TOO MUCH OR NOT ENOUGH? AN ANALYSIS OF BEST INTERESTS ASSESSMENTS FOR PATIENTS WTH ANOREXIA NERVOSA

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ABSTRACT

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In best interests assessments for patients with anorexia nervosa, judges face a complicated combination of ethical, medical, and legal considerations. This thesis dissects the question at the heart of that quandary: is it in the best interests of a patient with anorexia nervosa to withdraw compulsory treatment, including life-sustaining nutrition? Specifically, this research examines why that question is so difficult to answer. Using analogical case analysis, a critical framework based on theories of autonomy, and clinical studies, the project explains the Court of Protection's general approach to best interests assessments, followed by an analysis of its approach to cases concerning anorexia nervosa patients. This leads to the identification of two confounding factors; that is, two factors which make it impossible to arrive at a legally, morally, and medically satisfying answer to the identified question. The first is the dilemma of autonomy. The potential for anorexia nervosa patients to autonomously refuse medical treatment—despite their lack of autonomy in relation to decisions about food—forces the judge to decide between prolonging the patient's life at the cost of overriding her autonomy, or respecting her autonomy at the cost of her life. The second is the nature of compulsory treatment for anorexia nervosa. A hallmark of anorexia nervosa is patients' intense need for control. Given that compulsory feeding entails complete removal of control over the body and a severe infringement of the right to bodily integrity, the treatment is precisely the thing that *harms* anorexia nervosa patients. Thus, judges must decide between authorising the patient's death, or authorising and perpetuating suffering through treatment. In this way, the two confounding factors place judges in an invidious position. They create a conundrum such that there is no decision that can be deemed definitively 'correct'.

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INTRODUCTION

> *To be asked to make an order which will be likely to lead to the death of a sentient, highly intelligent and thoughtful individual who, if otherwise able and minded, might accept treatment which could assist her is as grave a decision as can be made.*
>
> *Postscript*
>
> *The Mental Health Trust has at my request kindly kept me informed of BG's progress. She returned home on the afternoon of the hearing. She was very pleased to be there.*
>
> *She has completed working through a list of tasks that she has set herself to do. She has ceased taking any oral nutrition and is now extremely weak. She is having daily contact with the palliative care team.*
>
> *Further Postscript*
>
> *I have been informed that BG passed away on 23 July 2022. That she remained living for as long as she did, was a matter of surprise to the treating team and of great distress to BG. Her last days were spent in a hospice.*
>
> Sir Jonathan Cohen, *A Mental Health Trust v BG (BG)*[1]

These words capture the concurrent pain and relief that is caused, both to judge and patient, by a death from anorexia nervosa. In many ways, it seems unfathomable that the withdrawal of life-sustaining nutrition could ever be in an individual's 'best interests'. Yet, that is the decision at which some Court of Protection judges arrive when applying section 4 of the Mental Capacity Act 2005. This thesis is concerned with identifying why it is so difficult to determine whether the judge's position is correct. It will be argued that, very often, there is no right answer. That is, there is no answer that is 'right' in the sense that it respects the patient (P)'s rights to autonomy and bodily

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[1] [2022] EWCOP 26 [50], [59-61].

integrity, protects her from harm, and preserves her life. The decision the judge faces is an impossible one.

For example, in the case above it could be argued—with a robust philosophical, legal, and ethical foundation—that Sir Jonathan Cohen's decision was wrong because allowing BG to die did not align with her true, 'authentic' wishes. Yet, as will be explored below, there are equally robust reasons why the decision could be deemed correct. This quandary stems from two features of anorexia nervosa: patients' (potential) ability to make autonomous decisions to refuse medical treatment, and the correlation between treatment and harm.

Usually, compulsory treatment is authorised with at least some confidence that the patient lacks the ability to form autonomous beliefs, desires, and decisions related to that treatment—most importantly the decision to refuse it. It is also authorised on the basis that it will prolong the patient's life and protect them from lasting harm. In cases concerning anorexia nervosa, the judge cannot rely on these justifications. It is the nature of anorexia nervosa that patients often retain the ability to engage in autonomous thinking about their medical circumstances, though not about food. It is also the nature of anorexia nervosa that the treatment—compulsory feeding—can be traumatic, infringes patients' right to bodily integrity, and provides no guarantee of long-term efficacy. For these reasons, patients' ability to retain autonomy and the nature of treatment are *confounding factors* in these cases. They are confounding in the sense that they make a problem that might otherwise have a logical, legal, and ethically sensitive solution intractable. Every possible decision leads to a highly undesirable outcome. The judge is in an invidious position.

Methodology

This thesis was developed using a doctrinal research approach, with a focus on critical case analysis. Terry Hutchinson and Nigel Duncan's two-step approach to doctrinal research was adopted; a preliminary case analysis represented the process of identifying the 'objective reality' of this area of the law, followed by an interpretation and analysis of those findings.[2] Published judgments, *ex tempore* judgments, and transcripts from live Court of Protection hearings were examined using the qualitative analysis software NVivo 14. Recurrent themes and patterns in judicial reasoning were highlighted, as well as the factors for consideration listed in section 4 of the Mental Capacity Act 2005 (MCA). The goal of this process was to create a general understanding of how judges in the Court of Protection approach best interests assessments for patients with anorexia nervosa—namely, how they apply the statutory provisions, and which non-statutory legal and ethical principles are drawn upon to reach their decisions. The NVivo 14 codes were then used to create diagrams illustrating the usage frequency of particular words and phrases. This formulated a perspective on which factors hold the most weight in these decisions: medical evidence, P's wishes and feelings, the presumption in favour of prolonging life, and so forth.

The judicial approach to these best interests assessments was subsequently analysed from a theoretical and clinical ethics perspective. A critical framework was developed based on theories of autonomy, as well as clinical studies involving interviews with anorexia nervosa patients. This framework was used to deconstruct the themes and areas of tension identified in the original case analysis.

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[2] Terry Hutchinson and Nigel Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research' (2012) 17(1) Deakin Law Review 83, 110.

This methodology bears the hallmarks of analogical reasoning. Individual cases were compared to reach an understanding of how the Court of Protection approaches this category of case in general. Cass Sunstein identifies the advantages of this methodology.[3] He argues that analogical reasoning allows for agreement on outcomes in areas where it is very difficult to reach consensus on general principles.[4] In cases concerning anorexia nervosa, the diversity of factual circumstances between cases makes it extremely challenging to reach accord on what are or ought to be the 'rules' that guide judges in making their decisions. By contrast, analogical reasoning involves comparison between particular elements of different cases, allowing for agreement as to whether they are similar enough to warrant having the same outcome. This helps develop insight into an area of law that is impossible to conceptualise through universal principles. Moreover, unlike an approach that attempts to definitively identify 'what the law is', analogical reasoning is flexible and adapts to take account of new contributions to the field.[5] A new case acts as supplemental data to enrich the comparison and add nuance, rather than threatening the factual accuracy of an established 'rule'. Given that four cases concerning anorexia nervosa were heard before the Court of Protection during the writing of this thesis, this feature of analogical reasoning was extremely valuable.

Sunstein accepts that this method has some disadvantages. It lacks the certainty of empirical data and does not have a strong theoretical foundation to support the claims

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[3] Cass R Sunstein, 'On Analogical Reasoning' (1993) 106(3) Harvard Law Review 741.

[4] ibid 782.

[5] ibid.

it yields.[6] However, empirical and quantitative research was beyond the scope of this thesis. Further, a critical framework was used to supplement the interpretation of the findings established through analogical reasoning. Considering these factors, the advantages of engaging in analogical reasoning for this research outweighed the disadvantages.

Context and Contribution

Between the enactment of the MCA in 2005 and 2019, only six cases concerning eating disorders were heard before the Court of Protection. By contrast, thirteen cases have been heard before the Court of Protection since 2020 and one more is awaiting judgment. This extraordinary shift in frequency indicates that cases concerning severe eating disorders are acutely relevant in the current socio-legal environment. This is especially true considering recent debates over whether anorexia nervosa can be considered a 'terminal' illness in some cases.[7] Specifically, the question of when it is ethical to withdraw compulsory life-sustaining treatment from anorexia nervosa patients is of pressing importance. That is the question which most frequently comes before the Court of Protection. It is also the crux of the debate on terminal anorexia; proponents argue that patients should not be subject to compulsory life-sustaining treatment if their eating disorder is 'terminal'—instead, they should have access to palliative care options.[8] Some argue that those options should include physician-

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[6] ibid 767.

[7] Jennifer Gaudiani, Alyssa Bogetz, and Joel Yager, 'Terminal Anorexia Nervosa: Three Cases and Proposed Clinical Characteristics' (2022) 10 Journal of Eating Disorders 1; Scott J Crow, 'Terminal Anorexia Cannot Currently Be Identified' 56(7) International Journal of Eating Disorders 1329.

[8] ibid.

assisted dying, which is particularly relevant in light of the Terminally Ill Adults (End of Life) Bill currently under debate in Parliament.[9] The aim of this project is to establish the baseline for determining whether and when withdrawal of life-sustaining compulsory treatment from anorexia nervosa patients is ethical: identifying precisely why it is such a difficult question to answer.

Legal research on this topic is generally limited to the first six cases concerning patients with anorexia nervosa; those which came before the Court of Protection between 2005 and 2019. Emma Cave and Jacinta Tan, John Coggon, Daniel Wei Wang, and Eric Ip have contributed some of the only articles that are specifically concerned with analysing this category of best interests assessment.[10] The majority of those articles discuss only one case, and none of them discuss judgments published after 2016. This thesis addresses that lacuna without overlooking the contributions of the first six cases. Additionally, research in this area is generally 'isolated' in the sense that it is focussed either on the law *or* philosophy *or* clinical ethics. This project aims to connect all three areas, allowing for a more nuanced account of the judicial approach to these cases.

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[9] ibid.

[10] Emma Cave and Jacinta Tan, 'Severe and Enduring Anorexia Nervosa in the Court of Protection in England and Wales' (2017) 23(17) International Journal of Mental Health and Capacity Law 4; John Coggon, 'Anorexia Nervosa, Best Interests, and the Patient's Human Right to 'a Wholesale Overwhelming Of Her Autonomy'' (2014) 22(1) Medical Law Review 119; Daniel Wei Wang, 'Mental Capacity Act, Anorexia Nervosa and the Choice Between Life-Prolonging Treatment and Palliative Care: *A NHS Foundation Trust v Ms X*' (2015) 78(5) MLR 871; Eric C Ip, 'Anorexia Nervosa, Advance Directives, and the Law: A British Perspective' (2019) 33(8) Bioethics 931.

Anorexia nervosa has the highest mortality rate of any psychiatric illness, and its incidence is rapidly increasing.[11] Five years after the COVID-19 pandemic, the volume of hospitalizations for eating disorders is still 25% higher than expected based on the growth in volume observed before and during the pandemic.[12] Considering these trends, it is crucial for academics, lawyers, and healthcare practitioners to understand how judges in the Court of Protection determine if withdrawal of life-sustaining compulsory treatment is in a patient's best interests, and the paradoxes that arise when making that decision.

Outline of Thesis

The first chapter of this thesis introduces the law on best interests assessments, providing an overview of sections 3 and 4 of the Mental Capacity Act 2005. It sets out the diagnostic and functional tests for mental capacity and the process by which the presumption of capacity is overturned. The chapter explores the factors that judges are required to consider in best interests assessments, followed by a general analysis of the application of those requirements in practice. This provides an essential foundation for understanding the law in this area.

Chapter two describes anorexia nervosa from a clinical perspective. It lists the diagnostic criteria and symptoms of the disorder, allowing for greater insight into the

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[11] Nathalie Auger and others, 'Anorexia Nervosa and the Long-Term Risk of Mortality in Women' (2021) 20(3) World Psychiatry 448; Alex M Trafford and others, 'Temporal Trends in Eating Disorder and Self-Harm Incidence Rates Among Adolescents and Young Adults in the UK in the 2 Years Since Onset of the COVID-19 Pandemic: A Population-Based Study' (2023) 7(8) The Lancet Child & Adolescent 544.

[12] Cassie Burley, Carly Milliren, and Tracy Richmond, 'Has the Pandemic-Related Increase in Eating Disorder Hospitalization Volume Returned to Pre-Pandemic Levels?' (2025) 76(3) Journal of Adolescent Health S20.

lived experience of the patients in the relevant cases. Chapter three analyses the key themes in best interests assessments for patients with anorexia nervosa. It identifies four core categories of factors in the decisions: (1) medical evidence and P's prospects of recovery, (2) the balance between sanctity of life and autonomy, (3) protection of dignity, and (4) the views of P's loved ones. This chapter draws out how these factors are connected to P's rights under the European Convention of Human Rights (ECHR). Crucially, it highlights the fundamental tension between the legal presumption that life should be prolonged and patients' right to personal autonomy.

Chapter four explores the first confounding factor in best interests assessments for patients with anorexia nervosa: patients' potential ability to autonomously refuse medical treatment. It provides a definition of autonomy, then evaluates the impact of anorexia nervosa on the ability of individuals to have autonomy. The analysis focuses on the two main ways in which anorexia nervosa is thought to impede autonomy: (1) the argument that anorexia nervosa patients cannot make authentic decisions, or only their past wishes were authentic, and (2) the argument that these patients cannot engage in rational thinking. This discussion leads to the conclusion that both claims rest on weak logical foundations. Patients may have the ability to hold autonomous beliefs and preferences regarding their medical treatment, despite engaging in irrational thinking about food. Where this is the case, judges are forced to choose between respecting P's autonomy at the cost of her life, and preserving P's life at the cost of overriding her autonomous refusal of treatment.

Chapter five analyses the second confounding factor in these cases: the uniquely torturous nature of treatment for anorexia nervosa. This chapter outlines the medical guidelines for compulsory treatment for anorexia nervosa. It then uses clinical data and excerpts from cases to draw out the connection between anorexia nervosa and the need for control. This allows for an analysis of how force-feeding, as total removal of control over the body, is often a traumatic process for patients with anorexia nervosa. This ties into an interrogation of the effectiveness of compulsory treatment, with a focus on long-term treatment patterns of refeeding and immediate weight loss, and the erosion of trust between patients and carers. The chapter also explores how force-feeding is a severe infringement of bodily integrity, a right which is distinct from personal autonomy and exceptionally important to patients with anorexia nervosa. These insights lead to the conclusion that treatment for anorexia nervosa patients is precisely the thing that harms them. This creates a second paradox for judges when making best interests decisions; they must withdraw treatment at the risk of P's death, or authorise treatment that produces and perpetuates suffering.

Boundaries

It is important to clarify the boundaries that were established for this research. Only cases concerning anorexia nervosa were analysed, not those pertaining to bulimia nervosa or hunger strikes. This is because anorexia nervosa has by far the highest incidence in the Court of Protection. Only one case concerning bulimia nervosa was found, and it concerned the question of P's capacity rather than a best interests assessment.[13] Further, hunger strikes involve distinct factual circumstances that create ethical and legal arguments in favour and against compulsory feeding that are different from those relevant to eating disorders. As such, they were considered to fall outside

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[13] *Lancashire and South Cumbria NHS Foundation Trust v Q* [2022] EWCOP 6.

the boundaries of this thesis. The focus on anorexia nervosa created a desirable homogeny within the cases studied. Similarly, cases were limited to those concerning adult patients. Again, the aim was to create consistency by concentrating specifically on the application of the Mental Capacity Act without the added complication of the Act's interaction with parental responsibility. Finally, the incidence of anorexia nervosa is up to three times higher in women than in men.[14] All of the patients in the relevant cases are women. Thus, the pronouns 'she, her, and hers' are used to refer to all anorexia nervosa patients in this thesis.

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[14] Annelies E van Eeden, Daphne van Hoeken and Hans W Hoek, 'Incidence, Prevalence and Mortality of Anorexia Nervosa and Bulimia Nervosa', (2021) 34(6) Current Opinion in Psychiatry 515.

CHAPTER 1: THE LAW ON CAPACITY AND BEST INTERESTS ASSESSMENTS

1.1: Capacity

The law on best interests assessments is enshrined in the Mental Capacity Act 2005 and the cases in which it is applied. For a best interests assessment to occur, the Court of Protection must first find that P lacks mental capacity to make decisions regarding her medical treatment. One of the core principles of the MCA is that P is assumed to have capacity.[15] This reflects the general stance of the Act: promotion of autonomy and anti-paternalism. The presumption against incapacity must be displaced, on the balance of probabilities, through the application of the tests for incapacity in sections 2 and 3 of the MCA.[16] A patient cannot be deemed incapacitous merely because she makes an 'unwise' decision—another principle aimed at protecting vulnerable individuals from paternalistic interferences.[17] This section is particularly important in cases concerning anorexia nervosa; the decision to refuse life-sustaining nutrition could easily be deemed unwise.

The diagnostic test for displacing the presumption of capacity requires that P be 'unable to make a decision…in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.[18] Under section 3 MCA, the functional test for incapacity requires that P be incapable of at least one of the

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[15] MCA s1(2).

[16] ibid s2(4).

[17] ibid s1(4).

