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Involuntary Hospitalisation for Life-saving Treatment of Anorexia

Faiza Ahmed*

I. Introduction

Within the broader context of contemporary principles of bioethics employed to make decisions regarding patients' health - autonomy (Kant), beneficence (Mill), justice (Rawls), and nonmaleficence,[1] and in a wider still interdisciplinary terrain of medical, psychiatric, legal and philosophical debate on questions of competence, autonomy, and welfare, this essay has a comparatively limited scope. Firstly, it applies moral principles from Mill, Kant and Rawls in turn to conclude that involuntary hospitalisation of anorexic people in life-threatening situations is generally justified. Secondly, it analyses the recent decision in *Northamptonshire Healthcare NHS Foundation Trust v AB*[2] to show that the decision regarding the anorexic's capacity to make decisions relating to her treatment was justified upon application of these moral principles. In that case, a 28-year-old woman with a severe and enduring eating disorder in the form of anorexia was held to lack the capacity to decide upon a life-saving treatment.

Firstly, following analysis of Mill's utilitarian and anti-paternalistic principles, it is submitted that the starting position against involuntary treatment can be subverted based primarily on a lack of autonomy argument. A soft-paternalistic justification for the conclusion is advanced, reconciling potential conflict between these principles. Secondly, Kant's Categorical Imperatives are employed to reach the position that treatment refusal is immoral due to its irrationality and therefore, there are strong reasons for overriding it. Moreover, allowing death of the anorexic contravenes the Humanity Formula and is therefore immoral. Finally, it is argued that in Rawls's Original Position, there are justifications for strong as well as weak paternalism that relate to the current question and therefore, involuntary hospitalisation should be allowed. It is ultimately concluded that application of these principles to the recent Court of Protection decision would yield the same result. It should be kept in mind that the validity of the moral principles themselves and of the long-term outcomes of applying these principles to the case of an end-stage anorexic are not comprehensively evaluated in this note; rather, emphasis is placed on the application of the existing principles, as a result of which the above conclusion is reached.

II. Mill's Harm Principle

Mill's central project presents the principle that 'the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to

* Faiza Ahmed is an LLB graduate from Keele University and is currently undertaking the Bar Course at the Inns of Court College of Advocacy. Thanks are due to Yossi Nehushtan for his invaluable comments on this note.

[1] TL Beauchamp, JF Childress, *Principles of Biomedical Ethics* (5th edn., OUP, 2001).

[2] [2020] EWCOP 40.

prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.'[3] Mill's vehemently anti-paternalistic position would *prima facie* mean that anorexic people should never be hospitalised against their will as their harmful behaviour is entirely self-regarding. This position is challenged on three grounds. First, whether the conduct is in fact entirely self-regarding; second, that it only applies to rational and autonomous agents; and third, that Mill's own theory allows for exceptions, within which the present case falls.

Firstly, the concept of 'self-regarding action' is ambiguous because it seems 'nearly impossible to achieve' due to the impact of death on the individual's relatives and close friends.[4] In most cases, anorexia involves the family in a profound way and it is considered not to be purely 'intrapsychic', but regarded as a 'systemic condition'.[5] Accepting the argument that there is harm to others, intervention could be justified on Mill's theory. In circumstances where the anorexic disables herself from the performance of a social obligation, the case leaves 'the province of liberty'.[6] This would mean that in cases where the anorexic has a definite duty such as caring for young children, compulsory treatment would be justified, but not where such a duty cannot be identified. The rule would then need to be decided on an individual basis, rather than a blanket anorexia-related policy. Thus, if the case of AB is considered, it can be said with some certainty that the harmful conduct is chiefly self-regarding, and the social obligation stipulation does not apply. Upon this analysis, forced nasogastric feeding would be unjustified. If one accepts the general argument that harm to others is indirect or insignificant compared to the primary harm to self, and the harm principle therefore operates to preclude compulsion, it may be useful to analyse Mill's liberty principle in more depth to consider its application to the present case.

