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Ethical Considerations in the Treatment of Eating Disorders

INTRODUCTION

Ethical treatment of eating disorders is complicated by a number of factors, including the use of multidisciplinary teams with different priorities, as well as the frequent lack of insight among patients regarding the seriousness of their disorder and need for treatment. Various professional organizations involved in the care of patients with eating disorders have their own defined set of ethical principles or standards. Despite subtle differences, most sets include variations of the following:

- respect for persons (deep regard for the worth and dignity of all human beings),
- autonomy (right to self-governance),
- beneficence (the duty to act in a way that provides the greatest positive consequences and the least negative consequences),
- nonmaleficence ("first, do no harm"),
- veracity (honesty or truth-telling), justice (treating people fairly and without prejudice),
- fidelity ("faithfulness"),
- duty to protect (responsibility to protect patients welfare from risk/harm), and
- privacy (right to protect personal information).

How professionals weigh these particular principles will often lead to a different approach to treatment; thus there is no clear-cut guideline for applying these principles to patient care. For example, in cases where the patient is a danger to herself (note: while males also have eating disorders, we will use female pronouns for simplicity in this paper), the need to protect the patient from harm may override the need to protect the patient's autonomy. Instead, we propose a number of issues to be considered on a case-by-case basis and emphasize the importance of sound clinical judgment and contemplation when making decisions regarding the treatment of eating disorders.

TREATMENT REFUSAL IN EATING DISORDERS

One of the primary concerns that professionals treating eating disorders face is that of treatment refusal and/or ambivalence. Anorexia nervosa, in particular, is often characterized by a denial of the seriousness of the illness (1), which can result in a lack of insight into the need for treatment. When patients do agree to treatment, they may refuse important components of treatment, such as intake of adequate meals or pharmacotherapy that may have reported weight gain effects. At the outpatient level, it appears as a lack of compliance with the treatment. At a higher level of care, including

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inpatient, residential, or partial hospital programs, it may result in treatment dropout. Health care providers, as well as family and loved ones of the patient, may desire to treat the patient against her will. Indeed, patients may be conserved if they are determined to lack competence to consent to treatment. As is the case with most minors, conserved patients may not have the legal right to refuse treatment. This may seem applicable to many patients with anorexia nervosa where malnutrition has impaired cognitive abilities (2) and where there is a severe lack of insight into the gravity of the disorder (3). Indeed, brain atrophy does occur in cases of severe malnutrition, and this may affect decision-making capacity (4, 5). However, the benefits of treatment may not outweigh the potential damage of denying patient autonomy. In our practice, for example, we have encountered patients with symptoms of posttraumatic stress disorder from enforced nasogastric tube feedings. Thus, the decision to begin treatment against a patient's will is not one to take lightly. Simply thinking irrationally does not suggest lack of competence to consent to treatment (6). One measure to use when determining treatment recommendations and potentially treating against a patient's will is using relevant history to determine whether the patient would make the same decision if she did not have an eating disorder. Truly evaluating reasons from a patient about refusal for treatment is important to understand whether she is simply acting irrationally or showing evidence of incompetence. For example, a patient may be refusing nasogastric tube feedings because of physical discomfort from a large tube, but may be agreeable to a smaller tube or to nocturnal feeds so that she is not conscious during the feed, thus eradicating the need for compulsory feeding.

There are cases where treatment against a patient's will may be warranted. This most frequently is seen in adolescents. There is additional need to protect adolescents from the potential chronic course of an eating disorder, which may occur without early intervention (7). Additionally, the timing of puberty with the onset of eating disorders suggests particular medical and health consequences of malnutrition on adolescents with eating disorders, and thus the importance of treatment in this population may be heightened (8). There are also many patients who have described a sense of relief from enforced treatment and feeding (9) and patients whose involuntary hospitalization led to a more positive mindset and consent to further treatment (10). The guilt and shame around eating can be so strong that being denied the choice to refuse food can actually relieve some of the guilt for patients. This is important to consider when evaluating costs and benefits of involuntary treatment in cases of treatment refusal.

Treatment selection

Selecting a level of care or a treatment approach may also bring about ethical considerations. The principle of beneficence pulls for the need to utilize evidence-based practice to ensure the best possible outcome for patients. However, current evidence for treatments of eating disorders suggests a success rate of about 50% (11, 12). Strober and Johnson (11) outline the importance for determining when a treatment is not working and a change in treatment approach may be needed. Although there are good treatments available for eating disorders, including family-based treatment, cognitive behavioral therapy, dialectical behavior therapy, and interpersonal therapy, even the best treatments do not show remission in 100% of patients, so a change of course must be considered for patients failing to respond. This leads to another decision point where ethical considerations must be weighed, including the patient's autonomy and choice, as well as the likelihood for best outcomes and protection from the harm that the continued use of ineffective treatment may bring. At times, when evidence-based practices have been exhausted and remain insufficient, clinical expertise and judgment is important to remain positive and hopeful. Indeed, a number of treatment approaches may be beneficial for treating eating disorders, but have not yet been evaluated in large trials.

