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**Definition of Anorexia Nervosa**

**SOURCE:**
Maryland medical center - [http://www.umm.edu/altmed/articles/anorexia-nervosa-000012.htm](http://www.umm.edu/altmed/articles/anorexia-nervosa-000012.htm)

**Introduction:**

People with anorexia have an extreme fear of gaining weight, which causes them to try to maintain a weight far less than normal. They will do almost anything to avoid gaining weight, including staving themselves or exercising too much. People with anorexia have a distorted body image -- they think they are fat (even when they are extremely thin) and won't maintain a proper weight.

Anorexia is an emotional disorder that focuses on food, but it is actually an attempt to deal with perfectionism and a desire to control things by strictly regulating food and weight. People with anorexia often feel that their self-esteem is tied to how thin they are.

Anorexia is increasingly common, especially among young women in industrialized countries where cultural expectations encourage women to be thin. Fueled by popular fixations with thin and lean bodies, anorexia is also affecting a growing number of men, particularly athletes and those in the military.

Anorexia most commonly affects teens, as many as 3 in 100. Although anorexia seldom appears before puberty, associated mental conditions, such as depression and obsessive-compulsive behavior, are usually more severe when it does. Anorexia is often preceded by a traumatic event and is usually accompanied by other emotional problems. Anorexia is a life-threatening condition that can result in death from starvation, heart failure, electrolyte imbalance, or suicide.

It can be a chronic disease, one that you deal with over your lifetime. But treatment can help you develop a healthier lifestyle and avoid anorexia's complications.

**Causes:**

No one knows exactly what causes anorexia. Medical experts agree that several factors work together in a complex fashion to lead to the eating disorder. These may include:

- Severe trauma or emotional stress (such as the death of a loved one or sexual abuse) during puberty or prepuberty.
- Abnormalities in brain chemistry. Serotonin, a brain chemical that's involved in depression, may play a role.
- A cultural environment that puts a high value on thin or lean bodies.
- A tendency toward perfectionism, fear of being ridiculed or humiliated, a desire to always be perceived as being "good." A belief that being perfect is necessary in order to be loved.
- Family history of anorexia. About one-fifth of those with anorexia have a relative with an eating disorder.
Risk Factors:

- Age and gender -- anorexia is most common in teens and young adult women.
- Dieting
- Weight gain
- Unintentional weight loss
- Puberty
- Living in an industrialized country
- Having depression, obsessive-compulsive disorder (OCD) or other anxiety disorders -- OCD is present in up to two-thirds of people with anorexia. OCD associated with an eating disorder is often accompanied by a compulsive ritual around food (such as cutting it into tiny pieces).
- Participation in sports and professions that prize a lean body (such as dance, gymnastics, running, figure skating, horse racing, modeling, wrestling, acting)
- Difficulty dealing with stress (pessimism, tendency to worry, refusal to confront difficult or negative issues)
- History of sexual abuse or other traumatic event
- Experiencing a big life change, such as moving or going to a new school

Treatment:

The most successful treatment is a combination of psychotherapy, family therapy, and medication. It is important for the person with anorexia to be actively involved in their treatment. Many times the person with anorexia doesn't think they need any treatment. Even if they do, anorexia is a long-term challenge that may last a lifetime. People remain vulnerable to relapse when going through stressful periods of their lives.

A combination of treatments can give the person the medical, psychological, and practical support they need. Cognitive-behavioral therapy, along with antidepressants, can be an effective treatment for eating disorders. Complementary and alternative therapies may help with nutritional deficiencies.

If the person's life is in danger, hospitalization may be needed, particularly under the following circumstances:

- Continuing weight loss, in spite of outpatient treatment
- Body mass index (BMI) -- 30% below normal. The normal range is a BMI of 19 - 24. BMI is a measurement that takes into account a person's height and weight.
- Irregular heart rhythm
- Severe depression
- Suicidal tendencies
- Low potassium levels
- Low blood pressure

Even after some weight gain, many people with anorexia remain quite thin and risk of relapse is very high. Several social influences may make recovery difficult:
• Friends or family who admire how thin the person is
• Dance instructors or athletic coaches who put a premium on having a very lean body
• Denial on the part of parents or other family members
• The person's belief that extreme thinness is not only normal but also attractive, and that purging is the only way to avoid becoming overweight

Involving friends, family members, and others in the treatment can help deal with these issues.