Secondly, Mill emphasises the importance of self-determination: '[a person's] own mode of laying out his existence is the best, not because it is the best in itself, but because it is his own mode'.[7] However, the liberties proposed by Mill are only valuable when the individual has 'sufficient rational development or normative competence' to exercise deliberative capacities.[8] In other words, in order to exercise personal autonomy and the right to self-determination, a person must be truly autonomous, which is contingent upon the use of rational deliberation and competence.[9] Mental capacity for decision-making is closely aligned with, and is a requirement for autonomy.[10] The anorexic lacks competence to make treatment decisions because of psychological and cognitive impairments that preclude her from appreciating the severity of her situation and its consequences, though

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[3] John Stuart Mill, *On Liberty* (CUP edn., 2013), 13.
[4] Eunseong Oh, 'Mill on Paternalism' (2016), Journal of Political Inquiry, 1.
[5] Simona Giordano, 'Anorexia and Refusal of Life-Saving Treatment: The Moral Place of Competence, Suffering, and the Family' (2010), 17(2), Philosophy, Psychiatry, & Psychology, 143.
[6] Mill (n 3).
[7] Mill (n 3).
[8] David Brink, 'Mill's Moral and Political Philosophy', *The Stanford Encyclopedia of Philosophy* (Zalta EN ed., Winter edn., 2018) <https://plato.stanford.edu/archives/win2018/entries/mill-moral-political/> accessed 30/12/19.
[9] Jill Matusek and Margaret Wright, 'Ethical Dilemmas in Treating Clients with Eating Disorders: A Review and Application of an Integrative Ethical Decision-making Model' (2010) 18 Eur Eating Disorders Rev 434
[10] Gareth Owen and others, 'Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge' (2009), 52(1), Inquiry 79.

she may be lucid in other areas.[11] Research clinicians consider the emaciated anorexic's desire to avoid treatment as a psychiatric symptom rather than a decision to refuse medical intervention.[12] Anorexic people requiring life-saving treatment presumably experience 'cerebral pseudoatrophy and biochemical changes as a result of nutritional deficiencies', impeding rational decision-making.[13] Similar compromising effects are seen when starvation leads to a biological threshold such as less than 75% ideal body weight.[14] Treatment refusal, despite danger to life, is so characteristic of this ego syntonic disorder that it is described in the DSM-IV,[15] following the illness criteria, and is considered a product of the illness itself, thus lending credence to the notion that it is non-autonomous, not just because it is non-competent, but also because it is non-voluntary.[16] This view is reflected in the legality of compulsory treatment in English law, underpinned by lack of capacity and competence, though considerations of best interest must also be taken into account.[17] In the case of AB, though she was held to have litigation capacity, the nature and clinical presentation of her illness was such that her decisions in relation to caloric intake and treatment were so infected by her fixated need to avoid weight gain at all costs that 'true logical reasoning in relation to those matters was beyond her capacity or ability.[18]

Therefore, it appears that a blanket prohibition against paternalistic intervention in the form of involuntary treatment can be challenged. For some, 'weak' or 'soft '[19] paternalism-restricting a person's self-regarding harmful conduct if their autonomy is compromised-is 'uncontroversial'[20] and it is argued here that 'autonomy-enhancing forms of paternalism'[21] may be applicable in the present case. This is based on Mill's bridge example, according to which a person about to cross a dangerous bridge may be deterred by a police officer to ensure that he makes this decision with full knowledge of its consequences, thus enhancing his autonomy to make an informed decision.

As the autonomy of the anorexic is compromised and their conduct is 'substantially nonvoluntary',[22] Feinberg's soft paternalism would allow compulsory life-saving

