Ethical dilemma of the therapeutic decisions in the care of the severe chronic anorexia nervosa: About a case

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When caring for patients suffering from severe anorexia, medical teams may feel deprived in the face of the ambivalent behavior of some of these patients who accept medical care but refuse nutrition. We present here the case of a woman suffering from severe chronic anorexia with a state of morbid malnutrition, which presented the ethical question of how to deal with this unreasonable attitude. These extreme cases raise several questions regarding avoiding malfeasance and when to provide palliative care in a management of psychiatric pathology.

Keywords: Anorexia, End of life, Ethics, Psychosis, Palliative care

INTRODUCTION

Anorexia is a mental condition characterized by voluntary food restriction that can lead to severe complications. In France, as in most industrialized countries, anorexia nervosa is the psychiatric disease with the highest mortality rate (Keel et al. 2003). Medical teams at times feel powerless when faced with the behavior of certain patients accepting hospitalization while refusing care, including nutrition. In these extreme cases, the choice of therapy is problematic, i.e., the question of whether to administer curative or even palliative care to which the patient has not consented. Some authors (O'Neil, Crowther and Sampson 1994) think anorexia is not a

lethal or terminal condition, because there is a treatment for it, while others (Ramsey and Treasure 1996) think anorexia is a lethal mental disorder and palliative care is a legitimate and ethical response to it.

These cases of patients presenting a pre-morbid state of malnutrition are not exceptional and raise the difficult ethical question of defining a reasonable response while respecting the patient (Draper 1998). We report such a case presented to our unit.

CLINICAL CASE

We present the case of Mrs. X, 56 years of age, suffering from anorexia nervosa for the past 30 years, hospitalized for

extremely severe malnutrition (body mass index, 9) complicated by deficiency-related heart disease, with valvulopathy and pancytopenia with gelatinous bone marrow transformation (Boullu-Ciocca et al. 2005). The patient's medical, surgical, and psychiatric history indicated a recent unhealed double fracture of the tibia treated with a cast, immobilization, and enforced hospitalization in a psychiatric facility because of dissociation syndrome with hypochondriac delirium.

This patient presented a psychotic personality: ambivalence, denial of disorders, dysmorphophobia, and hypochondriac preoccupations responsible for the behavioral disorder with physical hyperactivity. She expressed death anxiety during episodes of severe hypoglycemia.

This woman's personal biography showed her to be single with no children, and the fourth of seven children. A middle school teacher, she had not worked for at least 5 years for medical reasons.

At her admission in our department after an initial stay in the intensive care unit, the patient weighed 32 kg (with the cast) with a height of 155 cm. Cardiac function had improved with an ejection fraction of the left ventricle at 45% versus an initial ejection fraction at 25%, after a treatment by amines, vitamins, trace elements, and parenteral nutrition. The biological workup showed pancytopenia with gelatinous bone marrow transformation. From a nutritional perspective, albumin was at 15.3 g/l (normal range 30.0–47.0 g/l) and prealbumin, 54 mg/l (normal range 225.0–385.0 mg/l). Major hepatic cytolysis was noted with ultrasound of the liver considered normal.

Treatment included enteral nutrition, rapidly undermined by the patient, despite cautious anxiolytic treatment. We were quickly confronted with insoluble therapeutic choices:

- The patient's refusal of enteral nutrition encouraged the physicians to suggest the patient be cared for in psychiatry to relieve her psychological suffering and obtain her adherence to care and resume food intake.
- The indication for enforced hospitalization and neuroleptic treatment were justified but contraindicated by the psychiatrists given the risk of secondary cardiologic and metabolic side effects.

This double treatment with potentially lethal risks led us to consult our university-affiliated hospital ethics committee, which recommended implementing cautious neuroleptic treatment and admission to a psychiatric facility. Unfortunately, the patient died a few days after the progressive introduction of this treatment.

CASE ANALYSIS

French law

In France, the law of April 22, 2005,¹ called the Leonetti law, reinforces the right of patients to refuse any and all treatment. The physician is obliged to inform the patient, in a "clear, loyal, and adapted" manner, of the consequences of the refusal. If the patient persists in his or her wishes, the physician can only accept and set-up care to make the patient comfortable and palliate the effects of ceasing treatment. If the patient is not at the end of life (advanced or terminal stage of a serious or incurable disease) a reasonable period of time is required by law as well as a possible meeting with a second physician.

The law stipulates, however, that assessing the relevance and the risks and benefits is a medical responsibility. Most particularly, the law encourages healthcare professionals to collaboratively elaborate a treatment plan,² notably when the patient cannot express his or her will.

In its article 2 the Leonetti law³ also stipulates the possibility of implementing a treatment that could have the side effect of accelerating death under three conditions: that the patient be at the end of life, that the patient has been informed, or the family if the patient is not able to make decisions, and particularly that there is no other possibility to relieve the patient than implementing risky treatment.