[18] ibid s2(1).

following: understanding, retaining, using and weighing information, and communicating her decision.[19] It is important to note that this test is issue-specific, meaning patients may have capacity in relation to some matters but not others. In *A NHS Foundation Trust v Ms X (Ms X),* for example, Ms X was held to have mental capacity to take decisions about alcohol, but not the treatment of her anorexia nervosa.[20] The Court of Protection's jurisdiction to carry out best interests assessments is limited to the matters regarding which patients lack capacity.[21]

After the enactment of the MCA, there was some confusion as to whether the functional test in section 3 should be completed before the diagnostic test in section 2. The MCA Code of Practice dictates that establishing a lack of capacity is a two-stage process:

1. Does P have an impairment or disturbance in the mind or brain, and
2. Does the impairment or disturbance mean P is unable to make a decision?[22]

This suggests that MCA section 2 should be completed before section 3. However, in *PC & Anor v City of York Council,* the Court of Appeal held that the court must first ask whether P is unable to make the relevant decision, and *then* ask whether that inability is because of an impairment or disturbance in the mind or brain.[23] This decision

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[19] MCA s3(1).

[20] [2014] EWCOP 35 [30].

[21] ibid.

[22] Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice (London: TSO, 2007), 4.11, 4.13.

[23] [2013] EWCA Civ 478 [58].

was cemented by the Supreme Court in *A Local Authority v JB,* which clarified that the capacity test is a 3-stage process:

1. Can P make a decision for himself in relation to the matter? If not:
2. Is there an impairment or disturbance in the functioning of P's mind or brain? If so:
3. Is P's inability to make the decision 'because of' the identified impairment or disturbance?[24]

This reverses the order of the relevant MCA sections: the first stage is the functional test in MCA section 3, and the second and third stages are the diagnostic test in MCA section 2.

When applying Stage 1 to anorexia nervosa cases, judges in the Court of Protection focus on the invasive thoughts that are characteristic of anorexia nervosa and the distorted perceptions of nutrition and health that they produce. For example, the patient in *Midlands NHS Trust v RD (RD)* '[understood] that, if she does not eat or drink her juices, it will not be good for her, but she simply [did] not understand that it will lead to her death'.[25] According to Moor J, this meant that RD was able to understand and retain the relevant information, but could not weigh it—she failed the functional capacity test.[26] Further, judges often refer to patients as being 'overcome' by the thoughts connected to their anorexia nervosa, rendering them incapacitous in relation

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[24] [2021] UKSC 52 [67], [78-9].

[25] [2021] EWCOP 35 [11].

[26] ibid.

to decisions regarding nutrition and their medical treatment. In *A Local Authority v E (Re E),* Jackson J held that 'the compulsion to prevent calories entering [E's] system has become the card that trumps all others. The need not to gain weight overpowers all other thought'.[27] Similarly, in *Gloucestershire Health & Care NHS Foundation Trust v FD (FD),* Francis J held that 'when it comes to making a decision about nutrition or hydration, FD becomes overwhelmed by the anorexia'.[28] This reasoning will be analysed in greater detail below.

A comparison can be drawn between anorexia nervosa and other forms of phobia and fixation. In *F v F,* Theis MJ held that it was in the best interests of two sisters to receive the MMR vaccine against their wishes and the wishes of their mother.[29] One of the judge's justifications was that the sisters (one of whom was vegan) had become fixated on a non-vegan ingredient in the vaccine—gelatine—and could not 'consider and balance the wider picture'.[30] For example, they could not take into account the ingredients in medication they would have to consume if they acquired a disease that the MMR vaccine prevents.[31] Theis J's interpretation of the sisters' thought process mirrors judges' approach to anorexia nervosa cases; the fixations related to food are seen as preventing the patient from using and weighing all relevant information in order to take the decision. Again, this will be analysed more fully below.

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[27] [2012] EWHC 1639 (COP) [49].

[28] [2023] EWHC 2634 (COP) (Fam) [33].

[29] [2013] EWHC 2683 (Fam).

[30] ibid [22]. This reasoning was used to prove that the sisters were not 'Gillick competent' based on the test in *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402. They could not understand fully the treatment that was being proposed and therefore could not decide for themselves whether to receive the vaccine

[31] ibid.

Regarding Stages 2 and 3 of the capacity test, the Court of Protection recognises anorexia nervosa as an 'impairment' or 'disturbance' of the mind.[32] It also recognises the possibility of a causal connection between anorexia nervosa as an impairment or disturbance of the mind, and the ability to make decisions regarding medical treatment.[33] Crucially, section 2(3)(b) of the MCA forbids establishing a lack of capacity merely by reference to a condition of the patient's which 'might lead others to make unjustified assumptions' about her capacity. This means that judges cannot assume that a patient lacks capacity merely because she has a diagnosis of anorexia nervosa, which carries stereotypes about rationality and the ability to process information.

1.2: Best Interests

Section 4 of the MCA sets out the requirements for best interests assessments. As a starting point, judges must consider whether their decision is the least restrictive of P's rights and freedoms while still being in her best interests.[34]

The decision must not be based 'merely' on P's age or appearance, nor a condition or aspect of their behaviour which may lead to unjustified assumptions about their best interests.[35] The use of the word 'merely' indicates that the judge can consider

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[32] *The NHS Trust v L* [2012] EWHC 2741 (COP) [57]; *Re E* (n 27) [48]; *A Mental Health Trust v ER (ER)* [2021] EWCOP 32 [33].

[33] *The NHS Trust v L* [2012] EWHC 2741 (COP) [53]; *Re E* (n 27) [49]; *ER* (n 32) [21].

[34] MCA s1(6).

[35] ibid s4(1).

those factors in conjunction with other factors when reaching their decision. This drafting is clearly problematic; no judge should be able to rely on an unjustified assumption when making a decision. Ultimately, '[a]ll relevant circumstances' must be considered,[36] including:

- P's past and present wishes and feelings,
- Any of P's beliefs and values that would influence her decision if she had capacity,
- Other factors that P would consider if she were able to, and
- Whether P may recover capacity in relation to the issue, and if so, when.[37]

The judge must encourage P's participation in the proceedings 'so far as reasonably practicable'.[38] This can be a complex task in cases concerning patients with anorexia nervosa. Whilst many anorexia nervosa patients can be articulate and cooperative, other patients can engage in volatile behaviour or be too ill to participate.[39]

The Act also specifies that the judge must not be motivated by a desire to bring about P's death.[40] This is particularly relevant to cases concerning patients with anorexia nervosa, where the judge is typically contemplating the withdrawal of life-

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[36] ibid s4(2).

[37] ibid s4(6), s4(3).

[38] ibid s4(4).

[39] See *Re E* (n 27), in which E had already 'embarked down the palliative care pathway' [40].

[40] MCA s4(5).

sustaining nutrition. Section 5.31 of the Mental Capacity Act Code of Practice acknowledges this, stating that:

> There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death.[41]

As will be explained, this paragraph is often drawn upon by judges who decide that compulsory feeding is not in the best interests of patients with anorexia nervosa.

The judge must, 'if practicable and appropriate', consider the views of anyone who is named by, caring for, or interested in the welfare of P, as well as donees of a lasting power of attorney granted by P or deputies appointed for P by the court.[42] For patients with anorexia nervosa, this generally refers to their family members and close friends. According to Lady Hale in *Aintree University Hospitals NHS Foundation Trust v James* (*Aintree),* the goal of this section is to gather the views of P's loved ones on 'what [P's] attitude would be'.[43]

Finally, in accordance with section 3(1) of the Human Rights Act 1998, the court must interpret and give effect to the provisions in section 4 of the MCA in a manner which is compatible with the ECHR.[44] For anorexia nervosa patients, Articles 2, 3, and 8 are most often cited as being relevant to the decision. Article 2, the right to

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[41] MCA Code of Practice (n 22), 5.31.

[42] MCA s4(7).

[43] [2013] UKSC 67 [39].

[44] *Re E* (n 27) [13]; *Ms X* (n 20) [36], [46]; *The NHS Trust v L* [2012] EWHC 2741 (COP) [17].

life, is threatened by the possibility of withdrawing life-sustaining nutrition.[45] Conversely, compulsory feeding can be a severe intrusion into a patient's private life, which is protected by Article 8.[46] The invasive nature of compulsory feeding, particularly through restraint or sedation, can also amount to the kind of inhumane or degrading treatment which is prohibited by Article 3 ECHR.[47] Of these three, Article 8 is the only right which is not absolute; it is subject to restrictions made 'in accordance with law' where 'necessary in a democratic society... for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others'.[48] In *Lambert and Others v France,* the European Court of Human Rights held that the process of deciding whether to withdraw life-sustaining treatment, as well as the balance to be struck between patients' right to life and their rights to private life and personal autonomy, fall within Member States' margin of appreciation.[49] However, in these circumstances the Court reserves the power to assess whether the State has fulfilled its obligations under Article 2.[50]

1.3: The Court's Approach to Best Interests Assessments

Before analysing best interests assessments for patients with anorexia nervosa, it is important to understand how the Court of Protection approaches best interests assessments in general.

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[45] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 2.

[46] ibid, art 8.

[47] ibid, art 3; *Ms X* (n 20) [46].

[48] ECHR art 8(2).

[49] *Lambert and Others v France* App no. 46043/14 (ECtHR, 5 June 2015), para [148].

[50] ibid.

The concept of ‘best interests’ is meant to be construed widely; in *Aintree,* Lady Hale held:

> [I]n considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological. They must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be…[51]

Thus, the concept of ‘best interests’ is not limited to P’s medical welfare; rather, it encompasses their best interests ‘as an individual human being’ more broadly.[52] The Explanatory Notes to MCA section 4 state that the best interests decision ‘is not a test of “substituted judgement”…but rather…requires a determination to be made by applying an objective test as to what would be in the person’s best interests’.[53] Lady Hale’s statement seems to contradict this; an element of substituted judgement is inevitable when putting oneself in the place of the patient.[54] However, Lady Hale explained this apparent conflict by holding that it is ‘still a “best interests” rather than a “substituted judgment” test, but one which accepts that the preferences of the person concerned are an important component in deciding where his best interests lie’.[55] The judge is not putting himself in P’s shoes to decide what she would want were she able

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[51] [2013] UKSC 67 [39].

[52] ibid [45].

[53] Explanatory notes to the Mental Capacity Act 2005, para 28.

[54] [2013] UKSC 67 [39].

[55] ibid [24].

to make the decision. Rather, the judge is making a decision that is informed and shaped by P's personal beliefs, values, wishes, and feelings, but is ultimately a decision on what is in P's best interests. This reflects the commitment to autonomy that underpins the MCA. As Catriona Mackenzie and Wendy Rogers argue, the necessity of making a best interests decision that aligns as much as possible with P's wishes and values is demonstrative of the Act's 'strong anti-paternalist stance'.[56] Indeed, in *Barnsley Hospital NHS Foundation Trust v MSP,* Hayden J held that 'the focus must always be on identifying the views and feelings of P' in order to 'reassert P's autonomy'.[57] By ascertaining P's wishes and values from herself (where possible), and her loved ones, the court strives to keep P at the centre of its decision and avoid outright deference to the opinions of medical professionals.

Unsurprisingly, therefore, P's beliefs, values, wishes, and feelings are a 'significant factor to which the court must pay close regard'.[58] The MCA Code of Practice states that P's beliefs and values can be ascertained by referencing P's cultural background, religious beliefs, political convictions, or past behaviour or habits.[59] Moreover, the MCA Code of Practice states that section 4 'puts the person who lacks capacity at the centre of the decision to be made. Even if they cannot make the decision, their wishes and feelings, beliefs and values should be taken fully into account'.[60] However, P's wishes, feelings, beliefs, and values can never be determinative; the

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[56] Catriona Mackenzie and Wendy Rogers, 'Autonomy, Vulnerability and Capacity: A Philosophical Appraisal of the Mental Capacity Act' (2013) 9 International Journal of Law in Context 37, 42.

[57] [2020] EWCOP 26 [24].

[58] *ITW v Z* [2009] EWHC 2525 (Fam) [35].

[59] MCA Code of Practice (n 22) 5.46.

[60] ibid 5.38.

decision must be that which is in P’s best interests, considering the relevant factors as a whole.[61]

Regarding the weight assigned to P’s wishes and feelings, in *ITW v Z* Munby J held that judges should consider (a) the degree of P’s incapacity, (b) the strength and consistency of P’s wishes, (c) the potential consequences of P learning her wishes are not being given effect to, (d) the rationality of her views, and (e) ‘crucially, the extent to which P's wishes and feelings…can properly be accommodated within the court's overall assessment of what is in her best interests’.[62] As this list makes clear, the weight attached to P’s wishes and feelings is highly fact-specific. The difficult cases are those in which P’s wishes and feelings contradict, either at the time of the case or between different periods. For example, P may have wished to receive tube feeding in the past but no longer want to do so. Or she may express a desire to live but also refuse life-saving nutrition. In such cases, judges have the added task of ascertaining which of P’s wishes, feelings, beliefs, and values best reflect P’s true character system and most closely align with what P would want if she had capacity. Certain wishes must be assigned less or even negligible weight in order to prioritise those which the judge believes to be P’s ‘true’ wishes and values. This is connected to the problem of authenticity, which will be discussed below.

The MCA does not create a hierarchy of all the factors to be considered. Instead, the decision is ultimately a ‘value judgement’ by the decision-maker, which must ‘[give] effect to the paramount statutory instruction that any decision must be made in

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[61] ibid.

[62] [2009] EWHC 2525 (COP) [35].

P's best interests'.[63] The Explanatory Notes to section 4 MCA make this explicitly clear: 'all the relevant circumstances…must be considered, but none carries any more weight or priority than another'.[64] Thus, there is no set starting point or presumption that certain factors are more important than others; the decision must simply be the one that, in the mind of the judge, is in P's best interests.[65]

The Court of Protection once favoured a balance-sheet approach to best interests assessments, wherein judges would list benefits on one side of the 'sheet' and disadvantages on the other, allowing the judge to 'strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses'.[66] However, the court has moved away from this approach. MacFarlane LJ argued that one of the dangers of the balance-sheet format is that all elements of the table may be assigned equal value, 'as in a map without contours', even though certain factors undoubtedly carry greater or less weight than others.[67] The court has also recognised that some factors relevant to the best interests assessment are 'conceptually different' to others and are thus not amenable to a balance sheet approach.[68] Hayden J uses the example of comparing the sanctity of life to the distress of an infected bed sore.[69]

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[63] *Re: P (Statutory Will)* [2009] EWHC 163 (Ch) [39].

[64] Explanatory notes to the MCA 2005, para 28.

[65] *K v LBX* [2012] EWCA Civ 79 [66].

[66] *Re A (Medical Treatment: Male Sterilisation)* [2000] 1 FCR 193, 53*; C v A Local Authority* [2011] EWHC 1539 (Admin) [58].

[67] ibid.

[68] *Cambridge University Hospitals NHS Foundation Trust v AH* [2021] EWCOP 51 [66].

[69] ibid.

The balance-sheet approach is ethically problematic for the same reasons. Camillia Kong and co-authors argue that deciding between incommensurable goods requires 'drawing on substantive value sources and our evaluations of worth'.[70] This means engaging with our intrinsic values and intuitions, using qualitative evaluation to articulate why one factor carries more or less weight than another.[71] The balance-sheet approach wrongly rejects that type of reasoning in favour of an appearance of value-neutrality. As Kong and co-authors argue, the 'fraught issues' at stake in best interests assessments 'demand an orientation of valuing in ways that recognise their nature as intrinsic goods'.[72] That is, factors relating to the patient's case must be recognised as inherently valuable: of worth because of what they are, not as a trade-off of another factor. Each must be given 'what it is due' rather than the superficial status of advantage or disadvantage.[73] This requires vocabulary that expands beyond 'plus' or 'minus' and explains, with greater clarity and normative intuition, why particular factors are worth what they are worth in light of the facts of the case.[74]

Given the drawbacks of the balance-sheet, the Court of Protection has moved toward a different approach to best interests assessments. It conducts a 'balancing exercise'. In this exercise, judges isolate the factors at play in the decision and analyse those factors in light of the factual circumstances, assigning individual weight to each.[75]

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[70] Camillia Kong and others, 'An Aide Memoire for a Balancing Act? Critiquing The 'Balance Sheet' Approach to Best Interests Decision-Making'(2020) 28 Med Law Rev 753, 776.

[71] ibid; Charles Taylor, *Human Agency and Language: Philosophical Papers* (CUP 1985).

[72] Kong and others (n 70) 780.

[73] ibid.

[74] ibid 776.

[75] *Re F (A Child) (International Relocation Case)* [2015] EWCA Civ 882 [52].

When considered as a whole, the relative weight of the factors directs the decision-maker toward one path of treatment or another. Unlike the balance-sheet approach, which creates what is essentially a 'pros and cons' list that determines the final decision, the balancing exercise creates space for judges to make their own value judgement as to which course of action is in the patient's best interests based on the relative weight of the respective factors. Though still mechanistic to an extent—unsurprisingly, considering the question will always be a legal one which requires a definitive answer—the balancing exercise allows for recognition that the relevant factors are all unique and incommensurable. To use Hayden J's example, the sanctity of life and an infected bed sore would not be listed on opposite sides of the balance sheet, categorised simply as 'factor against withdrawal of treatment' and 'factor in favour'. Instead, the sanctity of life would (presumably) be assigned a great deal of weight, while the infected bed sore would be assigned comparatively less weight. The value of each factor is assigned individually through qualitative, normative evaluation. This creates a far more nuanced picture of the case, allowing for a holistic analysis of the patient's circumstances in light of her values and lived experience.

In most cases concerning patients with anorexia nervosa, the question is whether the factors in favour of withdrawing compulsory treatment hold greater overall weight than the factors against it, according to the judge's qualitative evaluations. The processes of judicial reasoning used to answer this question will form the basis of analysis in this thesis. Before engaging in that analysis, it is essential to survey the clinical features of anorexia nervosa to gain a clear understanding of the circumstances and decision with which the judge is faced.