A higher level of care may be warranted, and this decision should be made with the patient to minimize the need for involuntary or coerced treatment. Showing the patient that you have her best interest in mind and explaining treatment recommendations in terms of enhancing positive consequences and minimizing negative consequences (i.e., beneficence) can be helpful. For example, we recently recommended to a patient that she seek a higher level of care from the current outpatient therapy. The recommendation included the rationale, including the benefits of support during meals and the relief from the guilt of deciding whether and what to eat for a given meal and highlighting the negative consequences of continuing the current level of care, such as further distress and strain around meals and low energy, which were impacting her success at work. Emphasizing these points is important, as recommendations to seek alternative treatment may be seen as rejection or that the patient is too weak to manage the current treatment.

Multidisciplinary teams

Many patients with eating disorders employ the care of a variety of care providers, including psychologists or psychiatrists, dieticians, and internal medicine or family practice physicians. These care

providers must each practice within the scope of their own ethical guidelines, but also within the scope of their training and practice. It may be possible to learn about aspects of therapy from workshops and through clinical experience, but it is important for therapeutic approaches to remain in the hands of trained and licensed professionals (i.e., therapists, social workers, psychologists, psychiatrists). For example, a dietician should keep the focus of sessions on meal planning and problem-solving issues specifically related to food and should not be conducting therapy. Additionally, despite extensive education that many therapists may receive about the medical consequences of eating disorders and various metabolic and endocrine measures that may be impacted, it is important for those aspects of care to be managed by a physician.

Furthermore, dieticians, physicians, and even therapists are often involved in the management of obesity as well as eating disorders. This brings up new issues regarding the emphasis on "healthy weight" rather than healthy lifestyles and behaviors. Healthy weight may vary tremendously from person to person, and using algorithms to provide patients with a healthy weight range that may or may not be accurate for their own body and history can lead to distress when aspects of health do not return in that range. Thus ethical principles of respect for persons and nonmaleficence become relevant in determining a goal weight. For example, a patient with anorexia nervosa was recently given a healthy weight range of 120 to 125 pounds. When she reached that range and maintained the weight for 6 months, but still did not have a return of menses, she became discouraged. Medical doctors recommended additional weight gain, and when she reached 130 pounds, she resumed her menstrual period. However, she struggled with self-esteem at this weight and viewed herself as overweight because of the initial weight recommendation by her team. Thus, it is important to focus on health measures that are not connected to weight in order to reduce potential harm from making errors in weight recommendations.

Ethical issues specific to higher levels of care

There are numerous ethical considerations pertaining to both admission to a higher level of care and treatment within a higher level of care. When patients become ill enough to warrant partial hospitalization, residential treatment, or inpatient hospitalization, mental health professionals have a number of issues to consider. Under the principle of justice, clinicians should strive to use the least restrictive level of care (13). Furthermore, within the specific level of care, the least restrictive and coercive measures should be implemented to ensure fair treatment of the individual.

Perhaps of greatest consideration regarding ethical principles and higher level of care is involuntary admission. Compulsory treatment is a longstanding controversial issue in psychiatry. A recent review of this dilemma notes the importance of collaboration between clinician and patient in order to reduce the need for involuntary treatment (6). Compulsory treatment is often discussed within the ethical principle of duty to protect or "dangerousness." Factors important to take into account when deciding to involuntarily admit a patient with an eating disorder include their current medical risk, long duration of illness, and psychiatric presentation including comorbidities and trauma history (6, 10, 14). While there is great debate in the mental health community on this topic, most clinicians agree that compulsory treatment is warranted in cases of severe illness (15). Patients involuntarily hospitalized have been found to experience rates of weight gain similar to their voluntary counterparts (10), which may support this practice. However, involuntary treatment is not necessarily curative and may lead patients to take drastic measures to regain control after discharge as well as damaging therapeutic relationships (16). Thus, many important factors as well as a lengthy discussion with the patient involving rationale and motivations should be part of this extreme, but sometimes necessary, decision.

Many of the specific issues that take place at a higher level of care fall under the ethical principles of autonomy and justice. Infringement upon a patient's freedom of choice of individual liberties goes hand in hand with more restrictive treatment applications. These include such actions as monitored meals, movement and exercise restriction, contraband removal, bathroom observation, and enforced feeding. These measures can contribute to a loss of autonomy and control. When patients sense a loss of freedom and choice, this may encourage rebellion and a lack of compliance (17). Furthermore, these actions can also feel like a punishment if implemented sloppily and without sound rationale. Importantly, preserving patient autonomy is related to treatment outcome. In a recent review (18), it was posited that pretreatment autonomous motivation to change was associated with improved outcomes for dietary restriction, binging, and cognitive/affective indices of eating behavior. Thus, preserving patients' independence (and perhaps even a perceived sense of independence) may improve their recovery. Particular restrictive treatment measures in the context of higher levels of care will be addressed specifically. Many of these methods have not been examined empirically; however, special attention will be paid to empirical evidence in support of or against commonly practiced restrictive procedures.