[11] EM Goldner, CL Birmingham, and V Smye, 'Addressing treatment refusal in anorexia nervosa: Clinical, ethical, and legal considerations' in Garner DM and Garfinkel PE (eds), *Handbook of treatment for eating disorders* (2nd edn., Guilford Press, 1997), 450; Avis Rumney, *Dying to Please: Anorexia, Treatment and Recovery* (2nd edn., McFarland, 2009).
[12] Tiller, Schmidt, and Treasure, 'Compulsory Treatment for Anorexia Nervosa: Compassion or Coercion?' (1993), 162(5), British J Psychiatry, 679.
[13] K Vitousek, S Watson, and GT Wilson, 'Enhancing motivation for change in treatment-resistant eating disorders' (1998), 18 Clinical Psychology Review, 391.
[14] T Carney and others, *Managing anorexia nervosa: Clinical, legal, and social perspectives on involuntary treatment* (Nova Science Publishers Inc., 2006).
[15] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th edn., 2000).
[16] J Tan and others, 'Competence to make treatment decisions in anorexia nervosa: thinking processes and values' (2006), 13(4), Philosophy, Psychiatry, and Psychology, 267.
[17] *Re W* [1992], 2 FCR 788; *Re KB* [1994], 19 BMLR 144.
[18] *AB* (n 2) [64].
[19] Although there may be slight differences between the definitions of these, they are used interchangeably within this paper due to their appearance as such in the literature.
[20] LO Gostin and KG Gostin, 'A broader liberty: J.S. Mill, paternalism and the public's health' (2009), 123(3), Public Health 214.
[21] Brink (n 8).
[22] J Feinberg, *The Moral Limits of the Criminal Law* (1986), 12.

treatment to restore voluntary agency. These interventions 'must be directed solely to the eradication of those deficiencies' and to eliminate the 'very grounds that initially may have justified their enactment',[23] thus clearly delimiting the boundaries of paternalism such that autonomy is restored to the person 'governed' by illness.[24] In the case of the anorexic, involuntary hospitalisation and subsequent treatment aimed at restoring the autonomy of the patient can be ultimately argued to be autonomy-enhancing rather than restricting. Coming back to the bridge analogy, once the person has been warned of the dangers, they may certainly choose whether to cross the bridge, and indeed choose to end their life- according to Millian principles- as long as this decision is made autonomously. By extension, this also applies to all autonomous decisions to end one's life. In the case of the anorexic, once her autonomy has been restored following treatment, she may decide to end her life in any other way. To put it in Millian terms, power can only be exercised over a sufficiently rational and normatively competent anorexic to prevent harm to others.

Conversely, in the context of beneficence in bioethics, there are consequentialist justifications of paternalism based on welfare, which pose a potential conflict between Mill's utilitarianism and anti-paternalism, i.e. if utility is the only absolute principle with intrinsic value, 'the ultimate appeal on all ethical questions'[25], and saving the anorexic's life and improving their health is optimific, application of the harm principle is against this principle. Therefore, because the value of individual liberty lies in achieving human excellence, if there is a paternalistic way of realising excellence, it should be permissible.[26] Consistency in Mill's utilitarianism necessitates that even the right to self-determination is derived from its 'conducibility' to this principle.[27] However, this can be countered if one takes into account Mill's conception of 'utility in the largest sense',[28] which necessarily includes individuals pursuing their own preferred ways of life.[29] Therefore, taking a soft-paternalistic approach and ensuring that decisions made are autonomous reconciles autonomy and beneficence, as it ultimately enhances autonomy, thereby enhancing utility.

Thirdly, even if one subscribes to the idea that anorexic people are competent to refuse life-saving treatment and autonomy is the paramount consideration,[30] it could be argued that the present case comes under the exception to Mill's anti-paternalistic principle- the argument against self-enslavement. Kohler considers it contradictory and therefore irrational to use liberty for the purpose of renouncing liberty and defends the 'principle of the inalienability of the capacity of self-developing'.[31] This reasoning could be employed to justify the paternalistic prevention of any autonomous decision which could lead to

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[23] Alan Fuchs, 'Autonomy, Slavery, and Mill's Critique of Paternalism' (2001), 4(3), Ethical theory and moral practice, 231.
[24] Eric Matthews, 'Autonomy and the psychiatric patient' (2000), 17(1), J App Philosophy, 59.
[25] Mill (n 3).
[26] Oh (n 4).
[27] Feinberg (n 22), 384.
[28] Mill (n 3).
[29] Fuchs (n 23).
[30] Simona Giordano, 'Choosing death in cases of anorexia nervosa: Should we ever let people die from anorexia nervosa?' in C Tandy (ed.), *Death and Anti-death*, vol 6 (Ria University Press, 2008); H Draper, 'Anorexia nervosa and refusal of nasogastric treatment: A Reply to Simona Giordano' (2003), 17(3), Bioethics 279.
[31] Michael Kohler, 'Freiheitliches Rechtsprinzip und Betaubungsmittelstrafrecht' (1992), ZStW, 104.

