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Ethical challenges in forcible feeding among patients with anorexia nervosa and prisoners

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Summary

Forcible feeding is the most frequent behavioural intervention in the case of severely emaciated self-starving patients. The present article describes ethical problems, especially ethical challenges, in forcible feeding among anorexic patients and prisoners. On the basis of detailed considerations, the author formulated a metaphorical parallel between anorexia nervosa patients and prisoners, which may explain many adverse consequenes of force-feeding among anorexic patients. The main intention of the author of this article is to encourage a discussion on ethical questions concerning forcible feeding in the case of self-starvation.

Key words: self-starvation, anorexia nervosa, hunger strike, forcible feeding

Introduction

Attia [1] claims that anorexia nervosa is a grave and perplexing illness that has afflicted patients and challenged health care providers for centuries. Anorexia nervosa is a serious psychiatric disorder characterized by distorted body image which triggers intensive self-starvation and - as a consequence - significantly diminished body weight. The very essence of this eating disorder is a categorical refusal to change in conjunction with a profound denial of illness [2]. "The psychopathology of anorexia nervosa is difficult to label but (...) anorexia relates to an unwillingness to eat, a determination to be unnaturally thin, and evident contentment with being capable of refusing to eat and being emaciated. This has been termed "a hysterical symptom, a phobia of weight gain, an obsession, a delusion, or an overvalued idea" [3, p. 825]. Clinicians working with anorexia nervosa patients must face not only chronic, but also the life-threatening nature of this illness and this is probably the most difficult aspect of their work.

Anorexia nervosa is reported to have the highest mortality rate of any psychiatric illness and crude mortality among anorexia nervosa patients is between 4-20 % [4, 5, 6, 7, 8. 9, 10, 11, 12, 13]. This high mortality in anorexic patients is mainly due to starvation which causes: electrolyte imbalance and heart complications (mainly - silent pericardial effusion) or liver failure [8, 14, 15, 16, 17]; suicide [8, 12, 15, 16, 18] and alcohol poisoning [16].

Patients diagnosed with anorexia nervosa are a particularly difficult patient group [19, p. 624). These patients, in many cases, do not perceive themselves as "sick" [9, p. 678]. They do not want to eat and they typically manifest an intense fear of weight gain, even when they are bordering on physical collapse from malnutrition [8]. Additionally, they have difficulty cooperating with attempts to help them to regain weight, even when their health is endangered [20]: "They are preoccupied with ways to reduce their weight further, or at least to prevent any gain. They appear genuinely terrified at the prospect of being overweight, and some state openly that they would rather "be dead than fat" [3, p. 825]. In contrast to suicidal patients, they do not explicitly discuss a desire to end their lives, however their actions lead in that direction [19, p. 622]. A refusal of treatment that, in another patient, might look – suicidal – may, for the anorexic, be an affirmation of the only life she can conceive of living [9, 21, 22]. Although anorexia nervosa sometimes is described as suicide in "refractive doses" or "refracted doses" [21, p. 47; 23, p. 74], "it is the anorectic's determination to be self-defined, autonomous, individual that leads her to reject the option of suicide and to choose the far more difficult life of self-starvation – not in order to die, but in order to go on living (...), it is a rejection of death as a biological fact" [21, p. 47]. Anorexia is a paradoxical disorder in which the choice to starve is experienced existentially as the choice to be and every anorexic girl derives her fundamental meaning and satisfaction, her reason to live, from her efforts to become "thin" [9], but usually severely disturbed anorexic patients don't want treatment [24]. More often than otherwise, the anorexic individual will not perceive their self-starvation as problematic. Rather what is experienced as problematic are other people's attempts to interfere with the individual's dieting. This attitude may become more understandable in the light of the following words of anorexic patients "When I looked at myself in the mirror I saw someone beautiful"; "The clearer the outline of my skeleton became, the more I felt my true self to be emerging" [21, p. 40], "I can't explain how happy and relieved I can feel when I know I have lost some weight. As I stand on the scales and see that number I forget all my worries. I feel relieved. I feel this is me and the more weight I can lose the more I feel I have done good." [21, p. 44]. Some patients with anorexia nervosa describe the anorexia as their "best friend" [9, p. 679; 25, 26, 27]. Patients with anorexia nervosa, even if, seemingly motivated for treatment, may be ambivalent regarding working on getting better. They will be likely able to articulate that there are two sides to them, the side that wants to get on with recovery and the part of them that is terribly frightened of this prospect [12]. According to Tan and others [20], anorexic patients in this study have considerable ambivalence about treatment and they can experience it in several ways. First, there may be advantages to having anorexia, which the patient may not wish to give up. Second, the patient may feel that changing behaviour is not a choice she can make, even if she wants to. Third, the patient may wish to be coerced before she can comply with treatment. Fourth, the patient may feel simultaneous wishes to have and not to have treatment.

