Ethical Considerations in the Treatment of an Acutely Psychotic Patient with Anorexia Nervosa

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Introduction

The involuntary treatment of anorexia nervosa occurs in 13 to 44% of admissions (Clausen 2020). It is controversial and often negatively viewed by patients and medical professionals (Clausen 2020). Most often, it is the most medically ill patients that require involuntary treatment (Westmoreland 2016). These patients tend to fall under the subtype of severe and enduring anorexia nervosa which is often characterized by increased chronicity, severity and treatment resistance (Strand 2020). While evidence is still limited, it appears that patients with the severe and enduring anorexia nervosa subtype may benefit more from treatment that focuses on quality of life and harm minimization rather than treatment focused on normalizing weight (Carney 2019).

Table 1 Proposed criteria for "severe and enduring anorexia nervosa"

(1) a persistent state of dietary restriction, underweight, and overvaluation of weight/shape with functional impairment
(2) duration of > 3 years of anorexia nervosa; and
(3) exposure to at least two evidence based treatments appropriately delivered together with a diagnostic assessment and formulation that incorporates an assessment of the person's eating disorder health literacy and stage of change

(Hay & Touyz 2018)

Case

A 32 year old female with a history of anorexia nervosa and severe alcohol use disorder was brought to the emergency room on a detention warrant after making suicidal statements. She was found to have a blood alcohol level of 301, multiple electrolyte abnormalities and a BMI of 9.73. She was admitted to the medical floor and psychiatry was consulted for suicidal ideation and management of anorexia. At time of the interview, the patient was floridly delusional. She believed that her enlarged bilateral salivary glands, lanugo, difficulty ambulating, and cognitive slowing were due to "witchcraft" rather than her severe malnutrition. She believed she could live without eating because "God" was protecting her. She did not believe she had anorexia or that her weight was too low. She refused all forms of food, nutrition and medication offered to her while in the hospital. Using Grisso and Appelbaum criteria, she was determined to lack decision making capacity.

Mental Status Exam

- Disheveled
- Psychomotor retardation
- Guarded, evasive
- Slow speech, prolonged latency
- Flat affect
- Profoundly depressed
- Illogical
- Auditory and visual hallucinations present
- Paranoid with persecutory delusions
- Suicidal ideation present
- Poor insight and judgement

Physical Exam

- Alert, oriented x4
- Severely cachectic
- Enlarged bilateral salivary glands
- Lips, mucosa and tongue dry
- Poor dentition
- Lanugo
- Muscular wasting
- Unsteady gait

Labs

- WBC 2.14
- Hgb 8.9, Hct 26.9, MCV 101.1
- Magnesium and phosphorus wnl
- Albumin 2.9
- Potassium 2.9
- Calcium 7.9
- Glucose 60
- AST 94, ALT 67
- Ethyl Alcohol 301
- HgA1c <3.8
- EKG: QTc 474
- Vitamin B12, folate wnl
- Vitamin C 39
- Zinc 23.8
- Vitamin D 34.3

Treatment

Given the severity of the patient's psychiatric symptoms, her lack of decision making capacity and her precarious physical condition due to severe malnutrition and acute alcohol withdrawal, the potential need for involuntary treatment with forced feeding was assessed. The hospital ethics committee was consulted and discussed multiple considerations pertaining to her treatment including non-maleficence, autonomy, evidence for involuntary treatment, likely use of physical restraints in forced feeding and long term prognosis. The decision was made to consult palliative care for advanced care planning until a family meeting could be held with the patient's surrogate decision maker. The patient was determined to lack capacity and total parenteral nutrition with use of restraints/sedation if necessary was recommended. After 2 days of feeding, the patient's psychosis symptoms resolved and she was able to regain capacity. On the day of discharge, the patient was able to recognize that she has anorexia and the risks of refusing treatment. She was not endorsing suicidal ideation and was able to reliably contract for safety. It was recommended that the patient remain in the hospital to increase nutrition but she elected to leave AMA and follow up outpatient for treatment of anorexia.

Discussion

This case highlights the complexity of deciding when to initiate involuntary treatment for patients with severe and enduring anorexia nervosa. Often, patients who require forced treatment have a higher severity of illness and poorer prognosis due to the progression of their disease. In these cases, a palliative approach focused on symptom control and quality of life rather than remission of illness may be preferred (Strand 2020). Using this approach may preserve the therapeutic alliance and potentially decrease the cycling in and out of treatment programs that these patients encounter.

Conclusion

When considering forced treatment of anorexia nervosa, the principles of non-maleficence and autonomy can be difficult to reconcile. More studies are needed on the long term outcomes of involuntary treatment in severe cases.

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