death, given that death 'excludes all possibility of future personal autonomy'.[32] However, it is argued here that although Mill never directly addressed the ethical debate regarding suicide, not only might it be permissible under the harm principle, but also because while he considers being 'free not to be free' (slavery) wrong, this does not extend to death. Ending one's life 'initiates death, in which one is non-existent, neither free nor unfree'.[33] Thus, inability to exercise autonomy is merely a side effect of death, and an immaterial one at that. Whilst likening death to self-enslavement may be a misguided application, this is distinct from the question of anorexia. In that case, the comparison with a slavery contract does not end with relinquishing all future exercise of autonomy with death; it could be drawn secondarily because of the fact that the anorexic symptoms, such as food restriction, start as voluntary but 'ineluctably transform'[34] into nonvoluntary life-threatening behaviour, thereby precluding all likelihood of autonomy being exercised in relation to the condition. Further, this restriction of freedom continues until the anorexic is free of the disease, however that might be. This analysis places this scenario squarely within Mill's exception.

A potential problem may appear when one considers the subjective experience of those afflicted with anorexia: for some anorexics, it becomes indistinguishable from their personal identity. Consequently, their decision to refuse treatment stems from the value they place in thinness, rather than fear of treatment, which means that overriding their refusal is no longer merely a question of principles of autonomy but is inextricably linked with the subjective experiences of, and the reasons for refusing treatment by, the anorexic person. Perhaps they are 'evaluatively deluded' but it could be argued they still have the capacity to judge their quality of life and decide that the burden of therapy is too much, especially in cases of ineffective previous treatment, after which the anorexic sees death as the only option,[35] as was the case with AB. To address the dangers in associating values with competence, Tan et al propose checking the authenticity of the values to assess if they arise from the disorder or the person.[36] This line of reasoning raises questions regarding the underlying cause of treatment refusal, which may vary significantly due to the subjectivity of the experience, and is not within the remit of this essay but this may also have an impact on a discussion of act and rule utilitarianism.

III. Kant's Categorical Imperative

The principle of autonomy derived from Kant's work is significantly different from Mill's autonomy discussed thus far but has 'impacted profoundly on biomedical ethics,'[37] and will act as a starting point in the following discussion of the development of Kant's deontological ethics. Kant's autonomy is 'a matter of adopting law-like principles that are independent of extraneous assumptions that can hold only for some and not for other

[32] Carmen Tomas-Valiente Lanuza, 'The Justification of Paternalism' (1999), 30(4), Rechtstheorie, 431.
[33] 'John Stuart Mill' (24 May 2015) *The Ethics of Suicide Digital Archive* <https://ethicsofsuicide.lib.utah.edu/selections/john-stuart-mill/> accessed 29/09/2020
[34] A Andersen, 'Eating disorders and coercion' (2007), 164 Am J Psychiatry, 108.
[35] Cushla McKinney, 'To treat or not to treat: legal and ethical issues in the compulsory treatment of anorexia' (Master's thesis, University of Otago, 2010).
[36] Tan (n 16).
[37] Sacha Kendall, 'Ethics and Involuntary Treatment for Anorexia Nervosa in Context: A Social Work Approach' (Doctoral thesis, University of New South Wales, 2011).

agents.'[38] Thus, as per Kant's Supreme Principle of Morality, a morally good act is 'only in accordance with that maxim through which [one] can at the same time will that it becomes a universal law.'[39] For Kant, autonomy is inseparably connected with this principle; he views all rational beings as having the capacity for 'moral autonomy- for self-yet universal, legislation.[40] However, the contemporary "Kantian" notion of autonomy, 'which is one of the major theoretical frameworks underlying bioethical argumentation' has little to do with Kant's original,[41] as it describes individual autonomy in terms of self-governance: an autonomous person is 'capable of acting on the basis of effective deliberation, guided by reason, and neither driven by emotions or compulsions nor manipulated or coerced by others', as well as free from physical or psychological constraints.[42]

It is submitted that AB is not a rational, autonomous agent on either (original or contemporary) interpretation. As it has already been illustrated that she does not fit DeGrazia's definition, because her rational judgement regarding this field of decision-making is impaired, what follows is a demonstration that on Kant's theory, AB's decision to refuse life-saving treatment is immoral. This is because not only is she incapable of making universal decisions due to irrationality, but also because the decision to end one's life is inherently immoral according to Kant as will be illustrated below.

