might feel abandoned by a supportive family member who should be by their side.

Conclusion

There are a lot of contradictory opinions concerning compulsory treatment among anorexic patients. Anorexia nervosa is a very mysterious illness and its causes remain unknown. Many authors underline that such treatment is not efficient and in the future, modern therapeutic programs should include more specific definitions of "anorexic" incapacity. A guardianship is one of the first such solutions, but further studies and discussions must create a new approach to this difficult problem.

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