CHAPTER 2: THE NATURE OF ANOREXIA NERVOSA

2.1: Clinical Features of Anorexia Nervosa

Anorexia nervosa is a mental disorder defined by three diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR):

> A. Restriction of energy intake leading to a significantly low body weight. ‘Significantly low’ is defined as less than that minimally normal.
>
> B. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain despite being at a significantly low weight.
>
> C: Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.[76] The UK’s Royal College of Psychiatrists words this criterion slightly differently, stating ‘low body weight or body shape…is inaccurately perceived to be normal or even excessive’.[77]

There are two main subtypes of anorexia nervosa, which commonly overlap. Patients with ‘restricting type’ lose weight through dieting, fasting, and/or excessive exercise.

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[76] American Psychiatric Association, ‘Diagnostic and Statistical Manual of Mental Disorders, Text Revision’ (2022, 5th edition) 381.

[77] Royal College of Psychiatrists, *Medical Emergencies in Eating Disorders: Guidance on Recognition and Management* (2022) 152.

‘Binge-eating/purging type’ is characterised by episodes of self-induced vomiting or the misuse of laxatives.[78]

Severity of the disorder is determined by reference to P’s body mass index, or BMI. According to the World Health Organization (WHO), a normal, healthy BMI for adults is between 18.5 and 24.9.[79] DSM-5-TR states that patients with a BMI below 15 have extreme anorexia nervosa. Patients with a BMI between 15 and 15.99 are considered to have severe anorexia nervosa, a BMI between 16 and 16.99 is indicative of moderate anorexia nervosa, and a BMI at or above 17 is a mild case of the disorder. These parameters are not definitive. For example, the Royal College of Psychiatrists recommends using thresholds of risk to life. A BMI of 15 to 17.5 indicates low immediate risk to life, a BMI of 13 to 15 indicates medium risk to life, and a BMI under 13.2 indicates a high risk of life-threatening malnutrition.[80] Importantly, guidance from the National Institute for Health and Care Excellence (NICE) on recognition and treatment of eating disorders states that a BMI threshold should not be used when deciding whether to admit individuals to hospital. Rather, the person’s general physical and mental health should be evaluated, including whether their health is ‘significantly declining’ and whether sufficient support can be provided by loved ones and carers.[81]

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[78] American Psychiatric Association (n 76) 381.

[79] World Health Organization, ‘A healthy lifestyle – WHO recommendations’ (*WHO,* 6 May 2010) <https://www.who.int/europe/news-room/fact-sheets/item/a-healthy-lifestyle---who-recommendations> accessed 11 April 2025.

[80] Royal College of Psychiatrists (n 77) 43, 44.

[81] National Institute for Health and Care Excellence, *Eating Disorders: Recognition and Treatment* (2017) 34.

An intense fear of becoming fat—Criterion B of the disorder—is not alleviated by weight loss, but may increase as the patient's weight decreases.[82] Patients experience distorted self-perception of their bodies, as described by DSM-5-TR:

> Some individuals feel globally overweight. Others realize that they are thin but are still concerned that certain body parts, particularly the abdomen, buttocks, and thighs, are "too fat"…The self-esteem of individuals with anorexia nervosa is highly dependent on their perceptions of body shape and weight.[83]

Other psychological symptoms include anxiety, depression, thoughts of suicide and self-harm, poor attention and concentration, and memory disturbance.[84] Additionally, autism spectrum disorder (ASD) is more prevalent in patients with anorexia nervosa than in the general population.[85] This can create barriers to successful treatment, as will be explored below.

Severe and enduring anorexia nervosa (SE-AN) is a label used for patients who have particularly intense presentations of the disorder. There is no official definition of SE-AN, but the criteria typically focus on duration of the illness and previous attempts at treatment and recovery. For example, Phillipa Hay and Stephen Houyz list three criteria for SE-AN:

1. A persistent state of dietary restriction, underweight, and overvaluation of weight/shape with functional impairment

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[82] American Psychiatric Association (n 76) 382.

[83] ibid 383.

[84] Royal College of Psychiatrists (n 77) 57.

[85] Heather Westwood and Kate Tchanturia, 'Autism Spectrum Disorder in Anorexia Nervosa: An Updated Literature Review' (2017) 19(7) Current Psychiatry Reports 41.

2. Duration of > 3 years of anorexia nervosa
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.[86]

All of the patients in the relevant best interests assessments meet these criteria, and can thus be deemed to have SE-AN.

In May of 2022, the Royal College of Psychiatrists released a report entitled *Medical Emergencies in Eating Disorders: Guidance on Recognition and Management* (the MEED Guidelines). This report replaced previous guidance for clinicians: MARSIPAN—Management of Really Sick Patients with Anorexia Nervosa, released in 2010. The new guidance emphasises the features of anorexia nervosa that can compromise treatment. It details the behaviours that patients engage in to avoid gaining weight during hospital admission, such as micro-exercise, hiding food, self-induced vomiting, and drinking water before being weighed.[87] Patients can also be ashamed of their condition or deny that they are suffering from anorexia nervosa.[88] They may become violent toward staff who attempt to increase their nutritional intake.[89] However,

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[86] Phillipa Hay and Stephen Houyz, 'Classification Challenges in the Field of Eating Disorders: Can Severe and Enduring Anorexia Nervosa be Better Defined?' (2018) 6 Journal of Eating Disorders 41 <https://link.springer.com/article/10.1186/s40337-018-0229-8#citeas> accessed 09 May 2025.

[87] Royal College of Psychiatrists (n 77) 96.

[88] ibid 40.

[89] ibid 56.

physical restraint of patients is designated a ‘last resort’.[90] This has implications for the nature and use of force-feeding, to be explored below.

DSM-5-TR lists the ‘crude mortality rate’ of anorexia nervosa as 5%, with death most often arising due to medical complications associated with the disorder, or suicide.[91] One study found that for one in five individuals with anorexia nervosa who died, the cause was suicide.[92] Patients who require hospitalisation are less likely to recover from the disorder, as are patients who begin experiencing symptoms at an early age (between 8 and 14).[93] Crucially, studies show that early access to treatment is essential; full recovery becomes far more difficult to achieve after the first three years of the illness—the ‘critical window for effective intervention’.[94] Clinical trials show that patients with enduring anorexia (beyond three years) ‘often develop a history of negative treatment experiences and repeated treatment failures. Both patient and clinician typically experience a sense of hopelessness about the possibility of change’.[95] All of the patients in the cases heard by the Court of Protection have lived with anorexia nervosa for longer than the critical window of three years. Most of them also began

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[90] Royal College of Psychiatrists (n 77) 86.

[91] American Psychiatric Association (n 76) 384.

[92] Jon Arcelus and others, ‘Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders. A Meta-Analysis of 36 Studies’ (2011) 68(7) Archives of General Psychiatry 724.

[93] Gabriela Jagielska and Iwona Kacperska, ‘Outcome, Comorbidity and Prognosis in Anorexia Nervosa’ (2017) 51(2) Psychiatria Polska 205.

[94] Stephan Zipfel and others, ‘Anorexia Nervosa: Aetiology, Assessment, and Treatment’ (2015) 2(12) Lancet Psychiatry 1099.

[95] Phillipa Hay, Stephen Touyz, and Rishi Sud, ‘Treatment for Severe and Enduring Anorexia Nervosa: A Review’ (2012) 46 Aust NZ J Psychiatry 1136, 1143.

experiencing symptoms at a very young age; in some cases from as young as four years old.[96]

Understanding these clinical features of anorexia nervosa is essential to fully grasping the facts of the cases to be explored. It elucidates why and how these patients come to engage in the behaviours and hold the beliefs that are under judicial scrutiny.

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[96] *FD* (n 28) [1].

CHAPTER 3: THE COURT'S APPROACH TO BEST INTERESTS DECISIONS FOR PATIENTS WITH ANOREXIA NERVOSA

To comprehend how anorexia nervosa puts judges in an invidious position, one must first examine the factors judges consider when determining the best interests of patients with anorexia nervosa. That is, one must understand the typical process by which judges attempt to extricate a clear, correct answer to what is often an unanswerable question: is it in P's best interests to withdraw compulsory feeding?

Based on analysis of the case law, the key factors in best interests decisions for patients with anorexia nervosa can be grouped under four headings:

1) Medical evidence and P's prospects of recovery
2) Balance between sanctity of life and autonomy
3) Protection of dignity. (2) and (3) are closely connected to P's rights under the ECHR.
4) The views of P's loved ones

Each of these will be explored briefly in turn.

3.1: Medical Evidence and P's Likelihood of Recovery

Medical evidence is, unsurprisingly, central to judges' decisions on whether compulsory treatment for anorexia nervosa should be withdrawn. This category of factors includes P's likelihood of recovery, clinicians' views on the impact of treatment on P, and the potential 'futility' of treatment.

In the CoP, discussions of P's likelihood of recovery often centre on P's previous attempts to recover. Judges consider P's time in hospital undergoing force-feeding and the different unsuccessful treatments that have been attempted. These are indicative of how likely it is that P will recover in the future. In *Cheshire & Wirral Partnership NHS Foundation Trust v Z (Re Z)*, for example, Hayden J held that:

> It suffices to say that, despite the fact that she has been admitted to hospital on innumerable occasions and received many different treatments, outpatient support and therapeutic input, it is impossible to identify any time in her history where Z has made anything which could be characterised as a sustainable recovery in terms of her weight gain.[97]

With such statements, judges identify the cycle of P's admission to hospital, weight gain through force-feeding (though often not up to the target BMI), discharge, and immediate weight loss.[98] The use of all possible treatments, often over decades, none of which have led to sustained improvement in P's condition, suggests that force-feeding is of no benefit to P.[99] This supports the clinical evidence that once P has passed the 'critical window for effective intervention', as these patients have, likelihood of recovery becomes far lower.[100] This provides support for the conclusion that compulsory feeding is not in P's best interests.

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[97] [2016] EWCOP 56 (Fam) [1].

[98] See also *The NHS Trust v L* (n 32) [21].

[99] In *Ms X* (n 20), Cobb J distinguished *Re E* by emphasising that there was a treatment option that had not been attempted in that case. In *Ms X*, by contrast, 'there is no untried treatment…all treatments have been offered and failed' [56].

[100] Zipfel (n 94).

Judges also take into account the views and experiences of P’s medical team regarding treating P. When clinicians find themselves in difficult ethical positions—namely, when they believe it is not right to continue administering treatment—that provides insight into whether the treatment is in the patient’s best interests. For example, in a hearing for *Barnet, Enfield and Haringey Mental Health NHS Trust v CC & Ors* (*Re CC)*[101]*,* Hayden J discussed a judgment concerning the withdrawal of treatment from a comatose pastor. The judge held that to ask clinicians to treat the pastor ‘when the burdens were obvious and the prospects were futile was not something I could ask of the medical team. They would have been acting unethically’.[102] Here, Hayden J recognises both that clinicians cannot be compelled to treat patients, and that the factors which created an ethical dilemma for the medical staff provided evidence that the treatment was not in the pastor’s best interests. Similarly, in *Re Z* Hayden J held that ‘the obvious psychological distress [caused by compulsory feeding] to Z and, if I may say so, to her parents and to the medical staff is difficult to justify’.[103] Again, Hayden J uses the distress caused to medical staff as ancillary support for the claim that Z’s best interests would not be served by continuing to administer treatment. Whilst the interests of medical staff are not the subject of the judge’s decision, the clinicians’ views can elucidate the impact of treatment on the patient. This supplements the judge’s understanding of the other relevant factors—P’s likelihood of recovery, the extent of the interference with her dignity and autonomy, and so forth. This more nuanced picture of the factual circumstances enriches the judge’s ability to determine whether continuing compulsory treatment is in P’s best interests.

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[101] [2024] ECOP 65 (T3)

[102] *Re CC (hearing)* (CoP, 31 October 2024).

[103] *Re Z* (n 97) [7].

Finally, judges use medical evidence to assess whether compulsory treatment might simply be 'futile' and thus not in P's best interests. In *Aintree,* Lady Hale defines 'futile' as 'being ineffective or being of no benefit to the patient'.[104] As Cressida Auckland argues, subsequent cases have interpreted 'ineffective' as physiologically ineffective.[105] In cases concerning patients with anorexia nervosa, judges sometimes conclude that force-feeding is futile in this sense because P will die regardless of whether force-feeding is administered. For example, in *Ms X,* Cobb J held that compulsory feeding would be futile because it would simply exacerbate Ms X's alcoholism and accelerate her death through liver failure.[106] Judges also hold that force-feeding would be 'of no benefit' to P because it would do nothing substantive to cure P's anorexia nervosa and would merely cause her physical and psychological distress. The burdens of the treatment outweigh the benefits. In *RD,* Moor J held that compulsory treatment would 'achieve nothing and be futile', in the sense that it would 'cause [RD] further trauma, upset and psychological and emotional damage, whilst doing nothing significant to ameliorate her terrible anorexia nervosa'.[107]

It is important to note that, as Auckland argues, the decision that compulsory feeding is futile is not an objective conclusion. An objective judgement of futility would

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[104] [2014] AC 591 [40].

[105] Cressida Auckland, 'A Façade of Futility' (2021) 137 LQR 451, 462.

[106] *Ms X* (n 20) [22]. Similarly, Ms L's organ failure meant that force-feeding would 'be futile, carrying with it a near certainty that it would cause her death in any event'. *The NHS Trust v L* [2012] EWHC 2741 (COP), [68].

[107] *RD* (n 25) [40], [36]. Further, in *FD* (n 28), Francis J held 'All of FD's family and all of the clinicians who know her well believe that imposing further treatment on FD against her will would be futile. When I say "futile", I use it in the strict sense as in being hopeless, of no effect' [50].

rely solely on factual medical evidence and a statistical cut-off point for the predicted efficacy of treatment.[108] This is impossible in anorexia nervosa cases for two reasons. Firstly, deciding that force-feeding would be 'ineffective' demands both a factual finding that the chances of it working are low, and a subjective judgement that the chances are *low enough*. The judge must identify a threshold of ineffectiveness; exactly how unproductive for the patient must force-feeding be for it to be deemed ineffective?[109] The chances of prolonging P's life through force-feeding are never zero. The uncertainty lies in whether force-feeding might lead to recovery by allowing P to participate in other psychological therapies. Therefore, in deeming force-feeding futile, the judge makes a value judgement that the likelihood of those therapies succeeding is low enough.[110] Secondly, compulsory treatment that prolongs P's life can only be 'of no benefit' to P if her continued existence is of no benefit to her; in other words, if her life falls below a threshold that makes it worth continuing.[111] Judges who rely on the notion of 'futility' implicitly conclude that a life that is dependent on force-feeding for its continuance is not a life that is worth living, taking into consideration the patient's values and other factors at play in the case.[112] This, too, is a qualitative evaluation rather than an objective analysis of medical evidence.

This pattern of reasoning can also be seen in judges' discussions of the risks of treatment. In *St George's University Hospitals NHS Foundation Trust and Ors v LV*

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[108] Auckland (n 105) 17.

[109] Auckland (n 105), Rob Heywood, 'Moving on From Bland: The Evolution of the Law and Minimally Conscious Patients' (2014) 22 Medical Law Review 548, 553.

[110] ibid 465.

[111] ibid 467.

[112] ibid 465.

(LV), for example, the physiological risks of putting LV under general anaesthesia included refeeding syndrome, critical illness myopathy, requirement of a tracheostomy, infection, ICU-associated muscle weakness and neuromuscular problems, multi-organ failure, and death.[113] Morgan J held that she 'thought long and hard about all of those risks and detriments' before concluding that being put under general anaesthetic was in LV's best interests. The judge came to this conclusion despite recognising that the treatment might fail. Thus, according to Morgan J's assessment, the odds of it failing were not low *enough*, and LV's continued existence would be of benefit to her despite its uncertain trajectory. The chance to save LV's life was worth taking despite the myriad of serious risks.[114] The effect of this analysis is to show that in these types of cases, different judges inevitably weigh the respective factors differently. For another judge in Morgan J's position, the risks of treatment may very well have outweighed the potential benefits and thus have been deemed futile. However, because of the qualitative evaluations that are inherent in an assessment of the potential efficacy of treatment, there is no way to predict when a judge will deem compulsory treatment futile.

Evidently, P's medical circumstances—including her likelihood of recovery, previous attempts to recover, and the risks of further treatment—are of critical importance to these best interests decisions. It is also clear that, despite being shaped by evidence from medical experts, these factors are analysed as part of value judgements on whether treatment is futile in the sense of being ineffective enough or of no benefit to P. Though quantitative predictions of survival undoubtedly contribute to

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[113] [2025] EWCOP 9 (T3), [8], [15].

[114] Auckland (n 105).

the decision, the question is ultimately whether the judge believes treatment to be ‘worth it’ based on their evaluation of the different factors at play in the case.

3.2: The Balance Between Sanctity of Life and Autonomy

The second category of factors in best interests decisions for patients with anorexia nervosa relates to the principles of sanctity of life and autonomy. When considering these factors, judges often explicitly use the metaphor of a ‘balance’. That is, considering the facts of the case and medical evidence, whether the principle of sanctity of life carries more weight than the patient’s right to autonomy so as to ‘tip the scale’ in favour of continuing compulsory treatment, or vice versa.