The decision of the anorexic patient would be 'worthy of moral respect'[43] if it were not constrained by her desires or conceptions of the good, but rather based on 'recognition of what is objectively good as such, as determined by universal moral principles.'[44] The distinction between Kant's conception of autonomy and that employed by modern ethicists crystallises when it is considered that whilst patient autonomy (if the anorexic were capable of making autonomous decisions) would allow refusal of life-saving treatment, Kant's theory implies the exact opposite conclusion. For Kant, the maxim of suicide based on suffering is not universal and therefore immoral.[45] The maxim of foregoing life (the practical effect of refusing life-saving treatment) from self-love-because 'it threatens more evil than it promises pleasure'-[46] fails in the 'contradiction in conception' stage of Kant's First Categorical Imperative, as it is not conceivable as a law governing all rational agents.[47] This is because self-love stimulating a furtherance of life can be regarded as a law of nature;[48] but using self-love against life would necessitate the 'simultaneous promotion of death through self-love' as a law of nature, thus leading to a

[38] Onora O'Neill, 'Autonomy: The Emperor's New Clothes' (2003), 77 (1), Aristotelian Society Supplementary Volume 1, 16.
[39] Immanuel Kant, *Foundations of Metaphysics of Morals*, 39.
[40] Barbara Secker, 'The Appearance of Kant's Deontology in Contemporary Kantianism: Concepts of Patient Autonomy in Bioethics' (1999), 24(1), The Journal of Medicine and Philosophy, 43.
[41] Ibid.
[42] TA Mappes and D DeGrazia (eds.), *Biomedical Ethics* (4th edn., McGraw-Hill Inc 1996), 28.
[43] Jo Samanta and Ash Samanta, 'Holistic determination for oneself: a new paradigm for self-determination at end of life' (2013) 72(3) CLJ, 689.
[44] Matthews (n 24).
[45] I Kant, *Groundwork of the metaphysics of morals* (Gregor M and Timmermann J eds., CUP, 1998), 31.
[46] Ibid.
[47] Johnson and others, 'Kant's Moral Philosophy', *The Stanford Encyclopedia of Philosophy (Zalta EN ed, Spring edn., 2019)* <https://plato.stanford.edu/archives/spr2019/entries/kant-moral/> accessed 09/01/20.
[48] I Kant, *Grounding for the metaphysics of morals* (Ak IV, Indianapolis: Hackett, 1993) 422.

contradiction in that law,[49] preventing universalisation. Thus, in this case, there are no morally compelling reasons to accede to the anorexic's wishes. In fact, it could be argued that if the principle that lives should be saved whenever possible is universal, there would be 'compelling Kantian reasons for acting paternalistically'.[50] What Kant's theory does not take into account is the possibility that furtherance of life from self-love is not a universal law of nature; self-love could mean the opposite in certain circumstances. If the premise of this analysis is rejected, a principle that one should end her life when it 'threatens more evil than pleasure' might be capable of universalisation. But on Kant's philosophy, any self-harm-including behaviour associated with anorexia would be considered 'morally reprehensible', because it treats the human merely as means and 'transgresses the duty of self-preservation that one has to oneself'.[51]