So called "hunger strikes"[1] in prisoners may be motivated by a variety of factors. For example, sentenced young prisoners (particularly in the case of a first lengthy

[1] The term "hunger strike" is hardly rare in the existing literature on anorexia nervosa. Orbach's books in a feminist vein, entitled: "Hunger strike: The anorexic's struggle as a metaphor for our age" [28], "Hunger strike: The classic account of the social and cultural phenomenon underlying anorexia nervosa" [29] and "Hunger strike: starving amids plenty" [30], should be treated as exceptions that prove the rule. Conversely, this term is more frequent in articles on self-starvation in prisoners. There

sentence) use self-starvation (which may be treated as a variant of self-harm) as a method of reducing tension or an attempt to precipitate change. Only few prisoners choose to commit suicide (which may be chosen as a method of escaping punishment, a means to exercise autonomy, or a method of self-killing secondary to grief or guilt) by starvation as they are prevented from killing themselves by other physical means. On the other hand, the main motivation behind hunger strikes in remanded prisoners is unfair - in their opinion - charge or refusal of their bail application. Finally, asylum seekers at an early stage of imprisonment communicate their distress and the desire to change detention status through food refusal. Later, when it becomes apparent to the asylum seeker that he will be repatriated against his will, food refusal can be motivated be the desire to die rather than accept this tragic fate. Illegal immigrants most often express through hunger strikes their outrage that they have been treated as criminals when they don't perceive themselves as such [31].

The medical literature indicates that death from hunger strikes can occur between 42 and 79 days of a complete fast. After about a week, the hunger striker experiences dramatic weight loss. In the following weeks, he suffers from liver and intestine atrophy, followed by disturbances of the heart and kidneys. The pulse slows down and blood pressure falls. Patients complain of fatigue, faintness and dizziness. By about the 40th day, the striker becomes seriously ill and suffers from concentration problems and apathy [32].

Forcible feeding under existing regulations of the Mental Health Act

"Force-feeding may take the form of literally forcing a patient to eat; coercing her to eat by putting her under pressure to feed herself (oral re-feeding) (OR); or, by tube feeding" [6, p. 121]. Some clinicians use also nocturnal nasogastric re-feeding (inserting a plastic tube through the nostril to the stomach for feeding anorexics with a fluid diet) (NNR) [33].

It is understandable that forced treatment (especially in the case of anorexia nervosa) is a difficult situation for the patient, the patient's family, as well as hospital staff; however, it is sometimes essential to save a patient's life [19]. According to Draper [6, p. 121] among anorexic patients "death rate would undoubtedly be higher if anorexics were not force-fed once their weight became dangerously low".

In some cases, treating a patient with anorexia nervosa even despite resistance might be justified on the basis of consent. In such cases patients want clinical intervention, even though they may disagree with clinicians over the specific goals of that intervention, for example don't want to eat and don't want to gain weight. It is highly plausible that according to most clinicians, when a patient has voluntarily entered a treatment program and knows what such treatment will entail, she is also consenting to a certain amount of infringement upon her autonomy [8]. As a result, although less than 1% of the hospitalized patients with anorexia nervosa require tube-feeding, these patients are generally forcible fed [34]. It is noteworthy that a compulsory admission for anorexia nervosa does not require compulsory treatment, such as forced feeding by nasogastric tubes (NGT's) or other intrusive methods [35].

