a treatment plan by which she could abide, and that the healthcare system would endorse, is quite dismal. Cultural factors that are not clear also enter into the analysis. In Germany, is an 18-year-old deemed to be an adult? Would her judgment or lack thereof be subsumed under an age-related norm stating that her youth precludes her own ideas being considered as part of the equation? It is known that the teen brain develops to an adult state somewhat earlier in girls than in males,[12] but is this the case in a starved brain?

Given this array of issues, an ethics committee may be of immense help in assisting the medical care team in arriving at a consensus—under best circumstances. However, if no consensus could be developed regarding a plan that states the duty and wishes of patient, parents, and the medical care system, it might be necessary for the judicial system to make a final decision about whether this patient's wishes to be provided with nothing but palliative care would be the only way to stay the swinging pendulum of this decision.

Notes

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12. See note 8, Kotler, Cohen 2001.

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Commentary: Where Ignorant Armies Clash by Night

Leonard C. Groopman

When I think about and imagine treating Angela—smart, skeletal, manipulative Angela—I am at my medical and moral wit's end. After a while I have a hard time telling the difference between treatment and torture, between therapy and punishment. I don't know what palliation can mean in the face of Angela's will to mortify her flesh. What is palliation, other than a word we use to soothe ourselves, when Angela's very purpose seems to be to suffer? I feel torn between violating her will by forcing her to eat (in the name of beneficence) and getting rid of her by discharging her (in the name of respecting her autonomy).

Angela does not tell us very much, and what she does we cannot rely on; she prefers to show rather than to tell. If I could get a handle on Angela's internal world, perhaps I would have

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a lever with which to move her. I think of Kafka's Hunger Artist, whose wondrous capacity to survive without food turned out to be the result of never having found anything in the world that tasted good to him, and of Melville's Bartleby, whose life of refusal—"I prefer not to"—so infuriates those around him that they forcibly exile him from society, after which he stops eating, withers away, and dies. These literary associations may be nothing more than my attempt to give meaning to some as-yet-unknown neuronal misconnections in Angela's brain that are full of consequence but devoid of content. Or am I trying to understand something about Angela herself?

I turn from introspection and imaginative literature to medical literature. The etiology of anorexia nervosa is unknown—one expert calls it simply a "puzzling psychosomatic condition"[1]—and there is disagreement about the core psychopathology of anorexia: is it a psychotic disorder, a form of OCD, a mood disorder, or an overvalued belief? We know more about the epidemiology and phenomenology of anorexia than we do about its etiology. Approximately 0.5 percent of all women between the ages of 15 and 40 develop anorexia nervosa. Males account for 5 percent of all cases. Long-term follow-up studies have indicated mortality rates ranging from 5 to 19 percent, which at the higher end would make anorexia the most lethal diagnosis of any in psychiatry. Approximately 50 percent of people with anorexia nervosa will continue to experience some symptoms of the disorder throughout their lives.

Individuals with anorexia nervosa are extremely self-disciplined, able to suppress or override their hunger-induced drive to eat. They express an entrenched fear of fatness and demonstrate an unstoppable pursuit of thinness. This pursuit assumes supreme importance in their lives. They organize themselves around it and are willing to go to any length necessary to maintain their commitment to not gaining weight.

The starvation state of anorexia nervosa shares many characteristics with naturally caused and experimentally induced starvation. Starvation affects not only the body but also the mind and the behavior of the starving person. Obsessive preoccupation with food, slow eating, disturbed gastric emptying, mood lability, apathy, irritability, lack of libido, sleep disturbance, and cognitive impairments are all part of the clinical picture of starvation. Anorexia nervosa leads to a starvation state, but the physiological state of starvation itself fuels many of anorexia's ongoing symptoms. The disorder reinforces itself, taking on a life of its own. Reversal of the starvation state can alleviate some of the associated affective and cognitive disturbances. Reversing starvation is generally considered a precondition for any psychological treatment of anorexia.