**Lifestyle**

Treating anorexia nervosa involves major lifestyle changes:

• Establishing regular eating habits and a healthy diet
• Sticking with your treatment and meal plans
• Developing a support system and participating in a support group for help with stress and emotional issues
• Ignoring the urge to weigh yourself or check your appearance constantly
• Cutting back on exercise if obsessive exercise has been part of the disease. Once the person has gained weight, the doctor may set a controlled exercise program to help overall health.

**Medications**

There are no medications specifically approved to treat anorexia. However, antidepressants are often prescribed to treat depression that may accompany anorexia. Your doctor may also prescribe other drugs to help with OCD or anxiety. Medications, however, may not work alone and should be used in conjunction with a multidisciplinary approach that includes nutritional interventions and psychotherapy.

Selective serotonin reuptake inhibitors -- These antidepressants are sometimes prescribed for people with anorexia. Fluoxetine (Prozac) has been studied in people with anorexia and depression, with mixed results. In some early studies, it appeared to increase weight and improve mood over several months. But in another, it helped relieve symptoms of depression but did not affect the anorexia itself.

Recent studies indicate that the use of Prozac and other antidepressants may cause children and teenagers to have suicidal thoughts. Children who are taking these drugs must be monitored very carefully for signs of potential suicidal behavior.

People with anorexia may not be getting the essential nutrients their bodies need. Your health care provider may prescribe potassium or iron supplements, or other supplements to make up for any deficiency.

Cyproheptadine -- an antihistamine that may stimulate appetite. In one study, using high doses of cyproheptadine hydrochloride decreased the number of days it took people with anorexia to gain an appropriate amount of weight.
**Nutrition and Dietary Supplements**

People with bulimia are more likely to have vitamin and mineral deficiencies, which can affect their health. Vitamin deficiencies can contribute to cognitive difficulties such as poor judgment or memory loss. Getting enough vitamins and minerals in your diet or through supplements can correct the problems.

Always tell your doctor about the herbs and supplements you are using or considering using, as some supplements may interfere with conventional treatments.

Following these nutritional tips may help overall health:

- Avoid caffeine, alcohol, and tobacco.
- Drink 6 - 8 glasses of filtered water daily.
- Use quality protein sources -- such as meat and eggs, whey, and vegetable protein shakes -- as part of a balanced program aimed at gaining muscle mass and preventing wasting.
- Avoid refined sugars, such as candy and soft drinks.

Your doctor may suggest addressing nutritional deficiencies with the following supplements:

- A daily multivitamin, containing the antioxidant vitamins A, C, E, the B-vitamins and trace minerals, such as magnesium, calcium, zinc, phosphorus, copper, and selenium.
- Omega-3 fatty acids, such as fish oil, 1 - 2 capsules or 1 tablespoonful oil two to three times daily, to help decrease inflammation and improve immunity. Cold-water fish, such as salmon or halibut, are good sources; eat two servings of fish per week.
- Coenzyme Q10, 100 - 200 mg at bedtime, for antioxidant, immune, and muscular support.
- 5-hydroxytryptophan (5-HTP), 50 mg two to three times daily, for mood stabilization. Talk with your health care provider if you are on prescription medications before taking 5-HTP. Do not take 5-HTP if you are taking antidepressants.
- Creatine, 5 - 7 grams daily, when needed for muscle weakness and wasting.
- Probiotic supplement (containing *Lactobacillus acidophilus* among other strains), 5 - 10 billion CFUs (colony forming units) a day, for maintenance of gastrointestinal and immune health. Refrigerate probiotic supplements for best results.
- L-glutamine, 500 - 1000 mg three times daily, for support of gastrointestinal health and immunity.
Eating disorders
Source: http://news.bbc.co.uk/2/hi/health/1079435.stm

Eating disorders are responsible for the highest number of deaths from psychiatric illness.