Whilst the first formula does not have any content, the second formulation of the Categorical Imperative, provides a criterion regarding content in terms of a necessary end that genuine moral principles must meet: 'So act that you use humanity,…always at the same time as an end, never merely as a means.'[52] The argument here is that 'whenever a being has the capacity to be a rational being we should respect it as an end in itself and, furthermore, make it our end', independently of how far its capacity to be rational actually is.[53] Applying this to the issue of life-saving treatment of AB, any universal maxim would need to take into account the principle of respect for humanity, thus precluding institutional or state allowance of death of anorexic people by not administering life-saving treatment. Others have argued that treatment 'necessarily presupposes informed consent' and there is no duty 'to preserve life irrespective of the patient's will'.[54] It is submitted that not only does this argument fail to take into account the Humanity Formula, it can be countered because the unique medical and psychological circumstances of end-stage anorexics prevent them from exercising their true will. On the other hand, Kantian autonomy (with anti-paternalistic undertones) in the contemporary sense may be seen to stem from the Humanity formula because to deny other persons their rational agency 'is to treat them as simply means to their own good, rather than as ends in themselves.'[55] Taking such an absolutistic approach would inevitably mean that the will of the anorexic is paramount even if misguided, though the argument that the will in this instance is not fully rational or autonomous is reiterated.

To analyse the question from a different angle, the first formulation of the Categorical Imperative is now applied to the principle of involuntary life-saving treatment of anorexic people. The salient question here is whether it would be acceptable for everyone to act in the same way as those involuntarily hospitalising anorexics.[56] It seems possible to conceive of a world in which anorexic people are given compulsory life-saving treatment

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[49] I Brassington, 'Killing people: what Kant could have said about suicide and euthanasia but did not' (2006), 32(10) Journal of Medical Ethics, 571.
[50] Matthews (n 24.
[51] Melanie Hurley, 'Kant's Moral Theory and the Case of Anorexia Nervosa' (2012), 9 Codgito J Philos.
[52] Kant (n 45).
[53] Friedrich Heubel, Nikola Biller-Andorno, 'The contribution of Kantian moral theory to contemporary medical ethics: A critical analysis' (2005) 8(1) Medicine, Health Care and Philosophy 5.
[54] Ibid.
[55] Gerald Dworkin, 'Paternalism', *The Stanford Encyclopaedia of Philosophy* (Zalta EN ed., Fall edn., 2019) <https://plato.stanford.edu/archives/fall2019/entries/paternalism/> accessed 30/12/19,
[56] Jennifer Barrow and Paras Khandhar, *Deontology* (StatPearls Publishing LLC, 2019).

as there is no contradiction when it becomes a universal law, and it could be argued that rational individuals would *will* to act on this maxim in such a world. A potential issue arises, however, when this principle is generalised further, such that anyone can be compelled to receive life-saving treatment regardless of their decisional capacity. In that case, if it becomes universal law, the rational person would, in effect, *will* that they be unable to exercise their will, which would be overridden in certain circumstances, hence leading to a contradiction in will. At the same time, a contradiction in will arises when one *wills* to forego all future exercise of the same will (through death), thus making it difficult to reach a universalisable principle.

IV. Rawls's Original Position

John Rawls's theory of justice provides a framework for deciding moral questions such as this one by proposing a hypothetical 'original position' whereby rational and selfish agents make decisions behind a 'veil of ignorance' with little knowledge of themselves and their characteristics in the real world. The starting position is that any 'good' comes from rational decision-making. This framework can be employed to ascertain what the rational person would decide regarding compulsory life-saving treatment of anorexia. The argument made here is that Rawls's theory makes allowances for paternalism in some circumstances and that this issue falls within that category.

Rawls claims that the parties would acknowledge paternalistic principles to 'protect themselves against the weakness and infirmities of their reason and will in society' and seek to 'insure themselves against the possibility that their powers are undeveloped and they cannot rationally advance their interests'.[57] Therefore, a rational agent in the original position who considers the possibility of being an end-stage anorexic and thus cognitively impaired as discussed, would accept the possibility of paternalistic intervention guided by their rational interests or by the theory of primary goods. Rawls's position in relation to the theory of good adopted to account for primary goods is that the 'good is the satisfaction of rational desire'. That is, whatever is the 'most rational long-term plan of life'.[58]

It has been argued that Rawls's precise message regarding weak and strong paternalism remains unclear. His condition that 'intervention must be justified by the evident failure or absence of reason and will' may be interpreted so as to allow only weak paternalism and exclude prudential justifications if the absence of will is empirical. On the other hand, it could also be argued that Rawls believes only rational decisions must be protected and the theory therefore permits coercion on prudential grounds.[59] It is submitted that the addition of the passage that it is rational for persons to protect themselves against their 'irrational inclinations' and 'consequences of their imprudent behaviour' indicates the acceptability of strong paternalism 'aimed at preventing self-regarding harmful irrational conduct.'[60] Therefore, based on the rationality arguments above, it seems quite uncontroversial that compulsory treatment is justifiable following Rawls's theory. As far as AB is concerned, the fact that she did not want to die and saw many reasons to continue