However, nothing is stated about the patient's ability to exercise good judgment, and only the following is specified: "able or not able to express one's will." In the case of a patient presenting with a psychiatric disorder, the question of autonomy is eminently delicate. When can it be decreed that the will expressed by the patient is no longer valid? Judgment on the reasonableness or unreasonableness of a refusal of treatment becomes both objective (medical criteria of efficacy and utility) and subjective (relativity of the notions of reasonable and bearable). The frequent uncertainty of the progression of the patient's state with and without treatment reinforces the difficulty of the decision. Hence, the value of collegial and interdisciplinary reflection.

The ethical dilemma

Mrs. X's situation presented a true ethical dilemma in its juxtaposition of different principles (Beauchamps and Childress 2008): the principle of first doing no harm (*primum non-nocere*), the principle of beneficence, and the principle of autonomy.

The suffering induced by psychiatric decompensation and expressed by the patient both in her refusal to ingest anything, but also in her fear of death, could not remain without relief. However, this therapeutic response included a vital risk because the patient's somatic state was already highly altered by years of anorexia.

The first option would be to consider the patient's refusal as valid and not go against her wishes by imposing a treatment, thus allowing the inevitable advent of death given the impossibility of providing somatic treatment and possibly nutrition, but with the patient in a state of severe psychological suffering.

The other option would consist in implementing, and therefore imposing, a risky treatment to relieve the patient on the psychological level, with the aim of resuming the dialogue with her on whether or not to resume food intake, which she had consistently accepted in the past. Whichever option is selected, a major value is transgressed: in the first case, beneficence toward the patient versus her autonomy; in the second case, respect of the patient's autonomy at the expense of beneficence. But in Mrs. X's situation, evaluation of good and harm, and therefore appreciation of the balance between risk and benefit was particularly delicate and uncertain (Draper 2000).

In the clinical case presented herein, a decision was made despite the various factors at play, after consultation with the ethics committee whose main objective was to relieve the patient's psychological suffering in order to allow her to regain her capacity for autonomy. The negative effect, predictable but not desired, prevailed over the beneficial effect sought by the medical team.

CONCLUSION

This situation illustrates the difficulties encountered when somatic diseases and psychiatric problems intertwine, challenging both patients and caretakers.

This case demonstrates a conflict between beneficence and autonomy. By French law, autonomy is clearly the highest value, even in patients who are not

competent to make their own decisions. Respecting the patient's will, not impeding autonomy but rather returning it, working for beneficence, avoiding harm and futile aggressive treatment: these are the challenges faced by today's medical teams. Collegial consultation will never simplify decision-making, but it will allow each voice to be heard and the decision, thoroughly deliberated and well reasoned, will take on meaning for all those involved, even when the desired improvement cannot be achieved.

This case also highlights how difficult it can be to accompany a patient suffering from severe psychiatric and somatic disorders at the end of life, as can be presented by chronic severe anorexic patients. These patients wish to be able to live without eating, until a fragile balance is broken, where psychiatric treatment alone is no longer possible.

Finally, it is rare for a psychiatrist to be confronted with implementing treatment that can have a dual effect, as understood by the Leonetti law. The difficult therapeutic decisions made for this patient were clarified by ethical principles, without losing sight of the desire to live that this patient had always expressed.

ENDNOTES

1. Law 2005-370 of April 22, 2005 relating to patient rights and end of life, referred to as the Leonetti law, after its initiator.
2. Decrees 2006-120 of February 6, 2006 relating to the collective procedure, modifying article 37 of the medical deontology code.

3. Article 2 of the Law 2005-370 of April 22, 2005: "if the physician observes that it is impossible to relieve the suffering of a person, in the advanced or terminal stage of a serious and incurable disease, whatever the cause may be, that in administering a treatment that may have the effect of shortening life, the physician should inform the patient, without prejudice to the clauses laid out in the fourth paragraph of article L. 1111-2, the proxy designated in article L. 1111-6 or, if not present, the next of kin. The procedure followed is noted in the patient's medical file."

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Editorial Note

This severe case of anorexia nervosa brings to the fore the dilemma of wrestling with opposing principles of ethics, especially the conflict between honoring a patient's wishes and doing no harm when the patient has mental illness which prevents them from understanding the consequences of their choices. Further complicating this case is civil law giving primacy to patient autonomy. The patient's hydration and nutrition, central to the dilemma posed by this case, make it necessary to recall the proper Catholic teaching on this aspect of the case, and charitably apply it. The teaching is that "the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory, in so far as and until it is seen to have attained its proper finality" (John Paul II, Address to the participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas," no. 4, March 2004).

— Ed. JMT

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