The Eating Disorders Association estimates that about 165,000 people in the UK have eating disorders with 10% dying as a result, but experts believe it could be higher.

Most sufferers are women, but one in 10 are now men. Young people are vulnerable

The most common eating disorders are anorexia, bulimia and compulsive over-eating. But other disorders exist. For example, some people severely restrict the range of food they eat or several children have a psychological fear of food.

Anorexia, which involves depriving the body of food, is more common in young people. Children as young as three have been treated for it.

Bulimia, characterised by a cycle of starving and bingeing, is more likely in adults.

The emphasis on super-thin models has been blamed for the increase in eating disorders.

Experts say that these can have an effect on how people perceive themselves, but the causes of eating disorders are usually more complex and are linked to general feelings of self-worth.

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Anorexia nervosa

Around 5% of young girls in the UK are estimated to have anorexia nervosa. Boys and children from ethnic minorities are much less likely to be affected.

The condition results in death in up 20% of cases after 20 years of onset of the illness. A study by Heidelberg University put the figure at 16%.

Only around 60% of anorexics recover. The illness is also one of the most controversial areas in mental health.

Psychiatrists have singled out several characteristics which they say are typical of anorexics.

These include: a dominant, over-protective and critical mother and a passive or withdrawn father and a tendency to perfectionism, a strong desire for social approval and a need for order and control.

However, many of these characteristics have been the subject of dispute.
The media and its emphasis on super-thin models is also blamed by some for influencing the way people, particularly girls, see themselves and making them believe looks are all-important.

Feminists argue that it is not the images in themselves which are harmful, but the fact that women still derive much of their sense of self-worth from whether they please men.

Anorexia nervosa is a form of intentional self-starvation. What may begin as a normal diet is carried to extremes, with many reducing their intake to an absolute minimum. It is also characterised by obsessive behaviour. The majority of anorexics deny they have a problem.

Lack of food deprives the body of protein and prevents the normal metabolism of fat. The effects of this can include:

- an irregular heart beat caused by a change in the heart muscle. This can lead to heart failure and death.
- ceasing of menstruation
- dehydration, kidney stones and kidney failure
- the growth of fine downy body hair, called lanugo, on the face and arms
- wasting away of muscles, leading to weakness
- constipation or bowel irritation
- osteoporosis caused by lack of calcium.

Symptoms of anorexia

Symptoms of anorexia range from extreme weight loss for no discernable medical reason; ritualistic food habits, such as excessive chewing; denying hunger and exercising excessively to choosing low calorie food and hiding feelings. A person with anorexia may be excessively thin but still see themselves as overweight.

The average age for onset of the illness is thought to be 16, although the age range of anorexia is between 10 and 40. Around 90% of cases are female. Most have no history of being overweight.

Treatment for anorexia

Over 25% of anorexics are so weak that they require hospitalisation. This may involve force feeding as well as advice on healthy eating and counselling.

Many doctors believe that once a person's bodyweight has fallen below a certain level, they are no longer capable of making rational decisions. There has been wide-ranging debate over whether anorexics should be force-fed or whether they have the right to literally starve themselves to death.