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is little doubt that the term "hunger strike" implies a revolt and obviously, fits the characteristics of prisoners, but an unfortunate consequence of this attitude was lack of the term "hunger strike" within papers on anorexia nervosa (notwithstanding anorexia nervosa may be treated as a strong inner protest, which is especially apparent in psychiatric hospitals).

It must be underlined that nutrition is very definitely part of the therapy [6, p. 128). On the one hand, re-feeding without consent (enforceable treatment) is the part of psychiatric treatment and can be enforced under the Mental Health Act [36, p. 628]. According to Draper [6, p. 121] "Force-feeding (feeding without consent) has been recognised in the UK by the Mental Health Commission as a legitimate therapy to give under section 63 of the UK Mental Health Act 1983, and the legitimacy of force-feeding in conjunction with other therapies is also supported in case law" [2]. On the other hand, "If food is considered to be a therapy, then no competent patient is without the means to end her life since she simply has to refuse to eat and decline her consent to tube feeding. The advantage of so doing is that it is not necessary for the patient to make the clinician an accomplice to her decision." [6, p. 127]. But according to Keywood [38, p. 2], "the crucial factor in defining a substance as a medicine is its chemical composition", thus in the light of above words, food is not a medicine. Thus food doesn't fall under section 58, according to which "medication can be given without the patient's consent for three months. After that it is subject to the safeguards laid down in section 58" (as treatment requiring consent or a second opinion) [41]. Such a conceptualization may additionally influence anorexia nervosa treatment course, for instance clinicians feel justified in pursuing such interventions as forcible feeding, despite treatment resistance of patients given the fact that food isn't a medicine and doesn't fall within existing regulations of the Mental Health Act. Thus, the conceptualization that food isn't a medicine may influence unjustified interventions.

Do anorexia nervosa patients benefit from forcible feeding?

It is obvious that many medical and highly dangerous complications of self-starvation may remit after re-nutrition [39, 40].

It should be noted that many authors claim that compulsive-feeding is the best treatment for the symptoms of the disorder (as in the case of anorexia nervosa), but not the disorder itself. Section 145 of the Mental Health Act [41] defines medical treatment as follows: "Medical treatment includes nursing, and also includes care, habilitation and rehabilitation under medical supervision". Keywood [38, p. 3] suggests that "treatments which were ancillary to the core treatment did fall within the definition of medical treatment". Clearly, once admitted to hospital, the anorexic person may be force-fed and may be subjected to a variety of treatment programmes whose principal aim is to restore the anorectic to a "normal" weight [21]. Such interventions are very frequent, although many authors argue that "(…) without the existence of a core treatment, tube-

[2] The authors of the Mental Health Act [37] in the section, entitled "Feeding contrary to the will of the patient", recommend that artificial feeding in the case of a person suffering from a mental disorder should be placed in the same category as ECT (electro-convulsive therapy) [37, p. 86].

and:

"6. 18. i ECT can't be never imposed on any patient who retains capacity and not consenting;

ii in the case of patients without capacity, whether under a compulsory order or not, ECT cannot be administred without the express approval of the tribunal through its medical member;

iii that ECT should not be available on the equivalent of section 62" [37, p. 84].

feeding would have itself been unlawful (…)" [38, p. 3]. In the same vein, Draper [6, p. 121] says that "Feeding alone is thought to be ineffective – unless it is done simply to restore the patient sufficiently to enable her to participate in other psychiatric therapies. Sectioning for feeding should therefore, only to be considered as an adjunct to other therapies if it is to be justified by appeals to best interest. According to Tan and others [36, p. 630], "coercion is counterproductive and anti-therapeutic".