Individuals with anorexia nervosa frequently reject the labeling of their behavior as illness and say they want to be left alone. They generally come to medical and psychiatric attention involuntarily, through the insistence or coercion of other parties. The formation of a therapeutic alliance is notoriously difficult, as people with anorexia generally view authorities (perhaps not inaccurately) as wanting to control them. Many therapists believe that beneath the symptoms of anorexia lie feelings of powerlessness, self-contempt, and terror of growing up. Anorexics mobilize dieting, the pursuit of thinness, and food refusal as a way to feel powerful, special, and in control. Psychological treatments, which are the mainstay of therapy after starvation has been reversed, seek to help the person with anorexia develop alternative means of being powerful, special, and in control.

What do we know about the consequences of involuntary treatment,

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whether it be coerced outpatient therapy, involuntary hospitalization, or forced-feeding (an expression disliked within the community of eating disorder therapists)? Many clinicians, including me, can cite anecdotal experiences of patients who were initially hospitalized and treated against their will but later interpreted their treatment as an expression of caring, commitment, and belief on the part of the therapist. Thus, paradoxically, involuntary treatment sometimes becomes the basis for a therapeutic alliance.[2] If we tend to remember such cases, however, we tend to forget or ignore others, in which coerced treatment set the terms of a sterile, nontherapeutic or counter-therapeutic stalemate between patient and clinician.

Besides clinical anecdotes, there is some research relevant to the effects of involuntary treatment. Garda and her team studied a group of patients who had been hospitalized involuntarily for eating disorders and looked at the course of their perceptions of their need for hospitalization. They found that "nearly half of patients with eating disorders who denied a need for treatment on admission converted to acknowledging that they needed to be admitted within 2 weeks of hospitalization."[3] Most of those who "converted" were adults. Adolescents converted far less frequently. This finding tells us that anorexic patients, like people in general, sometimes change their minds about what is good for them after having been forced to do something they hadn't wanted to do. We do not know much, if anything, about the long-term perception and consequences of involuntary treatment, although there is evidence that those who receive mandated treatment have a poorer long-term outcome than those who choose to be treated.[4]

Let us return now to Angela, who has been in continuous treatment for some seven years and, having arrived at the age of majority, has repeatedly said that she "wishes for a palliative approach in which people would leave her alone, even if that means she might die." We are told, ambiguously, that although "her life is not acutely threatened, her condition, nevertheless, is serious." Although there is some time before Angela will have starved herself to death, unless her food refusal remits spontaneously, she will die if not involuntarily fed. She has already in the past been fed against her will. Colleagues in the intensive care unit warn of the risks of doing this again. Let us also assume that various treatment modalities have been tried—individual, group, family, cognitive, psychodynamic, and so on—and that the therapists have been competent, leaving our therapeutic armamentarium exhausted.

We seem to be facing a futile situation. Perhaps we should stop trying to keep her alive and, out of respect for her autonomy—after all, two psychiatrists have deemed her capable, and she is now 18 years old—let Angela decide whether or not to be fed, whether to live or die. If this case is about a conflict of basic principles in medical ethics—autonomy versus beneficence, with nonmaleficence weighing in on the side of autonomy—then perhaps we must conclude that it is our moral responsibility to leave her alone, hoping that she will change her mind and begin to eat, and, if she doesn't, consoling ourselves with having done our medical and moral utmost.

But there are aspects of the case that give me pause. Angela is a deceiver. She says different things to different people; she says one thing and does another. Should we trust *anything* she says, take *anything* at face value, including that she wants us to leave her alone? Does she want to be "left alone," or does she want us to "palliate" her—that is, take care of her, soothe her in a manner

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defined (or dictated) by her? Does she want to leave the hospital or remain in the hospital for so-called palliation? If she wants to go home, does she want her parents to leave her alone, or does she want them by her bedside, tending to (palliating) her when she wants? Is she asking to be without human connection, truly alone, or to be in control of the human connections that she has? ''Palliation'' for Angela might well consist of having others watch her slowly waste away, powerless to do anything. Perhaps that would be soothing to her. It would be torture to those forced to witness it.

Granting Angela her wish for so-called palliation asks too much of her caregivers. Just as there are ethical limits on what a doctor can do to a patient, so there are limits on what a patient can demand of a doctor. We are not obligated to do whatever our patients ask of us. (Think of the debate around physician-assisted suicide, with which Angela's case has several affinities.) It is unconscionable to ask any caring person to watch this 18-year-old girl slowly waste away and expire from a disorder that has a 50 percent chance of full remission and at least an 85 percent chance of survival.