Various measures are often taken to reduce caloric expenditure in patients being treated for eating

disorders. These include: bed rest for severely underweight or medically unstable patients, movement restriction (e.g., limiting walking around the unit, making patients sit rather than stand, redirecting fidgeting behavior), and exercise restriction for underweight patients or patients who overexercise for purgative purposes. For example, a recent male inpatient with anorexia nervosa, a BMI of 14, and a history of compulsive exercise (up to 7 hours per day) was not permitted to exercise or walk any more than necessary around the unit (e.g., from his room to the group room only). He said he felt as if his basic rights were being taken away and felt this was antitherapeutic because exercise was his only strategy to manage anxiety. Only after the rationale for this prohibitory action was explained in a caring manner was he able to accept and understand this restriction. Additionally, we attempted to meet him in the middle and allowed him monitored light stretching with the recreational therapist in order for him to alleviate some of his anxiety. Like monitored meals, patient autonomy is diminished with the use of enforced limited activity, but may result in enhanced treatment outcome and health, which is reflected in the ethical principle of beneficence.

Removal of contraband is a routine practice on psychiatric units treating many psychiatric illnesses. The purpose is to provide a safe and controlled environment for the milieu; however, it can also be perceived as yet another infringement upon one's personal rights and liberties. Given the universality of this practice across psychiatry, it is typically accepted and understood to be a safety measure for all patients. Some patients may be uncomfortable giving up their access to certain things (especially items such as diet pills or laxatives); however, most patients understand giving up these items to be part of a voluntary eating disorder program.

Bathroom observation is another common eating disorder treatment practice at higher levels of care. The purpose of patients being observed while in the restroom may be to protect them due to medical instability (e.g., to prevent a fall in the shower) or to ensure that they are not purging after meals. Although this appears to violate a patient's right to privacy and autonomy, it may protect her from the strong urges to act on their eating disorder impulses, which would provide support and benefit for positive consequences in terms of recovery and health. As with all restrictive enforcements, the rationale should be explained thoroughly as well as the implementation done sensitively. Additionally, this practice should be tailored to the patient. For example, same sex observers should always be used and the patient's trauma history be taken into account. We recently had a patient who had been sexually assaulted in a bathroom, thus we used extra precaution to preserve the patient's autonomy and respect including allowing her to ask for specific staff members with whom she felt most comfortable to accompany her. We had another patient who had rectal prolapse due to years of laxative misuse whom we allowed privacy after bowel movements so that she could tend to the damaged tissue without being observed. Given the inherently private nature of using the bathroom and the current patient population, this is one treatment practice that requires much explanation and sensitive practice.

Enforced feeding is a core component of most eating disorder programs. This ranges from patients having to ingest their allotted calories or risk losing privileges, to nasogastric tube feeding. Again, how this imperative part of treatment is implemented is crucial. Coercive refeeding may be seen as a hostile act by a health professional and thus strengthen conditioned food avoidance (17). The consequences enacted if patients refuse feedings may help elucidate whether ethical principles are violated. For example, losing privileges involving body movement may be explained as a simple protection of the patient's health and well-being, whereas refusing television privileges may violate principles of justice and autonomy and does not obviously promote patient health and well-being. Neiderman and colleagues (19) have delineated guidelines for decisions regarding nasogastric tube feedings in adolescents, but similar suggestions are likely beneficial for adults. The nine measures they outline revolve around providing patients with a great deal of information and psychoeducation as well as collaborative discussion between the patient and the treatment team. Monitored meals, which include food ritual redirection and normative eating instruction, are commonly practiced at a higher level of care and fall under the umbrella of enforced feeding. Meal support can be implemented in a way that is viewed as supportive and collaborative, but it can also be perceived as authoritarian and potentially increase shame and self-consciousness surrounding mealtimes.

Ethical treatment of minors requires special consideration. As noted above, these patients are likely at particular risk for health consequences and the potential chronic course of an eating disorder, and legal consent to treatment is placed with parents or guardians. Thus, voluntary hospitalization for an adolescent may actually reflect the decision of her parents rather than her own choice. Many hospitals allow a teenager of a certain age to contest treatment before an unbiased party, who evaluates the need for treatment. Many adolescents may suffer from difficulty with decision-making beyond effects of the eating disorder, as their limited life experience may impact their perception of risk. Thus,

compulsory treatment may be necessary for adolescents more frequently than for adults.

CONCLUSION

This review is by no means comprehensive of all of the ethical dilemmas that arise during the treatment of patients with eating disorders. Instead it is an attempt to summarize some of the primary issues and attempt to highlight the importance of clinical judgment in order to prioritize competing ethical principles. In some cases, the duty to protect from harm may override patient autonomy, just as is the case with a patient's right to privacy. In other cases, such as enforced feeding, it may be quite difficult to weigh the costs and benefits, but through open discussion of the rationale for these decisions, clinicians may minimize negative impacts on their patients.

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