In 1997, guidance was offered to doctors, telling them that they can force feed anorexics over the age of 18 under the Mental Health Act 1983. The anorexic must be shown to be incapable of making rational decisions about their condition. Other forms of treatment range from group therapy, family counselling and psychotherapy to antidepressants. Around one third of patients recover fully; another third improve significantly and the last third do not recover.
DEBATEBASE: Anorexics, Force-Feeding of


**Summary:** Should the medical profession force-feed anorexics as part of their treatment?

**CONTEXT:** Anorexia Nervosa is an eating disorder defined as severe, self-inflicted starvation and loss in body weight to at least 15% below that expected for the individual’s sex and height. In the UK (and many other western countries) anorexia nervosa is classified as a mental illness. Anorexia nervosa should not be confused with Bulimia (cycles of bingeing and vomiting). Anorexia is typically associated with women and body image and is thought to be made worse by unrealistic media portrayals of the female body. Having said this, one in ten sufferers is male. Mortality varies between 5% and 18%. Anorexia nervosa has been detected in patients from 6 to 76 years of age and has a far higher incidence in the Developed World, affecting 1% of female adolescents. Patients who are dangerously thin are sometimes force-fed through a naso-gastric (through the nose) tube. Normally, medical treatment cannot be administered without the consent of the patient, however, in the case of mentally ill patients, their distorted perceptions of reality may render them unable to make a choice. Despite this, medical ethics, pragmatics and human rights call the treatment into question.
### Debatabase table of arguments

<table>
<thead>
<tr>
<th>PRO</th>
<th>CON</th>
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<tbody>
<tr>
<td>1. Anorexics are typically treated under mental health legislation (e.g. the UK 1983 Act). They do not make a free choice because they are not rationally able to weigh up decisions and consequences. The patient is not ‘capable of forming unimpaired and rational judgements concerning the consequences’ (British Medical Association 1992).</td>
<td>1. Force feeding is undignified. The European Convention on Human Rights prohibits ‘degrading’ treatment in Article 3. The patient’s right to refuse treatment should be respected even if they are mentally ill. (N.B. Anorexia is not recognised as a mental illness in every country).</td>
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<td>2. Life is more important than dignity, many medical treatments are unpleasant or painful but they are necessary to preserve life. Psychological problems can only be treated if the person is alive.</td>
<td>2. An anorexic’s fear of weight gain, especially forced weight gain in hospital is an obstacle to treatment. If an anorexia sufferer thinks that they will be force- feed they may be less likely to seek treatment or advice.</td>
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<td>3. A healthier body weight is necessary to be able to treat the patient’s psychological problems. Studies in Minnesota show that when normal volunteers were starved, they began to development anorectic patterns. They over-estimated the sizes of their own faces by approximately 50%. This shows the impact of starvation on the brain.</td>
<td>3. 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 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.</td>
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<td>4. Medical ethics say that a doctor has a responsibility to keep the patient alive to administer treatment. In the UK Diana Pretty was denied the right to die by the House of Lords even though she consistently request it. The Israeli Courts ordered the force- feeding of political hunger strikers arguing that in a conflict between life and dignity, life wins. India prosecuted a physician who allowed a hunger striker to die. The medical profession take their responsibility for life very seriously on a global level.</td>
<td>4. Force-feeding has negative consequences. If the patient is dangerously thin and is then force-fed, it can led to Hypophosphataemia (reduction of phosphates in the blood) which causes heart failure. Anorexics are characterised by self-denial and often do not come forward voluntarily. They are even less likely to do so if they are faced with the possibility of force- feeding.</td>
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<td>5. Palliative care is defeatist and does not attempt to cure the problem. Doctors do not often have to deal with severe or chronic anorexia. Just because it is a very long treatment schedule that can be harrowing for a doctor, this not a reason to settle for palliative care. Better support structures ought to be put in place to enable the doctor to fulfil their obligation to the patient.</td>
<td>5. Some doctors advocate focusing on palliative care (relief of pain but not treatment of cause) due to the low full recovery rates of anorexia sufferers. Research Studies Show that over 10 years only approximately 20% of patients recover. Those patients who are sufferers for more than 12 years are unlikely to ever recover.</td>
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INDEPENDENT: Doctors get right to force-feed anorexic patients


Doctors are legally entitled to force-feed anorexic patients to stop them from dying, according to guidelines from the mental health watchdog.

The Mental Health Act Commission has for the first time prepared guidance for health authorities and social services because of confusion over how far doctors can go to stop patients from starving to death.