Broadly, the principle of sanctity of life is concerned with the value of human life. John Keown distinguishes between several approaches to the valuation of human life. ‘Vitalism’ claims that human life holds absolute value, meaning it should never be shortened and must always be preserved at all costs.[115] By contrast, the principle of sanctity of life holds that human life possesses an inherent dignity, meaning no one should ever be intentionally killed. Keown argues that all humans possess inherent dignity due to the radical capacities of human beings that generate rational abilities, such as understanding and choice. Patients do not lose their inherent dignity if they lack capacity to make decisions; Keown stresses that one does not lose a radical capacity simply because they lack the ability to exercise it.[116]

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[115] John Keown, ‘The Legal Revolution: From “Sanctity of Life” to “Quality of Life” and “Autonomy”’ (1998) 14(2) Journal of Contemporary Health Law & Policy 253, 256.

[116] ibid 257.

As the word 'sanctity' suggests, the principle is often thought to be rooted in Judeo-Christian doctrines which require respect for God's creation or the 'miracle' of human life.[117] This is highly contested. David Jones, arguing from a Catholic perspective, contends that the word 'sanctity' (in respect to human life) only became part of official Church teachings in the late twentieth century.[118] A secular version of sanctity of life would have to derive from a communal valuing of life; an understanding by all humans that all humans possess some inherent value. Emily Jackson denies the possibility of such an understanding.[119] She argues that there is nothing intrinsically valuable about human beings except from a religious point of view—the idea that life is a miracle bestowed by God.[120] Whether the sanctity of life is understood as a secular or religious doctrine has implications for the weight it is afforded in best interests assessments. Judges would be reluctant to attach significant weight to a religious understanding of the sanctity of life in cases concerning patients with atheist or agnostic beliefs. By contrast, the weight attached to a secular view of the sanctity of life would not vary with the religious views of the patient; by definition, the secular understanding of sanctity of life applies to all humans equally.

The law is oriented toward a secular definition rooted in legal precedent and human rights. When considering the sanctity of life in best interests assessments for patients with anorexia nervosa, judges often cite Sir Thomas Bingham, as he then was, in *Airedale NHS Trust v Bland*, where he held that 'profound respect for the sanctity of

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[117] ibid 256.

[118] David Albert Jones, 'An Unholy Mess: Why 'The Sanctity of Life Principle' Should Be Jettisoned' (2016) 22(3) The New Bioethics 185, 187

[119] Emily Jackson, 'Secularism, Sanctity and the Wrongness of Killing' (2008) 3(4) BioSocieties 125.

[120] ibid 131.

human life is embedded in our law and our moral philosophy'.[121] Accordingly, judges argue that the principle is 'fundamental' to cases of this nature.[122] They also link sanctity of life to their obligations under the MCA and the ECHR. In *Ms X,* Cobb J held:

> I am naturally steered to exercise my judgment in this case in a manner which attaches the highest (even if not absolute) priority to the preservation and sanctity of life; this approach corresponds with the obligation imposed on me by common law…by the provisions of Article 2 of the European Convention on Human Rights…and accords with the directive in section 4(5) of the MCA 2005.[123]

Although the MCA Explanatory Notes state that best interests assessments have a neutral starting point, in *Aintree* Lady Hale held that '[t]he authorities are all agreed that the starting point is a strong presumption that it is in a person's best interests to stay alive'.[124] Therefore, judges begin from the position that P's life should be prolonged. However, this presumption can be displaced. Paragraph 5.31 of the MCA Code of Practice permits best interests decisions that may lead to P's death in the 'limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery'.[125] Judges also cite Lord Goff's judgment in *Airedale NHS Trust v Bland,* in which His Lordship made clear that the principle of sanctity of life 'fundamental though it is, is not absolute'.[126]

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[121] *Airedale NHS Trust v Bland* [1993] AC 789, 826; *FD* (n 28) [49]; *RD* (n 25) [27].

[122] ibid.

[123] *Ms X* (n 20) [36].

[124] [2013] UKSC 67 [35].

[125] MCA Code of Practice (n 22) 5.31.

[126] [1993] AC 789, 866.

P's right to personal autonomy is also of critical importance. This is the fundamental tension in cases concerning patients with anorexia nervosa. The principle of sanctity of life demands one course of action—continue compulsory treatment—whilst respecting patients' personal autonomy demands the opposite—withdraw compulsory treatment. Judges acknowledge that feeding a patient against their will is a direct and severe infringement of patients' personal autonomy.[127] They note that it can represent an interference with the patient's private life, which is protected by Article 8 ECHR, and amount to inhumane treatment of the sort that is prohibited by Article 3.[128] Additionally, judges argue that depriving P of her autonomy may make recovery less likely.[129] The fact that adults with capacity have the right to exercise their autonomy by refusing treatment is also consistently recognised in these decisions. All of these factors provide justifications for displacing the presumption that life should be prolonged. Of course, it would be very problematic if no legal presumption in favour of preserving life existed. Considering basic ethical principles and fundamental human rights such as Article 2 ECHR, the presumption that life should be prolonged is correct. Equally, judges in the Court of Protection rightly recognise that there are some circumstances in which it can justifiably be overridden.

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[127] *Re E* (n 27) [125]; *Ms X* (n 20) [46].

[128] ibid.

[129] In *Re Patricia,* Moor J held that 'there could [not] be anything more distressing or upsetting or detrimental to the health and wellbeing of Patricia than to impose…treatment on her that she desperately does not want' [2023] EWCOP 70 T3 [10]. Similarly, in *FD* (n 28) Francis J held that 'if FD is given the power of control over her own decision-making…then there is…some possibility, some hope that FD will decide to see if she can move her life into a happier situation' [25].

Crucially, judges typically proceed on the assumption that patients with anorexia nervosa can possess some form of autonomy[130] despite extensive debate by clinicians, scholars, and philosophers interrogating that assumption.[131] This is perhaps attributable in part to the United Nations Convention on the Rights of Persons with Disabilities (CRPD), one of the general principles of which is respect for the individual autonomy of people with disabilities.[132] The CRPD creates a legal assumption that patients with disabilities, including mental disorders such as anorexia nervosa, possess autonomy. Patients' abilities to form autonomous beliefs, preferences, and decisions, and the relative weight they should hold in the best interests assessment, is a key point of tension in these cases. It will be analysed in detail below.

3.3: Protection of Dignity

Further, judges draw upon the concept of dignity as a factor against the presumption in favour of prolonging life.[133] They analyse whether compulsory treatment violates P's dignity to an unjustifiable extent and whether P should be allowed to 'die with

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[130] In thirteen cases, judges explicitly refer to patients' autonomy without querying its existence: *Re Z* (n 97) [19]; *Re E* (n 27) [115]; *BG* (n 1) [38]; *ER* (n 32) [31]; *Ms X* (n 20) [44]; *FD* (n 28) [9]; *Re Patricia* (n 129) [9]; *Re CC* (n 101) [17]; *Re LV* (n 113) [57]; *Betsi Cadwaladr University Local Health Board v Miss W (Miss W)* [2016] EWCOP 13 [38]; *Z NHS Foundation Trust v Patricia* [2023] EWCOP 41 [8]; *Patricia, in the Matter Of* [2023] EWCOP 42 [22]; *Northamptonshire Healthcare NHS Foundation Trust v AB* [2020] EWCOP 40 [5].

[131] See e.g., Tony Hope and others, 'Agency, Ambivalence and Authenticity: the Many Ways in Which Anorexia Nervosa Can Affect Autonomy' (2013) 9(1) International Journal of Law in Context 20; George Szmukler, 'Anorexia Nervosa, Lack of "Coherence" with Deeply Held Beliefs and Values, and Involuntary Treatment' (2021) 28 Philosophy, Psychiatry, & Psychology 151, 152; Charles Foster, 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?' (2013) 22 Medical Law Review 48.

[132] UN General Assembly*, Convention on the Rights of Persons with Disabilities: resolution adopted by the General Assembly*, 12 December 2006, A/RES/61/106, Article 3.

[133] *Re E* (n 27) [115]; *Re Z* (n 97) [19]; *Ms X* (n 20) [46].

dignity'.[134] The idea of dignity is rooted in the Kantian notion that all humans possess an inherent value which requires that they be treated as 'an end in themselves' and never a 'means to an end'.[135] Charles Foster describes dignity as 'objective human thriving,' or the state that is as close as possible to what humans should do and be in the relevant situation.[136] Other theorists argue that dignity is best described as a 'status' that is recognised and respected. For example, Suzy Killmister argues all humans deserve respectful treatment from others by virtue of the fact that they fall into the social category of human.[137] Similarly, authors such as William FitzPatrick use the idea of respect to argue that dignity is the foundation of human rights, writing that it is 'in' this status that demands respect 'that many hold that all persons possess a fundamental, inalienable dignity, which grounds…basic rights'.[138] For these authors, dignity is seen as the justification for the claim that a particular right is a human right.[139]

It must be noted that not all authors view dignity as a helpful or valuable concept. Ruth Macklin argues it is 'useless'—no more than an extension of autonomy.[140] Additionally, Peter Singer suggests humans possess no inherent quality

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[134] ibid; *Ms X* (n 20) [59]; *NHS Trust v L* [2012] EWHC 2741 (COP) [64].

[135] Immanuel Kant, 'Groundwork of the Metaphysics of Morals' in Mary J. Gregor (ed) *Practical Philosophy* (CUP 1996), 4:435.

[136] Jonathan Herring and Charles Foster, 'Welfare Means Relationality, Virtue and Altruism' (2012) 32 Legal Studies (Society of Legal Scholars) 480, 490.

[137] Suzy Killmister, *Contours of Dignity* (OUP 2020).

[138] William J FitzPatrick, 'Worth/Dignity' in Hugh LaFollette (ed), *International Encyclopedia of Ethics* (Blackwell Publishing 2013) 5546.

[139] Remy Debes, 'Dignity' (*Stanford Encyclopedia of Philosophy,* 2023) <https://plato.stanford.edu/entries/dignity/> accessed 5 July 2025

[140] Ruth Macklin, 'Dignity is a Useless Concept' (2003) 327 BMJ 1419.

that would justify dignity being exclusive to them.[141] An in-depth analysis of these critiques is outside the scope of this thesis.

Although the ECHR makes no mention of dignity, it is nevertheless understood—in alignment with FitzPatrick's argument—to be a foundational principle of human rights. The European Court of Human Rights labels respect for human dignity the 'very essence' of the ECHR.[142] The same is true of the CRPD, which recognises human dignity as the 'the foundation of freedom, justice and peace in the world'.[143] Both *FD* and *RD* cite Lady Hale in *P v Cheshire West:*

> '…it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities'.[144]

Thus, the protection of human dignity is a fundamental human right, one that the courts and UN have emphasised is no less important for individuals with disabilities. As discussed above, judges stress the importance of Articles 8 and 3 ECHR; compulsory treatment represents an interference into P's private life and can amount to inhumane treatment if P's values dictate that they do not want to be kept alive against their will.[145]

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[141] Peter Singer, *Practical Ethics* (CUP 2011).

[142] *Christine Goodwin v UK* App no 28957/95 (ECtHR 11 July 2002), para 90.

[143] UN General Assembly*, Convention on the Rights of Persons with Disabilities: resolution adopted by the General Assembly*, 12 December 2006, A/RES/61/106, Article 1.

[144] [2014] UKSC 19 [45]; *FD* (n 28) [48]; *RD* (n 25) [27].

[145] *Re E* (n 27) [126]; *Ms X* (n 20) [46]; *Z NHS Foundation Trust & Anor v Patricia & Ors* [2023] EWCOP 41 [32].

Such infringements of P’s dignity provide justifications for displacing the presumption that life should be prolonged.

Judges also recognise the value of ‘dying with dignity’. Sir Jonathan Cohen held that allowing E ‘to die with dignity and close to home’ was a factor against authorising treatment under sedation.[146] Further, in *LV,* Morgan J cited the dicta of Baroness Hale in *Aintree:* ‘where the patient is close to death, the object may properly be to make his dying as comfortable and as dignified as possible’.[147] Here, again, we see the core conflict between continuing invasive treatment that compromises P’s dignity, and the value of preserving human life.

3.4: The Views of P’s Loved Ones

Finally, to gather evidence about P’s wishes and beliefs, judges take into consideration the views of P’s loved ones. This is a requirement of the MCA, so far as it is practicable and appropriate.[148] The views of P’s loved ones are usually informed by years of watching their daughter, sister, or friend undergo traumatic and ineffective treatment. Very often, parents and loved ones believe treatment should be stopped to alleviate P’s suffering or restore her autonomy, though they do not want her to die.[149] In another hearing for *Re CC,* Hayden J stated that the evidence of CC’s parents was ‘every bit as important’ as the evidence of medical experts, and that sometimes the contribution of

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[146] *Re E* (n 27) [115].

[147] *LV* (n 113) [48].

[148] MCA s4(7).

[149] *Re E* (n 27) [36], *BG* (n 1) [41], *FD* (n 28) [14].

P’s loved ones ‘shines a different light’ on the circumstances.[150] Where the family agrees that treatment should be withdrawn, this provides evidence that P’s wish to stop compulsory treatment is authentic, and granting it may be in her best interests.[151] Familial views can also provide evidence to the contrary, such as in *LV,* where LV’s mother testified that she believed LV wanted help.[152]

With this understanding of the typical approach to best interests assessments for patients with anorexia nervosa, we can now explore why these cases are often unsolvable from a moral, legal, and clinical perspective. The first confounding factor is the relationship between anorexia nervosa and autonomy.

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[150] *Re CC (hearing)* (COP, 30 October 2024).

[151] *Re E* (n 27) [36], *BG* (n 1) [41], *FD* (n 28) [14].

[152] *LV* (n 113) [20].

CHAPTER 4: CONFOUNDING FACTOR 1—THE DILEMMA OF ANOREXIA NERVOSA AND AUTONOMY

4.1: What is autonomy?

There are many definitions of personal autonomy. At its most basic level, autonomy is the right to shape one's own life; to be a self-governing agent. Autonomy has numerous dimensions and subtypes. For example, 'autonomy' can refer to:

1. Decisional autonomy: the ability to make an autonomous choice
2. Practical autonomy: the ability to act on an autonomous decision
3. Global autonomy: the ability to make autonomous decisions over an extended period of one's life
4. Local autonomy: the ability to exercise autonomy in relation to specific decisions.[153]

This thesis is concerned with local and decisional autonomy, as it is most relevant in best interests decisions. The core question is not whether P has the practical ability to leave the hospital free from interference, but whether she is able to form an autonomous decision to refuse life-sustaining treatment.

The classic account of autonomy in the medicolegal context is the definition of decisional autonomy put forward by Tom Beauchamp and James Childress. These authors argue that respect for autonomy is one of the four principles of biomedical ethics, alongside (and no more important than) beneficence, non-maleficence, and

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[153] Jonathan Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (OUP 2020).

justice. According to their account, a decision is autonomous if made (1) intentionally, (2) with understanding, and (3) without controlling influences that determine action.[154] This definition is unsatisfactory for several reasons. Firstly, Beauchamp and Childress define 'with understanding' as having 'pertinent information' and 'justified, relevant beliefs about the nature and consequences of their actions'. [155] However, they do not explain what it means to have a 'justified' belief. Must the belief be justified based on the patient's long-term wishes and feelings, or based on the medical consensus as to the potential outcomes of the treatment? Additionally, they argue that patients should understand 'at least what a health care professional or researcher believes a patient or subject needs to understand in order to authorize an intervention'.[156] This makes the ability of a patient to possess autonomy dependent on a subjective assessment of a third party. A patient may understand everything that Doctor X believes they must understand to authorise an intervention, but not understand something that Doctor Y believes they must understand to authorize the same intervention. This is clearly problematic; a patient's ability to possess autonomy cannot depend on the doctor to whom they are assigned. Given that the foundational principle of autonomy is self-determination, this makes the definition unworkable.

John Coggon offers a different, more nuanced account of autonomy. He argues that there are three versions of autonomy, each of which correlates to a different type of 'desire'. 'Current' desires are an agent's immediate desires—what they believe they

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[154] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, OUP 2019) 102.

[155] ibid 131.

[156] ibid.

want now, without deliberation. 'Best' desires are desires that accord with the agent's overall schema of personal values, even if they contradict their current desires. Finally, 'ideal desires' are what the agent 'should' want according to a 'universal or objective standard of values'.[157] According to the ideal desire definition, an agent is only acting autonomously if she acts in alignment with what could be deemed a universal law. Current, best, and ideal desire autonomy each lead to actions that reflect the different desires. Coggon argues that all versions are, not incorrectly, used in medicine and have a role in life.[158] However, he also argues that best desire autonomy is generally to be preferred for 'serious' decisions.[159] It accords with the view put forward by Harry Frankfurt and Gerald Dworkin that autonomous decision-making requires that our first-order desires be endorsed by second-order desires (desires to have those desires).[160] Current desire autonomy reflects only first-order desires. To use the classic example, an 'unwilling addict' is not acting autonomously because, although he wants to use cocaine, he does not want to have the desire to use cocaine. Coggon argues that autonomy would best be respected by withholding cocaine from the addict and honouring, thereby, his second-order desires.[161] To act autonomously according to the best desire definition, an anorexia nervosa patient who refuses treatment must, on reflection and according to her personal value system, want to refuse treatment.

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[157] John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 Health Care Analysis 235.

[158] ibid 244.

[159] ibid.

[160] Harry G Frankfurt, *Importance of What We Care About* (CUP 1988); Gerald Dworkin, *The Theory and Practice of Autonomy* (CUP 1988).

[161] Coggon, 'Varied and Principled Understandings of Autonomy in English Law' (n 157) 245.