In a case of this complexity, our standard ethical principles fail us. Our concepts break down. What is autonomy in such a situation other than the algorithmic outcome of a cookbook evaluation by two psychiatrists? Does it really capture anything about this 18-year-old struggling with herself and her world to say that she is endowed with autonomy, that she ''has capacity''? In cases like Angela's our principles prove woefully inadequate, too weak for the job of helping us find our way through the human maze. We must fall back on our experience, on our knowledge, and on our understanding of the human heart.

Angela, like Melville's scrivener before her, has spent her life opposing, refusing, and defying. She does this with her self (her appetites), her parents, her professional caregivers, and her fellow patients. Opposition, refusal, and defiance have nourished and sustained her. We must be careful about taking that away, keeping in mind what happened to the banished Bartleby. She may need an external enemy, at the very least so that she can siphon some of her aggression away from herself, so that she doesn't actually end up ending her life. It wouldn't be the first case I have been involved with in which serving as the bad object proved to be the most therapeutic position I could adopt.

At the round table meeting I would share my thinking in the hope of persuading others that a palliative approach is not only not viable but not meaningful, and that a more aggressive plan of recommending involuntary feeding could be beneficial, both in keeping Angela alive and in continuing to provide her with something and someone to oppose.

To the lawyer's concerns about the hospital's legal liabilities, I would assure him or her that I am willing to document my thoughts in writing, including my professional assessment that Angela lacks capacity in any meaningful sense of the term. Furthermore, I welcome and even encourage a legal hearing, as I believe that going to court is likely to prove therapeutic for Angela. I have known of more than one case in which a court hearing has been a turning point in a patient's treatment. In court the patient faces the doctor on level ground, before an impartial judge. In more than one case in which I have been involved, a legal decision, whether in favor of the patient or against, led to compliance on the patient's part, obviating the need to treat the patient against her will. If Angela loses her suit, the willingness of the medical team to go before a judge, and the power and authority of the legal system, might allow

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her to stop fighting and accept help. If the judge decides in Angela's favor, I would not be surprised if Angela were to eat voluntarily. Having finally, definitively, "won," beaten the world of parents and doctors alike, Angela is vindicated and therefore has less need to continue fighting (more of my wishful thinking?). Angela deserves a trial of "court therapy," perhaps the only treatment modality she has yet to receive.

I would talk with Angela and ask her what she means—precisely, graphically—by "a palliative approach" and being "left alone." I would share with her some of my thoughts, that I will not accept being a witness to her self-starvation, nor will I subject the other patients or staff to such a thing. I will tell her that, despite the opinion of two other psychiatrists (which has been disputed by other staff members), I don't believe that she "has capacity" in other than a formulaic sense of the term, and that she will be treated against her will, despite the risks involved, unless she begins to eat voluntarily. I would inform her that she can take legal action (secretly hoping that she avails herself of that option), and that I am prepared to go before a judge. (I prefer that Angela initiate the legal proceeding, although if she doesn't I would consider that the hospital do so instead.)

I would share much the same with Angela's parents, and, in a ward community meeting, with the other patients as well, keeping private from all third parties my goal of manipulating Angela into the courtroom and my therapeutic hopes for a trial.

As I reject Angela's expressed wishes and recommend ongoing treatment, I remember the lines of Matthew Arnold's *Dover Beach*: "And we are here as on a darkling plain / Swept with confused alarms of struggle and flight, / Where ignorant armies clash by night."

Notes

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Commentary: Practical Wisdom and Theory

Mark T. Nelson

I would recommend that Angela's care team try force-feeding one more time, with the goal of stabilizing her health at a level at which doubts about her capacity can be quelled, and then allow her to decide what kind of treatment she is to receive thereafter. Even so, I would want more information from the people closest to her case, and I can imagine learning things that might lead to a different conclusion.

In recommending force-feeding, I do not mean to suggest that Angela's parents' wishes trump other considerations. The medical treatment offered

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