The legal position has not been clear and the commission took the decision to issue the briefing note after the case of Nikki Hughes, who died in January 1996. Ms Hughes had suffered from anorexia since her teens.

The Royal Shrewsbury Hospital, where she was treated, sought legal advice and was told that feeding her without her consent could have led to assault charges. Doctors were told they could not override her wishes not to eat.

In 1992, however, the High Court ruled that a 16-year-old orphan, known as "J" should not be allowed to starve herself to death, but could be treated against her will to prevent her suffering serious brain damage.

The commission's briefing note advises doctors that in certain situations, patients with anorexia nervosa, whose health is seriously threatened, may be compulsorily admitted to hospital.

While "the consent of the patient should always be sought", it goes on to say that some patients "may not be able to make an informed choice as their capacity to consent may be compromised by fears of obesity or denial of the consequences of their actions".

It adds: "The courts have ruled that feeding a patient by artificial means to treat the physical complications of anorexia nervosa can reasonably regarded as medical treatment for a mental disorder."

The move was welcomed by mental health experts and by pressure groups representing sufferers. A spokeswoman for the Eating Disorders Association said: "Any guidelines which help people interpret the Act surely must be good to clarify the situation for people."

Dianne Jade, principal and founder of the National Centre for Eating Disorders, said: "I have always approved of compulsory treatment for anorexics. In the condition the thinking processes in the brain are changed by starving and the patient is not in control or able to take care of herself."

Dr Jill Welbourne, an eating disorder specialist, said that it was a "step forward" for treatment of anorexics. "It explains that anorexia is a mental illness, health and safety is at risk and that voluntary treatment is not always possible or practicable."
June McKerrow, director of the Mental Health Foundation, said: "It makes the position clearer for clinicians and carers." But she called for anorexics to have access to treatment much earlier in their treatment: "Anorexia is a growing problem and unless ways of treating people are sorted out we will see more and more people reaching this unnecessary late stages of crisis."

As many as one in 20 people, of which the vast majority are women, display symptoms of anorexia, although most are never formally diagnosed. About one sufferer in 100 needs long-term treatment, and of these one-fifth die, half from starvation and half from suicide.

**Should the medical profession force-feed anorexics as part of their treatment?**


Anorexia Nervosa is an eating disorder defined as severe, self-inflicted starvation and loss in body weight to at least 15% below that expected for the individual’s sex and height. In the UK (and many other western countries) anorexia nervosa is classified as a mental illness. Anorexia nervosa should not be confused with Bulimia (cycles of bingeing and vomiting). Anorexia is typically associated with women and body image and is thought to be made worse by unrealistic media portrayals of the female body. Having said this, one in ten sufferers is male. Mortality varies between 5% and 18%. Anorexia nervosa has been detected in patients from 6 to 76 years of age and has a far higher incidence in the Developed World, affecting 1% of female adolescents. Patients who are dangerously thin are sometimes force-fed through a naso-gastric (through the nose) tube. Normally, medical treatment cannot be administered without the consent of the patient; however, in the case of mentally ill patients, their distorted perceptions of reality may render them unable to make a choice. Despite this, medical ethics, pragmatics and human rights call the treatment into question.

In cases of severe anorexia, should the medical professionals be able to force feed an anorexic person against their will? Is this a time where a persons individual rights can be waived without being against their human rights? Once the person has regained their health, would they have any valid legal recourse against the physician who provided the nourishment?
In chiaroscuro outline, on a high mountain plateau at sunset, as in a Bergman film, the three major ethical principles march entrained along the landscape: autonomy first, followed by beneficence, and then nonmalfeasance. The serious study of how these ethical principles apply to eating disorders, especially anorexia nervosa, has been woefully neglected. Jurisdictions in the United States and elsewhere differ sharply on whether anorexia nervosa—or any eating disorder—qualifies for judicially sustained legal commitment to hospital or whether separate petition for use of medications is required, if use of medications is allowed at all.