Jonathan Pugh expands on Frankfurt's and Dworkin's arguments through a rationalist account of autonomy. He argues that agents are not autonomous if they lack either theoretical or practical rationality in relation to the decision. Theoretical rationality concerns how we come to form our beliefs. To use Julian Savulescu and Richard W Momeyer's example, as Pugh does, an individual is theoretically irrational if they engage in a thought process like so:

(1) There is a risk of dying from anaesthesia. (True)

(2) I will require an anaesthetic if I am to have this operation. (True)

Conclusion: Therefore, if I have this operation, I will probably die.[162]

Given that the likelihood of the patient dying from anaesthesia is extremely low (a chance of less than 1 in 100,000[163]), this patient has formed a false conclusion based on true beliefs. This is a failure of theoretical rationality.[164] To make an autonomous decision, an agent cannot have these types of irrational beliefs about information that is material to the decision.[165]

By contrast, practical irrationality arises when individuals form desires based on beliefs that cannot justify those desires. Pugh argues that the question is 'whether we have a reason to want the object of a particular desire, given our beliefs'.[166] So, P's

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[162] Julian Savulescu and Richard W Momeyer, 'Should Informed Consent Be Based on Rational Beliefs?' (1997) Journal of Medical Ethics 283, 283.

[163] André Gottshalk and others, 'Is Anaesthesia Dangerous?' (2011) 108(27) The Deutsches Ärzteblatt 469.

[164] Pugh (n 153) 22.

[165] ibid 57.

[166] ibid 25.

decision to act on a first-order desire is autonomous if she has, not merely a second-order desire, but a ‘‘personally authorized preference’ for [the first-order desire] to be effective’.[167] A ‘preference’ is a desire to have a desire be effective, based on the agent’s conception of what is good. To be personally authorized, the preference must cohere with her ‘character system’: P’s set of preferences at time *t*, combined with her ‘acceptances’—beliefs based on what P accepts as true at time *t*.[168] Coherence requires that P have sufficient reason to make the decision, considering her preferences and acceptances. Thus, practical rationality demands that P endorse her desires based on preferences (which are in turn based on rational beliefs), and that the preferences cohere with her character system in the sense that they give her sufficient reasons to have those desires.[169]

Pugh’s definition of autonomy is helpful in the context of anorexia nervosa because, as will be shown, one of the core arguments against the ability of anorexia patients to possess autonomy is that the symptoms of the disorder make them inherently irrational. This will be explored below.

In contrast to the theories above, relational theories of autonomy focus on how agents’ capacity for autonomy is shaped, encouraged, and impeded by relationships and societal structures. In reference specifically to their assessment of the MCA, Mackenzie and Rogers use three ‘conditions’ to define autonomy. Firstly, an autonomous agent is *self-determining*: she can determine her ‘beliefs, values, goals and wants’ and can make

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[167] ibid 49.

[168] ibid.

[169] ibid 50, 57.

decisions ‘regarding matters of practical import to [her] life free from undue interference’.[170] Mackenzie emphasises how relational articulations of autonomy are relevant to this criterion; undue interferences can take the form of societal inequalities, including lack of accessibility to basic liberties for particular groups.[171] Secondly, autonomous agents are *self-governing*. They have the competence to ‘make choices and enact decisions that express, or are consistent with, [their] values, beliefs and commitments’.[172] Societal oppression can inhibit self-governance by perpetuating oppressive stereotypes that encourage the agent to act on false beliefs about her place in the societal hierarchy.[173] Finally, autonomous agents make *authentic* decisions. The values motivating them are ‘her ‘own’ in some relevant sense’.[174] This, too, can be understood through a relational lens; gender-based societal inequalities are often internalised by women, making it difficult to develop a clear understanding of who she truly is and what she values.[175]

It is essential to acknowledge feminist relational understandings of autonomy—they are of great relevance to anorexia nervosa patients. The development of anorexia nervosa often relates to aspirations for meeting societal standards of beauty and thinness. DSM-5-TR states that anorexia nervosa is associated ‘with cultures and

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[170] Mackenzie and Rogers (n 56) 42.

[171] Catriona Mackenzie, ‘Feminist Innovation in Philosophy: Relational Autonomy and Social justice’ (2019) 72 Women’s Studies International Forum 144, 148.

[172] Mackenzie and Rogers (n 56) 42.

[173] Mackenzie (n 171) 149.

[174] Mackenzie and Rogers (n 56) 43.

[175] Mackenzie (n 171) 149-50.

settings in which thinness is valued'.[176] Patients with anorexia nervosa are usually young women, making them particularly susceptible to gender and age-based social inequalities. However, this thesis will not apply a relational definition of autonomy. As will be shown, the ability of anorexia nervosa patients to have autonomy is queried—by judges, philosophers, legal authors, and clinicians—primarily on the basis of the rationality and authenticity of patients' thought processes. These factors can best be understood through individualist accounts of autonomy. Hence, an investigation of autonomy from a feminist relational perspective is outside the scope of this thesis.

By nature of the disorder, there are things about which patients with anorexia nervosa can never form autonomous desires. For example, the diagnostic criteria of anorexia nervosa dictate that patients form theoretically irrational beliefs about their 'fatness'. However, the following sections will explain how patients with anorexia nervosa can meet the criteria for autonomy in relation to certain factors that are relevant to the best interests decision. In some instances, patients have reached a stage of intractability in their illness and have engaged in autonomous thinking to recognise this. Therefore, there are two types of case: (1) those in which the patient can make autonomous decisions about *treatment refusal,* but not food, and (2) those in which the patient cannot make autonomous decisions at all. The problem for judges lies in making this distinction; in other words, establishing whether a patient has reached a clear and settled decision to refuse treatment, despite her non-autonomous thinking regarding nutrition.

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[176] American Psychiatric Association (n 76) 385.

4.2: An Aside: Hard Cases for Mental Capacity Assessments

In the legal system of the UK, autonomy and capacity are distinct concepts. Mental capacity is the ability to perform the task of decision-making in relation to a specific issue. It is established by reference to an explicit standard: the capacity test in the MCA. By contrast, autonomy refers to the ability to be self-governing; to make decisions for oneself according to one's unique values without interference from the state or other individuals. Within the UK's legal structure, to have capacity is to be deemed able to make a particular decision by understanding, using, and weighing the information that is relevant to that decision. The concept of autonomy encompasses a far broader spectrum of abilities. In their article analysing how the MCA can produce a finding that non-autonomous agents have capacity, Herring and Wall argue that '[c]apacity requires the mere understanding and use of relevant information. Autonomy requires much more…'[177] To be autonomous is to meet the different conditions described above, namely, to make decisions that are grounded in rational evaluations, endorsed by second-order desires, and aligned with the agent's practical identity. This is a wider range of abilities than those encompassed by the capacity test in the MCA.

The question of whether patients with anorexia nervosa lack mental capacity to make decisions regarding their medical treatment is notoriously difficult to answer. In part, this is because there are many permutations of the disorder. Patients often have a very good understanding of the facts of their situation, are eloquent, and can engage in complex reasoning. Indeed, the mother of one patient in a study conducted by Tan et

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[177] Jonathan Herring and Jesse Wall, 'Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act' (2015) Legal Studies 698.

al. expressed her conviction that '[patients'] mental capacity to decide is heightened'.[178] The authors concluded that patients were able to concentrate even at very low BMIs. Some patients maintained their reasoning abilities, and all patients were able to 'perceive and discuss their own difficulties and decision-making processes'.[179] Further, judges often recognise that patients are 'intelligent and articulate',[180] and can develop arguments which are 'powerfully expressed and carefully analysed'.[181]

Tan and co-authors argue that the true difficulties with capacity are related to patients' beliefs. Some participants struggled to believe facts presented to them by medical experts or believe that the information applied to them.[182] For example, patients can experience delusions about their weight and the risks of their malnutrition, such as this interviewee:

> *Interviewer*: About the risk of death, do you think it could happen?
>
> *Participant B*: Not to me.
>
> *Interviewer:* That's the opinion of doctors, and I wonder why you don't think it can happen to you.
>
> *Participant B*: Because you have to be really thin to die, and I'm fat, so it won't happen to me.[183]

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[178] Jacinta Tan and others, 'Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values' (2006) 13 Philosophy, Psychiatry & Psychology 267, 271.

[179] ibid 277.

[180] *Re E* (n 27) [126].

[181] *Re CC (hearing)* (CoP, 30 October 2024).

[182] Tan and others, 'Competence to Make Treatment Decisions in Anorexia Nervosa' (n 178).

[183] ibid 271.

This exchange mirrors the case of *A NHS Trust v ST & Anor,* in which Roberts J held that a 19-year-old girl suffering from a degenerative disease lacked capacity because she did not believe the information her doctors were communicating to her.[184] ST accepted that she had a serious disease and wanted to pursue experimental treatment in other countries so she could 'die trying to live'.[185] However, the judge held that ST did not believe that her medical situation was as 'precarious' as it was, which meant she could not understand, use, and weigh the information as required by the capacity test.[186] Notably, the Court of Appeal reversed Roberts J's decision after ST's death, holding that the absence of belief is not, in itself, sufficient to overturn the presumption of capacity.[187] Similarly to ST, anorexia nervosa patients may be articulate, intelligent, and aware that they have the disorder, but not believe that critical information is true or applies to them. Even so, Tan et al. argue that these issues are 'not products of a lack of understanding'.[188] The key problem is the presence of what the authors deem 'pathological values': values which stem from the anorexia nervosa and generate the paramount importance of thinness in the mind of the patient.[189] This is what creates incoherent reasoning patterns in relation to food: the patient may not want to die, but the desire to be thin leads to an inability to consume the food required to live.

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[184] [2023] EWCOP 40.

[185] ibid [4].

[186] ibid [78].

[187] *Hemachandran & Anor v Thirumalesh & Anor* [2024] EWCA Civ 896, [123].

[188] Tan and others, 'Competence to Make Treatment Decisions in Anorexia Nervosa' (n 178) 278.

[189] ibid.

In practice, the application of the capacity test to patients with anorexia nervosa is often problematic. Patients find themselves in a 'Catch-22'; they can engage in complex thinking about their eating behaviour, but that thinking is viewed as evidence of incapacity. Jackson J acknowledged this explicitly in *Re E,* holding that 'a person with severe anorexia may be in a Catch 22 situation regarding capacity: namely that by deciding not to eat, she proves that she lacks capacity to decide at all'.[190] As Wang argues, this reasoning means that anorexia nervosa patients can never have capacity to refuse treatment; their lack of capacity is determined by the diagnosis of anorexia nervosa and the corresponding decision to refuse food, bypassing the functional test for capacity in the MCA.[191] There is tension here with section 2(3)(b) of the MCA, which states that lack of capacity cannot be established merely by reference to a condition that might create unjustified assumptions about the person's capacity. In a way, this is what judges do when they cite patients' refusal of food as the reason they cannot have capacity; the fact that the patient has anorexia nervosa and its associated behaviours is used to overturn the presumption of capacity.

Of course, there are some matters in regard to which the patient will, indeed, lack capacity because of her disorder. Overvaluing of thinness impedes a patient's ability to use and weigh information related to food and nutrition. The key problem is the *scope* of incapacity that patients are deemed to have due to their anorexia nervosa. The Catch-22 creates an unjustifiably concrete link between the compulsion to refuse food that is associated with anorexia nervosa, and the decision to refuse *medical*

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[190] *Re E* (n 27) [53].

[191] Wang (n 10).

treatment. It confines the patient's general ability to make decisions to the (in)ability to make one decision: to consume food. As Jacinta Tan and Emma Cave argue:

> Even if the patient cannot make a capacitous decision about nutrition, they may be able to provide rational reasons for refusing treatment for Anorexia Nervosa. In such cases, clinicians or the court might accept that the patient can make a capacitous decision to do so.[192]

This is particularly relevant to *Northamptonshire Healthcare NHS Foundation Trust v AB,* where AB gave a list of reasons for refusing treatment that made no mention of the desire to lose weight or avoid caloric intake.[193] Roberts J still held that AB lacked capacity to make decisions about treatment for her anorexia nervosa because she could not 'weigh and use information in the limited sphere of decisions relating to her need to put on weight'.[194] This is difficult to accept, because the sphere of relevant decisions was not limited to AB's need to put on weight. They were also related to the trauma she experienced in force-feeding, her acceptance of the fact that further treatment would not be effective in her case, and so forth. Similarly, in *FD,* Francis J held:

> Whilst it is clear that FD knows and accepts that without nutrition and hydration she will die, I accept that FD lacks the capacity to make a decision on this subject because the anorexia overwhelms everything and she is therefore unable to use or weigh the relevant information to enable her to make a decision.[195]

This statement epitomises the Catch-22; FD's disorder is described as precluding the possibility of FD possessing capacity to make decisions regarding her treatment, despite her understanding of the consequences of food refusal. In this case, FD described her

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[192] Cave and Tan (n 10) 16.

[193] [2020] EWCOP 40.

[194] ibid 13.

[195] *FD* (n 28) [33].

reasons for refusing treatment as a wish to be freed from the 'torture' of force-feeding and the opportunity to reclaim her autonomy.[196] It is not clear how her anorexia nervosa could 'overwhelm everything' in relation to those beliefs and wishes. Anorexia nervosa produces a desire to lose weight, but FD's ability to use and weigh the information relevant to her other, primary reasons for refusing treatment may not necessarily be impeded by that symptom of her disorder.

Moreover, Sam Boyle argues that the Catch-22 allows judges to consider patients' reasons for refusing treatment as expressions of their anorexia nervosa, and thus further evidence of incapacity.[197] This will undoubtedly be accurate in some instances; patients often engage in reasoning to justify their refusal of nutrition that, whilst complex and well-informed, is based on their overvaluing of thinness or distorted body image. However, this is not always the case. Patients can offer carefully considered, rational reasons for treatment refusal that are not based on their desire for weight loss or other symptoms of anorexia nervosa. And yet, by grouping all of P's decisions into the category of 'decisions about food', judges leave no space for these more convincing reasons to be anything other than expressions of anorexic compulsions. The reasons become 'the anorexia talking'. Foster argues that judges read the MCA unnaturally to establish incapacity, interpreting patients' reasons for refusing treatment as deceitful submissions by their eating disorders.[198] Again, it is difficult to accept that this is the correct approach when patients explain their decision to refuse treatment using reasons that are not related to weight loss or caloric intake. The Catch-

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[196] ibid [9].

[197] Sam Boyle, 'How Should the Law Determine Capacity to Refuse Treatment for Anorexia?' (2019) 64 International Journal of Law and Psychiatry 250, 254-5.

[198] Foster (n 131) 61.

22 becomes even harder to escape; refusal of food is enough to establish a lack of capacity, and other reasons for refusing treatment are used to enforce that causal link.

Crucially, this judicial reasoning has implications for best interests assessments once lack of capacity is established. If a patient's comment is deemed a product of her anorexia nervosa, that statement is likely to be considered 'false' in some sense, or an expression of wishes that are not truly the patient's own. Statements viewed as such will inevitably be assigned less weight by the judge when conducting the assessment, which creates the risk of undervaluing the patient's contributions to her own case. This will be explored in full below.

Finally, the MCA presupposes a consequentialist approach to decision-making. According to section 3, patients must be able to 'use and weigh' information that is relevant to their decision. 'Using and weighing' implies a process of considering the consequences of assigning different weight to the information. This leaves no room for a deontological approach, wherein a patient might have an absolute principle by which they live their life that trumps all other considerations. In the case of anorexia nervosa, this principle might be the preeminent value of thinness, which would be problematic and indicative of incapacity. However, it could be a different principle, such as loyalty to the 'natural' progression of life and rejection of all medical intervention. It could also be veganism, such as in *F v F*.[199] The elder sister's veganism in that case dictated her decision—in her mind, there was no reason to weigh information because avoiding

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[199] [2013] EWHC 2683 (Fam).

consumption of animal produce was an absolute moral principle. The capacity test does not allow for this possibility.

For all these reasons, anorexia nervosa is a hard case for the mental capacity test. The complexity of applying section 3 to patients with anorexia nervosa—and the resultant Catch-22—hints at the unique way in which these individuals lack capacity.

4.3: The Impact of Anorexia on Autonomy

To demonstrate that anorexia nervosa patients may be capable of autonomous decision-making—as a separate question to whether they have capacity under the MCA—we must first establish the features of anorexia that are typically seen as impeding or barring these patients from making autonomous decisions.

Hope et al. conducted a study that led to four findings on the impact of anorexia nervosa on autonomy.[200] First, the authors argue that the disorder compromises patients' agency. Patients experience terror and anxiety at the prospect of eating, even if motivated to put on weight.[201] This impedes their ability to act on their desires: a failure of practical autonomy. Second, anorexia nervosa creates negative affective experiences that produce self-destructive preferences.[202] The authors describe it as a battle between objective evidence and emotional responses:

> Many people who suffer from anorexia nervosa do not usually think that they are overweight with respect to others, so much as feel that they are

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[200] Hope and others, 'Agency, Ambivalence and Authenticity' (n 131).

[201] ibid 25.

[202] ibid 30.

> 'fat', or 'huge' in an emotionally laden way…The goal of such people is usually to be 'thin' rather than some particular centile or objective weight; or, more accurately, 'thin enough *for me*' – an elusive unattainable goal which always floats just out of reach even as weight is lost and risk to health and life increases.[203]

In this way, the patient's response to treatment is guided by *false beliefs*. Patients ostensibly have true beliefs, but draw false conclusions using those true beliefs:

> (1) There is a risk of obesity from consuming calories.
>
> (2) Food has calories.
>
> Conclusion: Therefore, if I consume food, I will become fat.