According to MacDonald [8], the main reason given for rejecting the full implications of patient autonomy (for example in the case of forcible-feeding) in the case of anorexia nervosa is that treatment promises both physical and psychological benefits. Many clinicians are convinced that if the treatment succeeds in inducing weight gain, the patient will be healthier physically (for example, she will have less risk of heart attack) and mentally (she will have less starvation-induced cognitive impairment). Moreover, they believe the patient stands to benefit emotionally, both as a result of improved cognition and as a result of ameliorated relationships with friends and family. Thus if nutritional therapy of the patient succeeds in reducing cognitive impairment, she will be better able to think rationally and make her own decisions. It is useful to bear in mind that "Being emaciated is a goal in itself, not a means of achieving happiness" [3, p. 826]. The study conducted by Neiderman and others [42] revealed that although some patients and their parents regarded the experience of nasogastric feeding as wholly negative, they acknowledged the lack of suitable alternatives. Others had a more positive view and identified several helpful aspects; reactions were generally more positive than had been anticipated.

On the other hand, according to some researchers, strict behavioural interventions (they include, for example demanding that a patient eat 100 % of her/his meal or forcible feeding) in the case of anorexia nervosa patients may be defined as "mistreatment" [34], especially because Castro and others [43] described surprising results of their research: nutritional abnormalities in adolescent anorexia nervosa persist after short-time recovery and both non-weight restored and some weight restored individuals with anorexia nervosa experience chronic problems [44]. Because "the fundamental therapeutic aim in working with anorexia nervosa patients should be to facilitate the development of a secure, separate sense of self" [24, p. 81], such behavioural treatment programmes for anorexic patients are indeed paradoxical [21, 45]. It is well exemplified by a lot of very negative consequences of force-feeding in anorexia nervosa patients. For instance, involuntary nasogastric tube-feeding (which was described above as inserting a plastic tube through the nostril to the stomach for feeding anorexics with a fluid diet) for patients with anorexia nervosa is particularly problematic. Although according to Zuercher [46], patients who had received voluntary tube feeding gained significantly more weight per treatment week than those who received oral re-feeding alone[3] and patients who had received tube feeding evidenced no differences in recovery from anorexia's psychological aspects, satisfaction with treatment, or medical complication frequency than those who received oral kilocalories alone, efficacy of tube feeding (even voluntary) in anorexia nervosa treatment is of highly problematic. Such compulsory

[3] Patients who received tube feeding for at least one-half their length of stay gained 1 kg/week versus 0.77 kg/week for patients receiving oral re-feeding alone.

tube-feeding destroys the relationship of trust between patient and practitioner and jeopardises the patient's prospects of long-term recovery [47]. Also literally forcing food into the mouths of sufferers kind – decreases the chances of long-term recovery and it is doubtful that it is actually in the best interests of a patient [6, p. 121]. The study conducted by Robb and others [33] showed that "Over a comparable period of time, patients treated with nocturnal nasogastric re-feeding (which is a more subtle form of forcible feeding) had a greater and more rapid weight gain than patients treated with traditional oral re-feeding. Thus, supplemental nocturnal nasogastric re-feeding was more effective than oral re-feeding alone in weight restoration during hospitalization. The impressive results of the study conducted by Mehran and others [48] (which used questionnaires constructed according to the model of Osgood' semantic differentials in order to assess their perception of four meaningful concepts: feminity, figure, diet and clothing before and after a 3-month hospitalization) revealed that after force-feeding patients with anorexia nervosa patients tended to find their figure less valued and less light than before hospitalization. Similarly, after forcible feeding anorexic patients tended to evaluate their femininity as less good, more devalued, more dirty, and more passive. Gowers and others [49] claim that hospitalization without an intensive psychological programme may result in premature death and at least: worsening. Similarly, Draper [6, p. 133] claims that whilst feeding may be life-saving, it does nothing for the underlying condition – indeed it may worsen it. Another study revealed that having more that one hospital admission was associated with increased mortality [50]. There are also physical risks attached to tube-feeding, for example, pneumonia and over-hydration. Therefore, forcible feeding as a form of medical treatment for symptoms of anorexia nervosa is very hazardous [38]. It should be noted using the words of Treasure and Ramsay [34] that force-feeding therapy seems to be indeed "hard to swallow" for anorexia nervosa patients. These words sound especially tragic in the light of intriguing considerations of Zerbe [51] and Levens [24] that even words of clinicians are perceived by these patients as threatening, as "a stomach punch", or "feeding in big doses"; according to Zerbe [51], they need "homeopathic" doses of therapy.