There is little conflict on the need for life-saving commitment to hospital in other areas of serious psychiatric disorder, such as major depressive disorder with clear suicidal intent and means, with or without psychosis. Similarly, a patient suffering from schizophrenia with command hallucinations to harm others may be required to be admitted to hospital for safety and treatment, whether or not the individual perceives the process to be coercive.

Why are eating disorders, especially anorexia nervosa, viewed differently and through a more conflicted lens? There may be several reasons. First, there is no consensus on the core psychopathology of eating disorders, and hence our understanding of the disorder’s etiology is problematic. Differing beliefs about the nature of a disorder lead to different views regarding the legitimacy of the use of coercion, whether formally applied or informally perceived. Second, many outdated assumptions and frank mistruths exist about eating disorders, especially anorexia nervosa, including beliefs that these disorders are voluntary in nature and thus can be self-improved, that mandated treatment is futile, that chronicity is inevitable, and that eating disorders are indistinguishable from "normative cultural distress" about weight.

Leaving aside dogmatic conclusions about the etiology of eating disorders, the following statements about these disorders are generally accepted as factual:

1. Anorexia nervosa has the highest premature mortality of any major psychiatric disorder, estimated to be as high as 19% without treatment. It clearly can be a deadly disorder. Bulimia nervosa can be equally deadly when associated with hypokalemia or suicidality.

2. Eating disorders are multifactorial, and much remains unknown about the process by which widespread, culturally sanctioned, usually ineffective dieting transitions to a deadly disorder. The situation resembles that of a person boarding a canoe headed for Niagara Falls on a journey that begins voluntarily but inexorably transforms into a nonvoluntary propulsion toward the Falls, with the person at times not recognizing that the upcoming Falls even exist.

3. Eating disorders are spectrum disorders, and clinicians’ assumptions about the need for involuntary treatment may depend on whether their experience has been with mild or severe cases of this not uncommon disorder (its prevalence is the same as that of schizophrenia and childhood diabetes).

4. The core psychopathology of eating disorders is not, as has been intermittently proposed, a psychosis, obsessive-compulsive disorder, or a forme fruste of affective disorder, but rather overvalued beliefs. Overvalued beliefs are probably the most neglected category of psychopathology in the instruction provided in U.S. psychiatric residency programs, despite the fact that they were appreciated in detail by Kraepelin and Meyer and other great
psychopathologists. They are pragmatically defined as widely held sociocultural values or beliefs that are given ruling passion with risky, even deadly, behavioral consequences in a minority of the population, usually during the years of identify formation, the teens and early twenties. McHugh (1) has noted that the core of terrorism resulting in homicide (not suicide) bombing results from overvalued beliefs.

The overvalued belief at the core of eating disorders is summarily described as the overvaluation of the benefits of and need for weight loss or shape change, leading to dieting behavior, augmented with binge-purge behavior in some cases of anorexia nervosa and in 80% of cases of bulimia nervosa, and with severe overexercing in many cases. Bulimia nervosa may be viewed as an attempt at anorexia nervosa in individuals who do not have the extreme perseverance that allows the overriding of the hunger-induced drive to eat. This view suggests a core shared psychopathology for all eating disorders, and in the persuasive view of some, a transdiagnostic approach to treatment. The specific psychopathological motifs that form the two sides of the same psychopathological coin in eating disorders are a morbid fear of fatness vying in intensity with a relentless pursuit of thinness. As an indication of how seriously these core misbeliefs are taken, the avoidance of calories takes precedence over receiving the Host in the Mass in many Catholic patients with anorexia nervosa who take their religion seriously but take their fear of fatness and pursuit of thinness more seriously. This is not a touch of "cultural insanity" but a potentially deadly illness.

If a patient’s clinical condition meets common legal criteria for petition for involuntary admission to hospital and treatment, there is no reason the category of eating disorders should be excluded from consideration for life-saving treatment. The common criteria for involuntary care are that a patient has a psychiatric disorder; the disorder presents a substantial possibility of deadly outcome by direct action or inaction by the patient; and the patient does not recognize the need for treatment even though the illness is life threatening.