This patient has formed a false belief due to a breakdown of theoretical rationality: obesity is not an inevitable or even likely outcome of consuming food.[204] Hope et al. argue that these types of irrational beliefs are then expressed as preferences in order to justify contradicting the objectively true evidence:

> [W]hen physicians question her, emphasising the objective evidence that she is actually severely underweight and at risk of harm, she cannot rationally deny this. But she is still unable to bring herself to believe what she is being told or to accept treatment because of her affective experiences. So she must justify such refusal when called on to do so…The only logical argument is if she puts forward the view*: I would prefer to risk death than put on weight*. And this looks like a preference.[205]

Thus, the patient's autonomy is compromised in that her desires are not truly desires, but theoretically irrational beliefs warped into desires by emotional responses.

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[203] ibid 28.

[204] Pugh (n 153) 22.

[205] Hope and others, 'Agency, Ambivalence and Authenticity' (n 131) 30.

Third, anorexia nervosa generates internal ambivalence and fluctuation in preferences and beliefs. Interviewees describe a frequent shift between what the authors call two 'mindsets': the patient's mindset and the anorexic mindset.[206] Given that one mindset is motivated to recover and the other is not, one interviewee described it as being 'caught between a rock and a hard place'.[207] Finally, anorexia nervosa creates confusion around identity and the authentic self.[208] Many participants describe having two identities, the anorexic self and the real self, which often differ in strength and have conflicting desires.[209] One interviewee described the 'real me' as 'what I use to fight against [the anorexia] and to motivate me to want to beat it'.[210] This internal separation is problematic for autonomy because it raises the question of which mindset or identity is the *authentic* one; the one which coheres with the patient's character system, as required by the criteria for autonomous decision-making.

Moreover, Simona Giordano argues that anorexia nervosa patients' abnormal perception of hunger has a negative impact on their autonomy. She describes the problematic ways in which patients use information relating to food and hunger:

> People with eating disorders do not eat in response to their physiological impulses or needs, but rather 'commit' or 'delegate' their eating to self-imposed rules relating to when and what to eat. They utilize detailed information about caloric content, association, digestion, and assimilation modes as 'instructions'… Instead of being used for

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[206] ibid 30.

[207] ibid 31.

[208] ibid.

[209] ibid.

[210] ibid.

> improving health and well-being, it is utilized as a justification for an unhealthy and clearly harmful lifestyle.[211]

This abnormal use of information about food jeopardises autonomy because it is indicative of a failure of practical rationality. To flesh out the definition of practical irrationality, Pugh uses the example of Rosie, an individual who forms a desire to smoke on the basis of the rational belief that it will be damaging to her health.[212] This is a failure of practical irrationality because, as Pugh puts it, '[Rosie's] rational belief causes a desire that is not *justified* by the content of that belief; her desire to want to smoke is not a rational response to the belief that smoking is bad for her health'.[213] Likewise, the desires of patients with anorexia nervosa to self-starve are not rational responses to their true beliefs about food and the nutritional process. Their high-level understanding of caloric content and nutrition gives patients a strong reason to engage in healthy dieting practices; they understand far better than the average individual how the body depends on consumption of nutrients to operate. However, like Rosie, patients use their rational beliefs to engage in the opposite of what those beliefs dictate. The content of their beliefs about food (true information) cannot justify the desires that those beliefs generate (to engage in unhealthy dieting).[214]

From these analyses, we can conclude that there are two main ways in which anorexia nervosa is thought to inhibit the ability of patients to engage in autonomous thinking. Firstly, patients with anorexia nervosa cannot meet the authenticity criterion

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[211] Simona Giordano, *Understanding Eating Disorders: Conceptual and Ethical Issues in the Treatment of Anorexia and Bulimia Nervosa* (OUP 2005) 220-21.

[212] Pugh (n 153) 24.

[213] ibid.

[214] ibid.

of autonomy. Secondly, anorexia nervosa leads to breakdowns of both theoretical and practical rationality. The following sections will dissect the flaws of these arguments.

4.3: The Authenticity Problem

As alluded to in Hope et. al.'s study, anorexia nervosa is often perceived as having 'overtaken' the patient so that her actions and decisions are not truly her own. The illness and the patient are seen as two different entities, with the anorexia acting as a 'parasite' on the patient's mind and body.[215] Hence, one of the key arguments in this area is that patients with anorexia nervosa fail to satisfy the 'authenticity' criterion for autonomy. They are unable to make autonomous decisions about their medical treatment because those decisions are motivated by values that do not cohere with the patient's practical identity; they are not the patient's best desires. This argument will be referred to as the authenticity problem.

Herring and Wall draw on Hope et al.'s study to argue that the evidence of patients' divided identities and language of the 'real self' mean that only the desire to gain weight is authentic. [216] Hence, when a patient with anorexia acts on the desire to be thin, such as when they refuse treatment, 'their action is motivated by an inauthentic preference, goal or value, and is therefore not an autonomous action'.[217] Additionally, George Szmukler argues that anorexia nervosa 'supplants' the authentic values of the patient, so that the disorder, having developed 'a life of its own', undermines P's ability

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[215] Foster (n 131)

[216] Herring and Wall, 'Autonomy, Capacity and Vulnerable Adults' (n 177), 709.

[217] ibid.

to act in accordance with her true character system.[218] Where the resulting decisions will cause harm to P's authentic values, treatment against P's wishes can be justified; it is in her best interests because it protects and gives effect to her authentic values.[219] Foster captures the essence of these arguments by arguing that anorexia nervosa takes on 'a personality of its own—a personality that has parasitically occupied the patient', prompting a 'deceitfully made' decision to refuse life-sustaining treatment.[220] In short, these authors argue that the decisions of anorexia nervosa patients to refuse treatment cannot be autonomous because they are motivated by values which are foreign to the patient and attributable only to her illness.

The authenticity problem suffers from several major flaws. First, it overlooks a key aspect of anorexia nervosa: its ego-syntonic nature. This is crucial to establishing whether values that are 'inauthentic' or 'authentic' exist at all. While some patients experience internal division between their anorexic and non-anorexic selves, other patients *identify* with their disorder and see it as an inextricable part of their sense of self.[221] This was proven by Hope et al. in their interviews. Just as patients described divided selves, with anorexia existing as a separate entity within them, others saw their disorder as 'integral to a single self'.[222] For example:

> 'Once you've taken that [the anorexia nervosa] away, you've taken away part of my identity, so I'm bound to feel a bit lost.'

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[218] Szmukler (n 131) 152.

[219] ibid 153.

[220] Foster (n 215) 60-61.

[221] Hope and others, 'Agency, Ambivalence and Authenticity' (n 131) 32.

[222] ibid.

> ‘It [the anorexia nervosa] almost does become part of you and so in order to get it out of you I think you do have to kind of hurt you in the process, I think it's almost inevitable.’
>
> ‘It's like you're trying to take away the something that is a huge part of my life … and if that goes what am I left with?’[223]

These statements illustrate that it is not always accurate to describe the decision to refuse life-sustaining nutrition as being made by a foreign entity that has overtaken the patient. Rather, if the anorexia nervosa is part of the patient’s identity, then it is not clear that the values motivating her decision to refuse treatment are ‘inauthentic’. This is true even if the values are ‘pathological’, to use Tan et al.’s term, in that they derive from the anorexia nervosa.[224] In *King’s College Hospital NHS Foundation Trust v C & V*, MacDonald J found that the patient, Ms C, had capacity to refuse life-saving dialysis.[225] One of Ms C’s reasons for doing so, which MacDonald J took very seriously, was that the dialysis would prevent her from regaining her ‘sparkle’.[226] Just as Ms C was entitled to weigh the relevant information in accordance with this unusual value, so too might a patient with anorexia hold unusual values that are associated with her disorder but which still cohere with her character system. Pugh, Hannah Maslen, and Savulescu argue:

> [It] is quite possible for an agent to authentically hold the values that are characteristic of anorexia nervosa as part of her self-conception, particularly in the case of chronic sufferers who may have shaped and developed a coherent character system over many years to accommodate this “pathological” desire.[227]

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[223] ibid.

[224] Tan and others, ‘Competence to Make Treatment Decisions in Anorexia Nervosa’ (n 178).

[225] [2015] EWCOP 80.

[226] ibid [97].

[227] Jonathan Pugh, Hannah Maslen and Julian Savulescu, ‘Deep Brain Stimulation, Authenticity and Value’ (2017) 26(4) Cambridge Quarterly of Healthcare Ethics 640, 652.

As Mackenzie and Rogers' authenticity condition requires, these types of values cohere with this patient's 'sense of who she is and what matters to her'.[228] In other words, it is not accurate to deem the patient's decision inauthentic considering the values she holds at the relevant time if she endorses the values associated with anorexia nervosa as part of her coherent character system.[229] The values themselves cannot be labelled inauthentic, and her decision cannot be deemed non-autonomous on that basis.

Moreover, even if P does have values that are conclusively inauthentic, the authenticity problem assumes that we can identify and distinguish between P's inauthentic and authentic values at a given time. Despite recognising the divided identities of anorexia patients and the 'pathological values' produced by the disorder, in several papers Hope et al. have concluded that authenticity should not be relied upon to assess whether patients' decisions to refuse treatment are autonomous.[230] They argue that it would be impossible for doctors or lawyers to acquire a 'sufficiently robust' understanding of which of the patient's values are authentic and which are inauthentic at the time of the relevant decision.[231] Similarly, the observations of Maslen and co-authors demonstrate the challenges of attempting to identify a patient's authentic values:

> Experiences can…change over the course of an individual patient's illness and recovery: the anorexic patient at some points might

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[228] Mackenzie and Rogers (n 56) 43.

[229] ibid 228.

[230] Hope and others 'Agency, Ambivalence and Authenticity' (n 131); Tony Hope and others, 'Anorexia Nervosa and the Language of Authenticity' (2011) 41 The Hastings Center Report 19.

[231] ibid 27.

> experience her anorexic traits as inauthentic and seek to extirpate them; at other times she might view her anorexic parts as authentic, but significantly problematic and in need of management; other times she might embrace her anorexic parts as valuably authentic, seeking to promote rather than minimize them.[232]

This statement, which is supported by the interviews conducted by Hope et al.[233], reflects the difficulty of identifying authentic values given how the patient's relationship with her disorder changes over time. The same values can be authentic, inauthentic, or somewhere in between, depending on the patient's current lived experience. It could be argued that, objectively, authentic values retain their authenticity, and it is only the patients' experience of those values that changes. And yet, when there is already doubt as to the accuracy with which we can identify authentic values, the question of whether a value should be respected as authentic even if the patient does not experience it as such simply adds another level of uncertainty. Given the gravity of the decisions being made, that degree of uncertainty is unacceptable. Ultimately, there is no 'test' that can be used to reliably identify which of the patient's values are authentic at a particular time, if any. Without such a tool, the claim that a decision to refuse medical treatment is non-autonomous because it is motivated by an inauthentic value cannot have a strong evidential foundation. We cannot discern whether the value is authentic or inauthentic, so the basis of the argument falls away.

The final flaw of the authenticity problem is that it relies on the assumption that some values are more worthy of recognition than others because they possess certain characteristics. For example, decisions motivated by P's 'long-term' values are more

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[232] Hannah Maslen, Jonathan Pugh and Julian Savulescu, 'Authenticity and the Stimulated Self: Neurosurgery for Anorexia Nervosa' (2015) 6 AJOB neuroscience 69, 70.

[233] ibid; Hope and others 'Agency, Ambivalence and Authenticity' (n 131).

likely to be deemed coherent with her character system. Mackenzie and Rogers argue that a decision that has 'remained diachronically constant can be taken as more indicative of the person's values than one declared with no evidence of detailed consideration or consistency over time'.[234] However, they fail to explain exactly why this should be so. Indeed, Colin Gavaghan makes the important point that 'that which we most value can change throughout our lives, and that fact alone need not undermine respect for those values at any given time'.[235] People change, and so do their values. Thus, it is not necessarily correct to assume that longevity is indicative of authenticity. These assumptions that particular characteristics of values are indicative of authenticity mirror Coggon's argument on patients' right to act unwisely. He argues that 'patients are ostensibly free to act irrationally, but in reality only in accordance with an unspecified range of 'irrationalities''.[236] In the context of anorexia nervosa and autonomy, patients are ostensibly free to act in accordance with their own values, but in reality only in accordance with an unspecified range of values that are deemed authentic. The authenticity critique is problematic because, based on unsubstantiated assumptions as to what authentic values look like, it narrows the range of values that patients are allowed to rely upon when making decisions.

For these reasons, the authenticity problem cannot be defended as a barrier to autonomy for *all* individuals suffering from anorexia nervosa in *all* circumstances. There may be cases where the patient recognises particular values as attributable to her

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[234] Mackenzie and Rogers (n 56) 50.

[235] Colin Gavaghan, 'In Word, or Sigh, or Tear: Depression and End-of-Life Choices' in Pamela Ferguson and Graeme Laurie (eds), *Inspiring a Medico-legal Revolution: Essays in Honour of Sheila McLean* (Ashgate 2015), 249.

[236] John Coggon, 'Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection' (2016) 24(3) Medical Law Review 396, 401.

illness, which she sees as distinct from her personal identity, and deems those values undesirable for her own reasons. That patient would undoubtedly fail to meet the authenticity criterion of autonomy. However, this section has cast doubt on the use of authenticity as a means of determining whether the decisions of patients with anorexia nervosa about their medical treatment are non-autonomous.

4.4: The Rationality Problem

Indisputably, anorexia nervosa patients engage in irrational thinking about some things. The obvious example is food and nutrition. It has been shown that anorexia nervosa causes breakdowns of both theoretical and practical rationality, whereby patients form false conclusions and false or unjustified desires about food based on true information. However, the fact that anorexia nervosa patients are irrational in relation to food does not necessarily mean they are irrational, and thereby non-autonomous, in relation to every aspect of their medical circumstances. Pugh and Giordano put forward two arguments that weaken the claim that anorexia nervosa patients inherently lack autonomy as a result of failures of theoretical and practical rationality.

As discussed above, Tan et al. argue that anorexia nervosa produces 'pathological values' that lead to false beliefs about the patient's weight, generating logically unjustified desires.[237] This is demonstrative of both theoretical and practical irrationality. However, Pugh points out the importance of differentiating between *descriptive* beliefs and *evaluative* beliefs. In the case of anorexia nervosa, a patient may have a descriptive delusion (a false belief) if she does not believe that she is seriously

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[237] Tan and others, ''Competence to Make Treatment Decisions in Anorexia Nervosa' (n 178) 278.

underweight or that her weight puts her at significant risk of health problems. However, the diagnostic criterion of anorexia nervosa, namely 'undue influence of body shape and weight on self-evaluation', implies that P must also have an evaluative delusion. That is, the self-esteem of patients with anorexia nervosa must be *too* greatly influenced by their body shape.[238] But exactly how much influence must a factor exert before it becomes 'undue'? As Pugh argues:

> The claim that one dimension of a person's self-conception (in this case, body shape or weight) exerts 'undue influence' over the patient's decision-making, invites the thought that there is an objective standard of proportionate influence that different values should have on one's self-conception.[239]

Pugh explains that this is problematic because individuals can place different weight on different things and still be rational. There is no objective standard for how much influence different values ought to have on our self-worth. An individual can value her hair more than her eye colour, or vice versa, and neither individual is necessarily irrational. This is the case even if one takes an objectivist view: that values, which form evaluative delusions, can be objectively 'true' in the same way as descriptive facts.[240] This approach has what Pugh labels the 'significant caveat' that truths about values are 'far less precise, and less well-understood than truths about descriptive matters of fact'.[241] Our ability to assess the truth of evaluative beliefs is weakened because we lack the consensus (associated with facts) that allows us to determine whether a descriptive belief is false.[242] Therefore, one can question whether some of the core evaluative

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[238] Pugh (n 153) 224.

[239] ibid 225.

[240] ibid.

[241] ibid.

[242] ibid.

delusions that are associated with anorexia nervosa can be deemed ‘false’ at all. If a patient is well-informed and understands the precariousness of her medical situation—in other words, does not have descriptive delusions—then it is not clear that she can be said to be experiencing a breakdown of theoretical or practical rationality. This could only be established if we are willing to accept the uncertainty associated with the claim that there are objective truths about values.

Further, Giordano emphasises how ‘distortions’ in thinking processes are connected to the identity of the patient as a person with anorexia nervosa.[243] The obvious argument is that the patient’s ‘defective’ reasoning—the use of information about food to form unjustified desires about dieting practices—is caused by her eating disorder. However, Giordano argues that anorexia nervosa does not cause these thought processes, because it *is* these thought processes. Having anorexia nervosa and engaging in dysfunctional use of information about food are consistent with one another, which calls into question whether the use of information can be called defective. When we say, ‘X has anorexia nervosa’, we are saying that she has the symptoms listed in DSM-5-TR, which means she engages in thought processes and behaviours that promote self-starvation. Unlike an individual who crosses train tracks without knowing the train is imminently arriving, the anorexia patient *intentionally* engages in her ‘dysfunctional’ interpretation and use of information.[244] The gap in information that makes the train track-crosser non-autonomous does not exist for the anorexic patient. In this way, her

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[243] Giordano, ‘Understanding Eating Disorders’ (n 211) 230.

[244] ibid.