[57] John Rawls, *A theory of Justice* (Belknap Press, 1971).
[58] Ibid.
[59] Heta Hayry, *The Limits of Medical Paternalism* (Routledge, 2002).
[60] Lanuza, (n 32).

living[61] is a clear manifestation of the fact that her judgment is severely impaired with regard to decision-making about treatment and it is not inconceivable that if the choice were to be made by a rational person who pre-empts the lack of choice in the matter, they would exercise their rational capabilities to continue living.

Furthermore, one could advance the idea of 'future-oriented consent' or 'real-will theory' as the basis for providing anorexics with cognitive and rational deficiencies life-saving treatment: their will is not really being interfered with because if they were fully rational, they would choose to do the same thing.[62] This argument can also be derived from Rawls' theory when he offers guidance for paternalistic intervention and states that we must be able to argue that with the recovery of the individual's rational powers, they would accept and agree with the decision. Although somewhat controversial, some support for this argument as it relates to anorexia can be gained from research regarding coerced patients' perceptions of hospitalisation. Guarda et al. found that a significant number welcomed their hospitalisation following only two weeks of nutritional rehabilitation.[63] Fost similarly sought to justify paternalism when there was a high likelihood that the person would be subsequently thankful and those supporting the intervention would wish the same on themselves.[64] This further supports the proposition that because treatment refusal in anorexic people is not usually because they in fact wish to die, compulsory life-saving treatment for anorexia should be allowed. However, a further consideration is the long-term consequence of life-saving treatment. The arguments advanced in this note relate chiefly to the life-*saving* treatment and not treatment of anorexia in general. But if adverse long-term consequences manifest in the form of repeated, intrusive and forced, ineffective treatment, as in AB's case, or increased likelihood of mortality due to other reasons,[65] it is questionable whether this policy in fact promotes 'utility in the largest sense' or is the 'most rational life plan'.

It is important to distinguish between involuntary life-saving treatment of end-stage anorexics based on a lack of rationality analysis and prohibition of suicide/treatment refusal as a general principle. It is submitted that as Rawls's theory rests upon the bedrock of rationality, as long as the decision to end one's life is made autonomously and rationally, those in the original position are unlikely to find reason to consider it immoral, particularly as they are unaware of the circumstances that lead to the decision in question.

V. Conclusion

It is worth noting that the conclusion that this essay seeks to advance focuses primarily on the interpretation and application of Millian, Kantian, and Rawlsian moral principles to the case of AB's anorexia and does not claim to include a comprehensive and cross-disciplinary analysis of all the relevant considerations to be taken into account. For instance, the individual and subjective psychological experiences of different patients and

[61] *AB* (n 2) [64]
[62] Gerald Dworkin, 'Paternalism', in Rolf Sartorius (ed.), *Paternalism,* (University of Minnesota Press, 1983) 19
[63] A. Guarda and others, 'Perceived coercion and change in perceived need for admission in patients hospitalized for eating disorders' (2007) 164(1) Am J Psychiatry, 108.
[64] N Fost, 'Food for thought: Dresser on anorexia nervosa' (1984) 2 Wis L Rev, 375.
[65] R Ramsay and others, 'Compulsory treatment in anorexia nervosa. Short-term benefits and long-term mortality' (1999) 175 Br J Psychiatry, 147.

the ambiguity in the question regarding the life-threatening circumstances requiring involuntary hospitalisation preclude a conclusive and widely applicable principle from emerging, even if these were the only considerations. That is, it is possible that different ethical considerations may be relevant depending on the cause of imminent death as well as the reasons for refusal of treatment. Nevertheless, upon consideration of arguments within the scope of the essay, it can overall be concluded that anorexic people should be involuntarily hospitalised for life-saving treatment and 'best-interest' legal considerations notwithstanding, the same may be said regarding the case of AB.