Involuntary care can be compassionate care. Although accounts remain sparse in the literature, several recent publications have reported that anorexia nervosa patients who are treated involuntarily do as well in acute treatment as "voluntary" patients. In sum, after treatment, they offer a grudging or overt "thank you" rather than wishing "a plague on you" (2, 3).

The article by Guarda et al. in this issue contributes substantially to supporting the practice of using perceived coercion or frank pressure to be admitted in order to treat severely ill eating disorder patients. The study illustrates how short-term beneficence trumps autonomy in selected situations and how quickly autonomy is restored with treatment. Within several weeks of the start of treatment, the ego-syntonic nature of the eating disorder diminishes, yielding to the patient’s recognition of the need for treatment and autonomous support of treatment. By following changes over time in patients' willingness to endorse the need for treatment, several goals are accomplished at once: the need for treatment that is perceived as coercive is validated by the seriousness of the eating disorder; the beneficent use of perceived coercion does not endure long as a perception but changes to a gradually strengthening therapeutic alliance with the treatment team; and autonomy returns as leader of the train of principles on the mountain plateau.

The ethical principle of nonmalfeasance, the third in the train of principles, is widely abused in diagnosis and treatment (not to mention health care funding) of eating disorder patients, but a detailed discussion of this misuse must be deferred to another time. In the meantime, the report by Guarda et al. on perceptions of coercion and need for treatment in eating disorders is
a welcome contribution to the field, and one that may help sway jurisdictions that currently do not view the use of coercion or involuntary treatment with eating disorder patients as necessary and validated. Still, as the authors note, long-term follow-up after mandated or "coerced" treatment is needed to assess long-term outcomes. The one published study using indirect methods of following the long-term outcome of involuntarily treated anorexia nervosa patients (4) suggests less favorable outcomes for those receiving mandated treatment, but not as any direct negative consequence of the acute involuntary treatment itself.

Eating disorders, especially anorexia nervosa, raise significant ethical challenges and dilemmas regarding even the diagnostic terms and criteria commonly used, treatment methods, length of stay, health care funding, and feasibility of preventive intervention. These ethical challenges are not beyond study, however, and research is urgently need to elucidate them.

**SCOTLAND: Doctors told to force-feed anorexics**

**Published Date:** 25 March 2007

By KATE FOSTER

DOCTORS have been issued with controversial new guidelines which spell out for the first time when they are legally allowed to force-feed anorexic patients close to death.

The rules state that if two doctors believe an anorexic patient is mentally ill and in danger of dying, the patient can be sedated and tube-fed against their will.

The new Scottish guidelines, issued by the Mental Welfare Commission, also allow dangerously underweight children to be force-fed against the wishes of their parents.

Anorexia affects a growing number of Scots and there has been severe criticism of the lack of specialist services. Scotland on Sunday can reveal that each year around 30 patients are already tube-fed without consent north of the Border.

The practice is allowed under existing mental health laws, but until now there has been no specific guidance on when and how anorexic patients should be force-fed, leaving medics vulnerable to compensation claims.

Patients' groups last night expressed concern about the guidelines because they fear doctors will be more likely to resort to force-feeding rather than trying to persuade patients to consent to treatment.

But Dr Flora Sinclair, medical officer for the Mental Welfare Commission, said they wanted to ensure the practice was only carried out as a last resort and under strict criteria.

Patients who become extremely ill as a result of their eating disorder need to be kept alive by artificial means, such as a tube inserted into the nose or stomach which gives the body vital nutrients.

However, many people with anorexia are so ill they do not want any kind of sustenance. In such cases,
they must be sedated and treated against their will because they are often so frail that it is too
dangerous to try to hold them down.

Sinclair said: "Doctors would only be able to resort to something like this without the patient's consent
if there were very serious concerns that they may die. It's not just if they are refusing food and getting
thinner, it's where there's a real physical risk that they may collapse and die. It's basically to save their
life."