‘dysfunctional’ reasoning patterns are actually ‘coherent and functional to the disorder’; if she did not engage in them, she would not have anorexia nervosa.[245]

Giordano accepts, rightly, that this argument does not disprove the claim that anorexia nervosa patients engage in irrational thought processes. Instead, it weakens the argument that patients are non-autonomous *as a result of* those thought processes. In one sense, some facets of anorexic thinking are still objectively irrational and thus non-autonomous; for example, the desire to restrict calories to the point of self-starvation. In another sense, however, that same irrational behaviour does not mean the patient is non-autonomous, because they are engaging in it intentionally as someone for whom anorexia nervosa is their way of existing. Interviews show that anorexia nervosa is often seen as a life partner, or an inextricable part of who the patient is. One participant in a study by Tan et al. stated, ‘I don’t think I could be the person I want to be… without anorexia, because it’s a part of me’.[246] Drawing on this expression of inextricability, Giordano argues that the eating-disordered behaviour cannot be ‘corrected’ by providing information or modifying the patient’s beliefs. Rather, ‘“dysfunctional” information and beliefs are a part of the disorder itself, and a part of the person herself’.[247]

Thus, the ‘defects’ in patients’ thought processes that *are* anorexia nervosa are not necessarily ‘defects’, but rather ‘part of [the patient’s] system of thought, her fears,

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[245] ibid 231.

[246] Jacinta Tan, Tony Hope, and Anne Stewart, ‘Anorexia Nervosa and Personal Identity: The Accounts of Patients and their Parents’ (2003) 26(5) International Journal of Law and Psychiatry 533, 539.

[247] Giordano, ‘Understanding Eating Disorders’ (n 211) 231.

her emotional life, her feelings, and her objectives'.[248] These dysfunctions constitute the eating disorder, which is a significant part of who the person is. There is a redundancy in stating 'you cannot have autonomy because you engage in irrational thinking caused by your eating disorder'. The irrationality is the eating disorder, and the eating disorder is who the person is, so in a way this is merely stating, 'you cannot have autonomy because you are who you are'. This circularity weakens the claim that the irrational thinking of anorexia nervosa patients causes them to lack autonomy.

Admittedly, this argument cannot account for a patient who is gradually recovering from anorexia nervosa. Unlike when a patient exhibits determination to engage in self-starvation, signs of progress toward recovery would make it difficult to argue that defective reasoning in relation to food is coherent to the patient's disorder. The patient would, presumably, no longer identify with her disorder—the anorexia nervosa is no longer 'her', so the dysfunctional thoughts become something to be conquered or rehabilitated rather than a part of who the patient is. Where present, the defective reasoning patterns would impede the autonomy of a patient who is successfully distancing herself from her disorder. However, none of the patients in the cases before the Court of Protection can be said to be recovering from anorexia nervosa. Far from it—these patients suffer from the most severe form of the disorder and are experiencing its symptoms to the greatest degree. When considered in relation to judicial reasoning, therefore, Giordano's argument remains valid.

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[248] ibid 230.

The arguments above show that, although more convincing than the authenticity problem, the irrationality argument still presents with critical logical and moral gaps that render it a questionable justification for the assertion that anorexia nervosa patients are inherently non-autonomous. This creates space for the claim that patients with anorexia nervosa can engage in autonomous decision-making about some matters, whilst remaining non-autonomous about others.

4.5: Best Interests Decisions and the Value of Autonomy

It is essential to distinguish between the two things about which patients with anorexia nervosa are making decisions in this legal context:

1. Whether to refuse food.
2. Whether to refuse medical treatment, including compulsory feeding.

These are very different questions. Refusal of food is the core of anorexia nervosa. The patient would not have anorexia nervosa if she did not have a desire to refuse food. By contrast, refusal of medical treatment is a much broader question that involves consideration of a wide variety of factors, both medical and non-medical, food-related and non-food-related. Rather than a decision simply about weight-gain, refusal of compulsory treatment is a decision 'about the quality of [the patients'] lives' and 'the relative value of their lives in the light of its quality'.[249] For this reason, patients may be able to make an autonomous decision about refusal of medical treatment, if not refusal of food.

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[249] Heather Draper, 'Anorexia Nervosa and Respecting a Refusal of Life-Prolonging Therapy: A Limited Justification' (2000) 14 Bioethics 120, 133.

As a baseline, it has been shown that patients with anorexia nervosa are frequently able to engage in complex arguments, insightful reflection, and articulate reasoning. It has also been shown that patients are not inherently non-autonomous as a result of their eating disorder, or at least that this claim relies on weak justifications. Thus, unlike patients experiencing schizophrenic episodes or in persistent disorders of consciousness, it is not clear that patients with anorexia nervosa are unable to form autonomous decisions or desires about *anything*. Pugh refers to this as the 'elephant in the room'.[250] Many of P's preferences, beliefs, desires, and wishes relating to refusal of medical treatment—but not refusal of food—may be autonomous.

Moreover, Pugh argues that for a patient with anorexia nervosa to lack autonomy regarding a decision, the main driving factors behind that decision must be 'bad' reasons; those which are not endorsed by second-order preferences, do not cohere with her sense of self, and are based on irrational evaluations.[251] That is, we can only conclude that a patient lacks autonomy to refuse medical treatment if it is the problematic beliefs and desires which are 'primarily operative in the patient's decision-making process'.[252] There is no evidence that this will always be the case for patients when deciding to refuse medical treatment. Whilst the decision to refuse food may be motivated by 'bad', irrational desires and therefore non-autonomous, the decision to refuse treatment may be motivated by completely different reasons. In Heather Draper's words:

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[250] Interview with Jonathan Pugh, Senior Research Fellow, University of Oxford (Oxford, 6 February 2025).

[251] Pugh (n 153) 231.

[252] ibid.

> What of the sufferer from anorexia who refuses therapy, not because she thinks that her condition is not life-threatening, nor because she refuses to accept that she has a problem at all, but because for her … the burden[s] of therapy …are such that she prefers to take her chances with death?[253]

Patients with anorexia nervosa may reject treatment not necessarily because they fear weight-gain or believe they are not at risk of death, but because the prospect of a life of suffering, spent fluctuating between torturous weight-gain and weight-loss, is unacceptable to them. These are very different from reasons for refusing food. As Giordano argues, 'the two mental processes that lead a patient to refuse food and to refuse medical treatment…are not necessarily one and the same'.[254] For example, in Ms X's letter to the Official Solicitor she wrote:

> I understand the professionals concerns and the effect that this has had on all of them and I do recognise that everyone wants for the best. However I now feel I have had enough of the continual pressure of mental health staff and services [for the last 14 years] and that rather than helping me, it is actually making me worse. It is hard for everyone but there is a lot I can't deal with concerning therapy - it's just not something I have found able to be involved in, it's just too hard…I am fully aware of what is wrong with my health and the effects of my wish to refuse treatments will have upon it. Whatever time I have left I just want to live each day alongside my granddad and [siblings], who are my world. I want them to know 'me' rather than this illness and to have some nice memories of our time together.[255]

This statement demonstrates that Ms X reached a decision to refuse treatment, not necessarily because of a fear of being fat, but for other clear, informed reasons: the burdens of treatment were too high, the treatment was ineffective, and she wished to

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[253] Draper (n 249) 131.

[254] Simona Giordano, 'Anorexia Nervosa: A Case for Exceptionalism in Ethical Decision Making' (2019) 26(4) Philosophy, Psychiatry, & Psychology 315, 318.

[255] *Ms X* (n 20) [51].

spend time with her family without being defined by her illness. Similarly, in *Re E* the patient expressed her recognition that '[s]he has endured a lot of pain with very little benefit' and that '[s]he wants to live for the remainder of her life as she chooses, and if necessary to be allowed die with dignity'.[256] E wanted to become a doctor, but also knew that what she would need to do to become one—undergo force-feeding—would have too great an impact on her quality of life.[257] Again, this shows the reasoning process of an individual who has concluded that continuing the pattern of treatment to which she was subject for 18 years was not acceptable to her. It is not the same reasoning process as that which she would have undertaken when deciding to refuse food.

Indeed, the statements from Ms X and E demonstrate the hallmarks of *richly* autonomous thinking. Autonomy is a matter of degree; a decision can be 'richly' autonomous, or 'weakly' autonomous. Herring and Wall define a 'richly' autonomous desire as one which reflects a 'settled decision' and 'genuine part of the person's life vision'.[258] Ms X and E's decisions are settled in that the patients have reflected on the decision and found it to align with their system of values—family, identity, dignity and so forth.[259] They have reached the decision to refuse medical treatment, not because of their desire to be thin, but because they seek freedom from decades of suffering, respite from cycles of ineffective treatment, and the ability to engage with loved ones without the threat of force-feeding. Thus, whilst the decision to refuse food will, for a patient

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[256] *Re E* (n 27) [76].

[257] ibid [79].

[258] Herring and Wall, 'Autonomy, Capacity and Vulnerable Adults' (n 177) 716.

[259] ibid.

with anorexia nervosa, almost certainly be non-autonomous, there is every reason to believe that the decision to refuse medical treatment can be autonomous.

It is important to consider one of the factors often used in the Court of Protection as a reason to continue compulsory treatment: the fact that P expressed a desire to live in the past or made progress in treatment before deteriorating. The patient's former willingness to engage in treatment is seen as evidence that her current desire to stop treatment is inauthentic, and thus non-autonomous. However, as Gavaghan argues, this is not always accurate. Changes in P's desires are not necessarily 'a betrayal of [P's] previous values, but rather, a result of the reality that reserves of energy and determination are not infinite'.[260] There may come a point at which P decides that the suffering associated with force-feeding is no longer acceptable to her, though it may have been tolerable in the early stages of her illness. When patients have undergone cycles of treatment for decades, the logical question to ask is whether that cycle should continue forever. A patient can know, arguably better than anyone else, that the time has come when it can be said enough has been done. This is a natural progression, not the kind of misalignment with P's character system that is demonstrative of a non-autonomous decision to refuse treatment. Although P's past desires and progress should be taken into consideration and used to interpret her current circumstances, as the MCA requires, they should not be relied upon to dismiss her existing wishes as inauthentic.

The possibility that a decision to reject compulsory treatment can be a richly autonomous one based on the patient's wishes and feelings about the quality of her life

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[260] Gavaghan (n 235) 249.

becomes even more important when one considers the value of autonomy. From the perspective of Immanuel Kant, to respect the patient's personal autonomy is to recognise her unique moral value. Kant argues that autonomy is the foundation of dignity, an immeasurable property possessed by all human beings. The patient's autonomy is her right as an 'end' in herself, rather than a means to an end. According to Kant's philosophy, 'autonomy of the will is the sole principle of all moral laws and of duties in keeping with them'.[261] Kant's conception of autonomy is substantive, in the sense that it requires that the decisions of agents are moral according to a universal standard. Onora O'Neill argues that this formulation is helpful in bioethics because the task for medical practitioners (and judges) is to find ways to 'live up' to those standards in medical settings; it provides ethical guidance.[262] By contrast, John Stuart Mill's articulation of autonomy is that it is valuable not for its ability to protect our substantive moral value, but for its prudential value. He argues that 'if a person possesses any tolerable amount of common sense and experience, his own mode of laying out his existence is the best not because it is the best, but because it is his own mode'.[263] Hence, autonomy is valuable because it allows us to make our own decisions about our own lives, not because it helps us to do things that are more morally 'correct'. This is situated within Mill's broader utilitarian theory; the 'harm principle' states that the only justifiable use of coercion is to prevent harm to others, where the benefits of that restriction of autonomy outweigh the costs.[264] Mill argues that this level of freedom is productive because it allows individuals to flourish and engage in diverse ways of

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[261] Immanuel Kant, *Critique of Practical Reason* (Mary J Gregor tr, Revised edn, CUP 2015) 5:33.

[262] Onora O'Neill, *Autonomy and Trust in Bioethics* (CUP 2009) 95-6.

[263] John Stuart Mill, *On Liberty* (first published 1859, CUP 2012) 121.

[264] ibid 22.

thinking, which generates societal advancement.[265] That is, he argues that if our modes of life lack diversity, humans 'neither obtain their fair share of happiness, nor grow up to the mental, moral, and aesthetic stature of which their nature is capable'.[266] Autonomy is necessary to protect our various and divergent ways of life and, thereby, promote progress in society.

Expanding on a Millian conception of autonomy, Pugh argues that autonomy is intrinsically linked to the well-being of patients. Rather than viewing beneficence and autonomy as separate principles, proper consideration of the patient's autonomy is a necessary requirement of contributing to their well-being.[267] The view that 'healing' is the only goal of the principle of beneficence is problematic; it relies on an 'objective *ranking* of the different objective elements of well-being,' when in reality our medical decisions 'concern a far greater range of goods than those that are adequately captured by the end of healing'.[268] We frequently make decisions in the medical context which pursue goals other than healing but which still contribute to our well-being. For example, a patient could choose not to undergo non-emergent epilepsy surgery because the procedure and recovery would interfere with her studies. If we supported a narrow view of beneficence that recognised healing as the only goal, then there would be a conflict here between autonomy and beneficence. However, if we reject that narrow view of beneficence, fewer such conflicts would arise, and we could accept that:

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[265] ibid 124.

[266] ibid 122.

[267] Pugh (n 153) 254.

[268] ibid.

> [A]s long as an individual's choice is autonomous, that should give us at least a *pro tanto* reason to believe that respecting that choice will benefit that person …because on this view there is prudential value to directing the course of one's life in accordance with one's own beliefs about what is of value, and with one's own beliefs about which values should take precedence.[269]

The traditional view of 'beneficence' must be expanded to avoid the falsity of ranking elements of well-being, and to recognise how it relates to and overlaps with autonomy. Understanding the connection between well-being and autonomy is a critical factor in gauging the value of autonomy in the medico-legal context.

There is disagreement about which of the Kantian or Millian understandings of autonomy should be applied in bioethics. An investigation into that debate is beyond the scope of this thesis. Instead, what should be understood from this section is that autonomy is universally considered to be inherently valuable. This means that an autonomous decision by an anorexia nervosa patient to refuse treatment should be afforded significant weight in the best interests decision. Careful attention should be paid to the reasons underlying the patient's decision to ascertain whether it bears the hallmarks of autonomous reasoning, and thus is worthy of respect.

4.6: The Conundrum of Autonomy in Judicial Reasoning

In *Ms B v An NHS Hospital Trust,* the patient, Ms B, was tetraplegic and relied on a ventilator. Her wish to die by removing the ventilator was repeatedly denied. When she was finally deemed to have capacity and control over her death, Dame Butler-Sloss held:

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[269] ibid 256.

> There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient… She is clearly a splendid person and it is tragic that someone of her ability has been struck down so cruelly. I hope she will forgive me for saying, diffidently, that if she did reconsider her decision, she would have a lot to offer the community at large. [270]

Although made in reference to a different disability, these statements spell out the dilemma that judges face when making best interests decisions for patients with anorexia nervosa. On one hand, judges must recognise the possibility that the patient with anorexia nervosa has made an autonomous decision to refuse medical treatment. They must resist the paternalistic urge to protect a patient who engages in irrational thinking about food. On the other hand, recognising the patient's personal autonomy will, in all likelihood, lead to the death of a young, sentient person. This is especially poignant considering that anorexia nervosa is, at least in theory, always a reversible illness. Judges frequently describe patients as intelligent, generous, kind, and dear to their families. They express immense regret that these patients are refusing treatment. It is, in Sir Cohen's words, 'as grave a decision as can be made'.[271] The obvious sentiment is that the judge believes, as Dame Butler-Sloss did, that the patient is making the *wrong decision*. Yet, the law protects the rights of individuals with capacity to refuse life-saving treatment, including food and water.[272] When a judge holds that withdrawal of compulsory treatment is not in P's best interests, he potentially infringes an exercise of autonomy that is explicitly recognised by the law. In this way, the ability of patients

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[270] [2002] EWHC 429 (Fam) [94-5].

[271] *BG* (n 1) [50].

[272] *R (on the application of Nicklinson) v Ministry of* Justice *[2014] UKSC 38.* Lord Sumption held: 'A person who is legally and mentally competent is entitled to refuse food and water, and to reject any invasive manipulation of his body or other form of treatment, including artificial feeding, even though without it he will die' [255].

with anorexia nervosa to autonomously refuse medical treatment puts the judge in an invidious position. He is 'stuck' between respecting the patient's autonomy and thereby authorising her death, and preserving her life at the cost of overriding her autonomy.

The ability of anorexic patients to autonomously refuse treatment brings the friction between autonomy and sanctity of life to the fore. The law does not consider the sanctity of life to be an immutable principle. It has been shown that the presumption in favour of preserving life—which the law ultimately equates with protecting the sanctity of life[273]—can be overturned.[274] The judge is not in a legal deadlock. Nonetheless, he must grapple with the fact that protecting P's autonomy would require undermining the principle of sanctity of life to at least some extent: the decision would lead to her death. The possibility of an explicit, autonomous treatment refusal having taken place is a critically important factor in that decision. It is a factor which does not arise when, for example, the patient is in a persistent disorder of consciousness. In this way, the task of striking a balance between protecting autonomy and preserving the sanctity of life is made more complicated by patients' ability to autonomously refuse treatment. The judge is denied the comfort of holding that the sanctity of life should be preserved, knowing, with at least some confidence, that the patient has not made an autonomous decision to the contrary.

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[273] *Ms X* (n 20) [36].

[274] Not only in the cases under consideration, but in cases such as *Great Ormond Street Hospital v Yates* [2017] EWCA Civ 410 and *Alder Hey Children's NHS Foundation Trust v Evans* [2018] EWHC 308 (Fam), in which the withdrawal of life-sustaining measures was held to be in the best interests of 8- and 21-month-old children suffering from severe illnesses without approved treatments.