Force-feeding among prisoners

The course of forcible-feeding in the case of anorexia nervosa described above contrasts with the legal ruling on hunger strikers in prisoners which is that doctors have no role to play in forcible feeding of them.

Society and the law now acknowledge that a competent prisoner may choose to commit suicide by starvation. A prisoner's decision, regardless of whether it appears to be foolish, cannot be overruled unless the individual is incompetent [31]. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner [52]. It was announced that a prison medical

officer would not be neglecting his duty if he did not feed a competent prisoner against his will. If the opinion of the prison doctor and the outside opinion from psychiatrist confirm that the prisoner is competent, the doctor is expected to advise the prisoner that he will receive medical help in the hospital wing and will be offered food. The prisoner must be informed that medical intervention in the form of artificial feeding will not occur unless the prisoner requests it. This statement was in line with the British Medical Associations Central Ethical Committee. Although this committee reminded doctors that their primary duty is "the obligation of preserving human life", at the same time, went on to argue that competent prisoners' wishes not to be fed could be respected by doctors without fear of discipline by The General Medical Council [31]. Cases of force-feeding of prisoners (especially asylum seekers) by doctors result in great concern. Doctors coming into contact with a prisoner on hunger strike should be aware of their professional, legal and ethical obligations [53].

A right to die?

Discussions which focus on forcible feeding among anorexic patients are often similar to these concerning self-starving prisoners, but in the case of anorexia nervosa, a difficult ethical problem for the clinician arises when it becomes clear that the patient with anorexia nervosa does have capacity (competence) and rejects the treatment in the full understanding of the consequences [37] (as was mentioned above, in the case of self-starving prisoners this situation is easier). "Are the conditions in which the anorexic's decision might be judged 'irrational', but not 'incompetent'? Are there even situations in which the decision to refuse treatment might be both rational and competent?" [9, p. 682].

Thus sufferers from anorexia cannot be involuntarily subjected to any therapies unrelated to their eating disorder. But Draper [6, p. 122] asks: "Could an anorexic competently decide to withdraw from therapy not on the grounds that she didn't want to eat, nor that she was 'fat' but because the quality of her life was so poor that the therapy was no longer of benefit to her, or that it was on balance more of a burden than a benefit?" Thus the author discusses the problem of anorexics that are simply fed up with the illness and feel their "vegetation"; "Many anorexics feel like alcoholics, that they are just one step away from disaster. When suicide occurs it is often within this context. The individual is seeking relief from the endless terror and the exhaustion of a battle to maintain her positions" [54]. Similarly, according to Manley and Leichner [12, p. 33], "The patient may come repeatedly during the treatment process to a point where she feels exhausted and that she can no longer continue to struggle against the anorexia" (these feelings are to some extend understandable since up to 25 % of patients with anorexia nervosa never achieve a full recovery) [55, p. 534]. Therefore, when a person who has suffered from severe anorexia for years, without sustained relief from treatment, chooses to die, she presents psychological and ethical dilemmas for her family, her therapists, and, at times, the courts, but a decision always must be made as to whether or not the anorexic is competent to make her choice to die.

Draper [6] suggests that there might be a role of palliative approach for patients who are long time sufferers and who refuse therapy, only in the case of patients who have already been force-fed on previous occasions; are competent to make decisions concerning their quality of life; have insight into the influence which their anorexia has over some aspects of their lives, and "are not at death's door" [6, p. 122 – 123]. It is argued by Draper that in these cases, the decisions to refuse therapy is "on the par with other decisions to refuse life-prolonging therapy made by sufferers of debilitating chronic or acute onset terminal illness and that in such cases palliation might justifiably replace aggressive therapy." [6, p. 122]. According to Draper [6, p. 124], when a competent patient refuses therapy (whether or not this patient has a terminal illness or a poor quality of life or will die as a result), even a "pro-life" clinician who believes that any life is better than no life at all, is ethically and legally bound to accept this refusal[4]. On the contrary, Melamed and others claim that "Anorexia nervosa is not inevitably a progressive terminal illness. For this reason, it is preferable that treating physicians focus on the preservation of life" [19, p. 621].