She added: "We thought it was important to have practice guidelines for people thinking about giving
artificial nutrition without patient's consent. We are trying to ensure that if people are going to use
these provisions they are going to do it properly. This makes it clearer and introduces specific
safeguards that have to be put in place. This is not to make it more attractive as a treatment option."

Sinclair said doctors could also forcibly treat children under the age of 16 who were refusing food,
even against their parents' wishes.

She said: "By far the best thing is to come to a negotiated compromise, but there may be times when
clinical teams have to treat against the will of both parents and children."

The guidance also warns that doctors must take legal advice if they are considering stopping treatment
in line with a patient's wishes, a decision that would lead to the death of the patient, because of the
legal and ethical considerations of withdrawing life-sustaining treatment.

Scotland had 217 people diagnosed with anorexia, bulimia and other eating disorders last year, 35%
more than the 161 patients in 1999. Experts estimate that the true number of undiagnosed cases is far
higher and it is thought that 83,000 Scots have some form of eating disorder.
Yet there are few NHS services for such patients, and doctors have to refer the most extreme cases to
two private centres, Huntercombe Edinburgh Hospital in Uphall, West Lothian and the Priory in
Glasgow.

Mark Reilly, head of services for the eating disorders support group B-eat, said: "This is a sensitive
issue as treatment against a patient's will is not always successful. Eating disorders are most
successfully treated when the problem is addressed early on.

"Where there is this dilemma it may be helpful to have guidelines, but it does raise the debate about
whether it promotes the practice."

Anorexia is a complex mental illness in which sufferers starve themselves even when they are
dangerously thin. Refusing to eat is a way of coping with their emotions and problems and keeping in
control. Experts believe 20% of those seriously affected will die as a result, from associated conditions
such as heart failure which may occur years later.

Experts fear the size zero craze led by models with a waist measurement of just 22 inches is triggering
more eating disorders among women.

Fiona Campbell, who is recovering from anorexia after suffering from the condition for 20 years, said
she believes the guidance will save lives.
She said: "When people's weight drops with an eating disorder their ability to make rational decisions becomes more difficult and their obsessive tendencies become more pronounced. It is very important that there is something in place that can help."

Scottish Conservative health spokeswoman Nanette Milne said: "If people are this ill they need to be treated and this is a life-saving measure. But it then has to be followed up with proper psychiatric treatment and there are serious concerns about the lack of facilities for these patients, and it's crucially important that they are given the proper treatment because this is a serious illness."

SNP health spokeswoman Shona Robison said: "The idea of force-feeding is something that makes me feel very uneasy and I would want to meet with the Commission to talk about this. Obviously this would be used only in extremis, but then not eating is only a symptom of what is really mainly a mental illness. The key difficulty is a lack of available mental health services, and that is what needs to be addressed."

**Disorder leads to disease and death**

ANOREXIA nervosa is an eating disorder mainly affecting adolescent girls, but boys can also suffer from the condition.

Its cause is unknown, however biological and social factors are believed to contribute. Puberty, bullying, peer pressure to lose weight and other life stresses are often catalysts.

Health practitioners usually diagnose anorexia when someone's body weight is at least 15% below their expected weight.

Symptoms include depression, cessation of periods, delayed development in puberty and loss of interest in socialising.

There are many medical risks associated with anorexia, including irregular heartbeat, mineral loss, reduced fertility and osteoporosis. Sufferers are encouraged to seek help from their GP.

Hospitalisation can be required when body weight drops 20 to 25% below normal weight. Treatments include talking therapies and medication.

Severe anorexia can prove fatal. Lena Zavaroni, the Scottish child prodigy, developed severe anorexia and depression.

Despite spending two years in a Canadian clinic for eating disorders, the singer, from Rothesay on the Isle of Bute, died of pneumonia aged 36 weighing less than five stone.

Brazilian model Ana Carolina Reston died from anorexia-related complications last year, aged 21.