To sum up, "It is undoubtedly awful to watch someone – possibly a young someone – die when they can easily be saved. However, if justice is to be given to those sufferers who can neither live with their anorexia nor without it, we must listen carefully to their refusals of therapy" [6, p. 133].

Conclusion

From the existential point of view, an anorexic patient's decision not to eat is one of the few decisions this person has ever made. As Wright [21, p. 88] points out, "If the anorectic's choice not to eat, followed to its inevitable conclusion, leads her to her own death it is, nonetheless, a search for another life. It is an attempt to create and conquer internally what she feels is impossible to conquer and control in the world around her". There are many benefits of self-starvation for every anorexic person: "it gives her a sense of achievement, of being better than others; it enables her to feel in control of her body and to gain the experience of being able to make her own decisions about herself; it gives her a sense of power" [21, p. 64]. In the light of the words above, it is understable that anorexic patients subjected to strict behavioural regimes as involuntary tube feeding and overall, force-feeding, feel as prisoners. According to McLeod [56, p. 112], for such a patient "the hospital must seem like a prison where she is being punished for seeking autonomy by being deprived of what little autonomy she has managed to find". But even though we say that for the anorexic person the hospital is perceived as kind of "a double prison", if the anorexic person dies, there

[4] Draper describes the distinction between passive euthanasia and competent refusal of life-prolonging therapy. According to Draper [6, p. 124 – 125] "The moral difference between passive euthanasia and competent refusal of therapy lies in who makes the final decision. Euthanasia is something which one person gives to another – whether or not it is voluntary. Withdrawing from therapy is something which one does to, or for, oneself. Respecting autonomy means that we are bound to take our own moral decisions and others are bound not to interfere; but it also means that we are responsible for the decisions which we make".

will be no chance of recovery [9]. Tan and others cite the following words of one of the anorexic patients' mothers: "It's very (sighs), very upsetting. It's like, I don't know, it's like she's in a prison, and I just feel so helpless about it, I don't know what to do anymore, I don't know what to say. It's just very difficult [36, p. 639].

It is not strange that more and more authors who analyse "schizophrenic" discrepancy between physical and psychological recovery in anorexia nervosa patients and they propose modern treatment models that focus on such real (not only physical) recovery from this grave illness [57].

As was mentioned above, forcible feeding in the case of anorexia nervosa contrasts with the legal ruling on hunger strikers which is that doctors have no role to play in forcible feeding. This distinction is so clear because in the case of prisoners the border between competence and incompetence is easier to recognize than in the case of anorexic patients. In this case, there is a real danger that sometimes competent patients may be treated as incompetent and conversely. Thus the suggestion of palliative care for anorexics which seem to be competent, in this context is hazardous, because it would encourage aggressiveness of pro-anorexic attitudes [58] and simply because the anorexic patient sometimes seem to be competent and sometimes: incompetent (It is evident in state of the art literature on anorexia nervosa treatment: it is nearly impossible for the clinician to differentiate between overt refusal and less determined resistance.) Additionally, at the moment of hospital admission, her life is mostly in grave danger, and furthermore, she is admitted first of all because of such danger. Undoubtedly, "imposing the medical model upon the events comprising an episode of anorexia is only one of several ways to give meaning to these events." [47, 59] and the metaphor of "imprisonment" in this context is interesting. But it is important to claim that all these discussions may be very fruitful for deep analyses of efficacy of various methods of treating anorexia nervosa.

There is no doubt that anorexia by its very paradoxical and difficult nature, challenges the clinicians' personal beliefs, for example, concerning death and life, longing for death, specific relation between body and mind/spirit, but such analysis is worth the effort and after carefully conducted treatment, when the patients are indeed healthy and really grateful, such clinician is entitled to be proud. Self-starving among prisoners seems to be easier to understand, but also is a very difficult problem for clinicians. Although many difficult questions concerning anorexia nervosa remain unanswered, I hope that this article will make it possible to understand and admire the immense effort of clinicians working with self-starving individuals.

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