It could be argued that the distinction between richly and weakly autonomous decisions might aid judges in navigating these cases. Herring and Wall argue that weakly autonomous decisions warrant more protection than richly autonomous ones. Specifically, the authors argue that a richly autonomous decision to refuse a major medical procedure might warrant respect, but a weakly autonomous decision to do so might not. That is, a weakly autonomous decision may be insufficient 'to justify doing an act that will lead to serious harm'.[275] In cases concerning patients with anorexia nervosa, the relevant act—withdrawal of compulsory treatment—is very likely to lead to serious harm. In accordance with Herring and Wall's argument, the rule for judges could be that richly autonomous decisions to refuse treatment should be respected and weakly autonomous ones should not. Yet, this would simply make the decision more complicated for judges. The question would become not only whether the patient has made an autonomous decision to refuse treatment, but whether she made that decision in a manner that is richly autonomous enough to justify not overriding a potentially seriously harmful decision. This adds greater uncertainty to a situation that is already exceptionally ethically complex.

Equally, in reference to the *Re Patricia* line of cases, Kong states:

> [In] this particular judgment…there is a conflict of our interpretation of autonomy…[I]n the original case we can see that there is quite a thin account of autonomy…we can see it in Patricia herself, where she has a desire not to be force-fed, where this desire to refuse treatment really tracks these strongly felt anorexic values. But she also has these longstanding commitments and values which are reflected in her desire to travel…the value that she places on education, about physical strength, about the desire not to die. It's a question about how we honour that in this best interests decision. To use this example, Patricia, it would be thinking about how this anorexic compulsion to refuse treatment and

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[275] Herring and Wall 'Autonomy, Capacity and Vulnerable Adults' (n 177), 717.

> food might not be tracking deeper values that she has about her life, about family, about relationality, about her identity, and about the aspirations she has in the future.[276]

In these statements, Kong does not necessarily advocate for protecting ‘thick’ (rich) autonomy over ‘thin’ (weak) autonomy. Instead, she implies that protecting Patricia’s ‘thick’ sense of autonomy would *justify* overriding her decision to refuse medical treatment. Patricia’s refusal of treatment does not ‘track’ her thickly autonomous desires, so the best way to protect her autonomy is to allow compulsory treatment to continue. This argument would provide judges with a logical and ethical foundation for concluding that they can respect P’s autonomy while also preserving her life. However, the goal of *possibly* realising a vague conception of what P’s life *might* look like if she did not have anorexia nervosa is an insufficient justification for overriding an autonomous refusal of medical treatment. This is due to the second confounding factor in these cases: the nature of treatment for anorexia nervosa.

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[276] Anita Rani and Nuala McGovern, ‘BBC Woman’s Hour’ (02 April 2025) comments by Camillia Kong <https://www.bbc.co.uk/sounds/play/m0029j91> accessed 02 April 2025.

CHAPTER 5: CONFOUNDING FACTOR 2—THE UNIQUE TORTURE OF TREATMENT

5.1: The Clinical Nature of Compulsory Treatment for Anorexia Nervosa

The MEED Guidelines provide a roadmap for medical staff—including dietitians, nurses, psychiatrists, and physicians—for safe refeeding of patients with anorexia nervosa. One of the key goals is to avoid refeeding syndrome. When patients are critically malnourished, the reintroduction of food can cause disturbances in electrolytes, which affects the cardiovascular and neurological systems. This can lead to organ failure.[277] At least one patient in the relevant cases, E, suffered from refeeding syndrome in the past and was likely to suffer from it again when her new feeding regime was implemented.[278] CC also described suffering from refeeding syndrome.[279]

To avoid refeeding syndrome, clinicians must slowly reintroduce calories and monitor for changes in patients' phosphate levels.[280] The Guidelines emphasise the lack of certainty around how many calories a refeeding regime should use. In the absence of this data, the Guidelines shape their recommendations around the risk level of patients. Patients who are 'acutely ill' or with a BMI under 13 are given the most cautious diets, and those who have no medical comorbidities can be fed more aggressively. [281]

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[277] Royal College of Psychiatrists (n 77) 77.

[278] *Re E* (n 27) [107].

[279] *Re CC* (n 101) [29].

[280] Royal College of Psychiatrists (n 77) 77.

[281] ibid 82.

The baseline for refeeding is three meals and three snacks per day, taken orally.[282] When patients resist oral nutrition, nasogastric tube (NGT) feeding is the next option for refeeding. Tubes are inserted through the nasal passage, allowing liquid food to be passed directly into the stomach.[283] However, patients can continue to resist treatment by tampering with the NG tube—pulling it out and re-inserting it, cutting it, biting through it, or other means.[284] For example, Ms L bit through her NG tube by 'curling up the tube from the back of her throat with her tongue and swallowing the distal end'.[285] This creates the risk of liquid food or the tube entering the lungs.[286] Actions such as these and extreme resistance to receiving nutrition may lead to NGT feeding under restraint. The MEED Guidelines state that NGT feeding under restraint 'may need to be considered as a life-saving intervention, although it should only be required very rarely'.[287] The Guidelines stress that this practice should be used 'as infrequently as possible to follow principles of least restrictive practice and prevent traumatisation of patients and those around them'.[288] Restraint involves staff trained in safe restraint practices holding down the arms, legs, and/or head of the patient, allowing for the NG tube to be inserted and food pushed through the tube.[289] Restraint can also be administered mechanically, using devices such as belts, mittens, and cuffs, or

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[282] ibid 83.

[283] NHS North Trees and Hartlepool, 'Nasal Tube Feeding' < https://www.nth.nhs.uk/resources/nasal-tube-feeding/ > accessed 14 May 2025.

[284] ibid 91.

[285] *The NHS Trust v L* [2012] EWHC 2741 (COP) [26].

[286] ibid.

[287] Royal College of Psychiatrists (n 77) 92.

[288] ibid.

[289] SJ Fuller, S Thomson and J Tan, 'Nasogastric Tube Feeding Under Restraint: Practical Guidance for Children's Nurses' (2022) 35(2) Nursing Children and Young People 18.

chemically through the administration of anti-psychotic drugs.[290] The diagnosis of osteoporosis associated with severe anorexia nervosa creates the risk of musculoskeletal injury and bruising when patients fight under restraint.[291] They are also susceptible to cardiovascular failure.[292] Given the extremely sensitive nature of these treatment strategies, the NICE guidance states that they should only be administered by 'multidisciplinary teams who are competent to do so'.[293]

Almost every patient in the cases under analysis experienced NGT feeding under restraint. BG received more than 1,000 such feeds, requiring restraint by four staff members.[294] LV required restraint by seven staff members for her twice-daily NG feeds.[295] These feeds were still ineffective because LV developed the ability to regurgitate the feed while it was being delivered and purge any remainder afterwards.[296]

When NGT feeding is ineffective even under restraint, treatment can escalate to the use of percutaneous endoscopic gastrostomy (PEG) tubes. This involves the surgical placement of a feeding tube directly into the stomach through the abdomen. The MEED Guidelines describe PEG feeding as an appropriate intervention only when there is 'a dysfunctional swallow and long-term nutritional adequacy cannot be achieved

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[290] Care Quality Commission, 'Brief guide: restraint (physical and mechanical)' (2018) < https://www.cqc.org.uk/sites/default/files/20180322_900803_briefguide-restraint_physical_mechanical_v1.pdf> accessed 15 May 2025.

[291] *Re Z* (n 97) [7].

[292] Royal College of Psychiatrists (n 77) 49.

[293] NICE, *Eating Disorders: Recognition and Treatment* (2017) 36.

[294] *BG* (n 1) [15].

[295] *LV* (n 113) [4].

[296] ibid.

orally'.[297] They state that it should be avoided 'in all but the most severe cases'. [298] The procedure is described as having high morbidity and even mortality.[299] Minor complications include wound infection and tube leakage, and major complications include haemorrhage, bowel perforation, and necrotizing fasciitis.[300] Though more invasive, PEG tubes can reduce the risk of NG tubes being tampered with and spontaneous vomiting of feed. However, some of the patients in the relevant cases received PEG feeding and still managed to resist. Francis J held that FD 'repeatedly removed her PG tube…in the context of a description by FD of her life as being "torture"'.[301] E also pulled out her PEG line, which resulted in scars on her abdomen that she showed to independent medical experts.[302]

The next level of treatment is parenteral nutrition: the delivery of food directly into the patient's bloodstream through a central line in the chest or a peripherally inserted central catheter (PICC) line in the arm.[303] MEED states that parenteral nutrition is 'hardly ever indicated for the treatment of eating disorders' and 'should be reserved for rare cases when the gastrointestinal tract cannot be used safely'.[304] Finally, in the most extreme cases, patients can be fed under sedation for long periods of time. For

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[297] Royal College of Psychiatrists (n 77) 93.

[298] ibid.

[299] ibid.

[300] Ata A Rahnemai-Aza and others, 'Percutaneous Endoscopic Gastrostomy: Indications, Technique, Complications and Management' (2014) 20(24) World Journal of Gastroenterology 7739.

[301] *FD* (n 28) [23].

[302] *Re E* (n 27) [77].

[303] Cleveland Clinic, 'Parenteral Nutrition' <https://my.clevelandclinic.org/health/treatments/22802-parenteral-nutrition> accessed 15 May 2025.

[304] Royal College of Psychiatrists (n 77) 94.

example, the proposed (and adopted) course of treatment in *LV* was to put LV to sleep under general anaesthesia, intubate her, put her on a ventilator, and feed her while she was unconscious for seven to fourteen weeks.[305] This was held to be a better option than feeding by central line while under mechanical restraint, due to the risk of LV pulling out the central line and causing an air embolism.[306] Similarly, it was held that E would be fed under sedation for 'a year more'.[307]

It is evident from the cases that these treatments induce profound physical and psychological distress for patients. The word 'torture' is frequently used to describe the experience of force-feeding. Ms L's mother explained that 'Ms L watches the food coming through the tube and it is "torture" for her'.[308] In 2023, Patricia stated that NGT feeding under restraint 'was a matter of enormous fear and terror to her'.[309] She described it as:

> [T]he worst thing that has ever happened to her as it made her feel suicidal; it involved agonising pain; and she considered it to be torture. She said that, if it was tried again, she would fight and she was, therefore, very scared of physical harm and genuinely fearful that the restraint would kill her.[310]

Further, Francis J held that FD 'regards her present existence as simply, to use her words, "torture". In other words, continuing with forced treatment is to subject her to a

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[305] *LV* (n 113) [8].

[306] ibid.

[307] *Re E* (n 27) [44].

[308] *The NHS Trust v L* [2012] EWHC 2741 [37].

[309] *Z NHS Foundation Trust & Anor v Patricia & Ors* [2023] EWCOP 41 [18].

[310] ibid.

life of "torture"'.[311] In addition to the terror of the treatment itself, force-feeding can produce distress by evoking past traumas. E experienced force-feeding as a 're-enactment' of the serious sexual abuse she experienced as a child.[312] Similarly, in *Ms X*, Dr Glover opined that:

> [T]he roots of Ms X's emotional and psychological disturbance lie buried within her traumatic childhood…starvation numbs her emotions, and re-feeding arouses them. During periods of re-feeding (and afterwards) Ms X finds her emotional state increasingly unbearable and seeks solace in alcoholic anaesthesia.[313]

Thus, compulsory treatment can make patients confront past traumas aggressively and outside the safe environments created during psychotherapeutic sessions. Participants in one clinical study described feeling as though they were being punished or imprisoned, and being treated like a child or 'a vegetable'.[314] FD repeatedly expressed her revulsion at being treated like 'a piece of paper' during her treatment.[315] All this evidence illustrates the intense distress that compulsory feeding can cause patients. It many cases, it generates feelings of lost autonomy, dehumanisation, punishment, and self-disgust.

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[311] *FD* (n 28) [8].

[312] *Re E* (n 27) [89].

[313] *Ms X* (n 20) [19].

[314] Jacinta Tan and others, 'Control and Compulsory Treatment in Anorexia Nervosa: The Views of Patients and Parents' (2003) 26 International Journal of Law and Psychiatry 627, 632.

[315] *FD* (n 28) [9], [44].

5.2: Anorexia Nervosa and the Need for Control

Underlying the accounts of suffering during compulsory treatment is the core feature of force-feeding: the removal of control over the body. There is a very strong connection between anorexia nervosa and the need for control. This can manifest in many ways, including obsessive-compulsive behaviour—up to 79% of patients with anorexia nervosa experience obsessions or compulsions at some point.[316] DSM-5-TR states that children who show obsessional traits are at an increased risk of developing anorexia nervosa, and obsessive-compulsive behaviours are an associated feature of anorexia nervosa.[317] Moreover, DSM-5-TR lists 'a strong desire to control one's environment,' 'overly restrained emotional expression,' and 'inflexible thinking' as features associated with anorexia nervosa.[318] It states that 'weight loss is often viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control'.[319] Franzisca V Froreich and others found that fear of losing self-control was one of the two strongest predictors of eating pathology, alongside ineffectiveness.[320]

These findings are supported by the work of Tan et al. Their interviews with anorexia nervosa patients indicate that patients' relationship with control is central to the disorder. In one study, patients were not asked about control, but its importance was nevertheless mentioned frequently. One interviewee observed:

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[316] Zipfel (n 94)

[317] American Psychiatric Association (n 76) 385.

[318] American Psychiatric Association (n 76) 385.

[319] ibid 383.

[320] Franzisca V Froreich and others, 'Dimensions of Control and Their Relation to Disordered Eating Behaviours and Obsessive-Compulsive Symptoms' (2016) 4(14) Journal of Eating Disorders.

> I think it all begins with a need to control when individuals feel [sic] that various areas of their lives are out of control, and they're not happy about other areas of their lives, and so they look for another way to feel in control, to feel happiness, and a way you can guarantee it is by food, by weight, by exercise…[321]

As this statement suggests, control is seen as a way of correcting failures and imbalances in the patient's world. That desire manifests in control over the patient's diet, as food is the one thing over which she can (ostensibly) exercise complete control. This interviewee explains how control over food is defended when other parts of their life are directed or dominated by others:

> I think it's a form of control. Um, you go to school, you do this, you do that, you do the other. But nobody, nobody can make you eat. Yeah. Even if they sit on your chest and force food down your throat, no one can make you eat, and no one can make you eat more than you want to…I think what happens is they probably lose control of one thing, and it all, and then it's just a vicious circle.[322]

Tan and co-authors argue that patients' resistance to treatment stems just as much from the need for control as from the fear of gaining weight. [323] One interviewee stated that the 'harsher' treatment became in removing her sense of control, the more difficult it was to accept treatment at all.[324] Similarly, in *Re CC* an expert stated that CC recalled that 'the 'straw that broke the camel's back' was when…she felt like she had 'lost control''.[325] Further, Miss W expressly stated: '[c]urrently I am struggling because I

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[321] Tan and others, 'Control and Compulsory Treatment in Anorexia Nervosa' (n 314) 638.

[322] ibid 633.

[323] ibid 634.

[324] ibid.

[325] *Re CC* (n 101) [31].

have no control over decisions in my life'.[326] Such statements make clear that the feeling of having lost control is at the core of patients' struggles with anorexia nervosa and its treatment.

Additionally, it is important to emphasise that ASD is consistently overrepresented in groups with anorexia nervosa.[327] The need for control is universally understood to be associated with ASD; DSM-5-TR lists 'insistence on sameness, inflexible adherence to routines' manifesting in 'extreme distress at small changes' and 'difficulties with transitions' as one of the diagnostic criteria for the disorder.[328] This provides further evidence that a pathological need for control is a central feature of anorexia nervosa and its associated conditions.

The importance of control to anorexia nervosa patients has profound implications for the moral justifiability of force-feeding. Compulsory treatment deprives patients of control over their bodies and diets, the exact parts of their lives over which they most want to have complete control. The treatment compounds the distress patients experience as a result of their disorder and perpetuates the feelings of failure and imbalance that generate the need for control. In this way, force-feeding 'rubs salt in the wounds' of anorexia nervosa patients; it makes the experience of having anorexia nervosa more psychologically distressing. By contrast, the amputation of a leg due to diabetic neuropathy is serious, but does not aggravate an underlying symptom of diabetes. The leg is not central to why and how the patient experiences diabetes. Force-

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[326] *Miss W* (n 130) [29].

[327] Westwood and Tchanturia (n 85).

[328] American Psychiatric Association (n 76) 57.

feeding is uniquely torturous in that it targets one of the fundamental features associated with anorexia nervosa. It makes control over the body impossible to achieve, often in a manner that is violent and invasive. There is no compromise solution that enables force-feeding with control; if a patient consumed the requisite calories with control over that process, she would not have anorexia nervosa. This is why the nature of compulsory treatment is the second confounding factor in these cases: the treatment judges must consider authorising is *precisely* the thing that harms the patient.

Judges are not blind to this paradox. The fact that compulsory treatment deprives patients of control is cited in some cases as a reason to overturn the presumption in favour of prolonging life. For example, Francis J held that FD 'only sees herself as being controlled, subject to unwelcome and inhumane treatment and allowed no opinion of her own and no control of her own destiny'.[329] Similarly, Morgan J described the proposed course of treatment for LV as a 'risky, invasive and perhaps frightening process in which all control is taken from her—a person for whom control is of enormous importance'.[330] These statements illustrate the ethical dilemma judges face when considering authorising compulsory treatment. Anorexia nervosa presents the unique complication that treatment and suffering are coexistent; the more aggressive the treatment, the more seriously the patient suffers. When more extreme tactics such as sedation and restraint are used to enforce feeding, the patient is subject to a more forcible deprivation of control over her body, and thus experiences greater distress. Judges are again placed in an invidious position, forced to choose between authorising

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[329] *FD* (n 28) [9].

[330] *LV* (n 113) [56].

this particularly agonising harm or authorising the patient's death by allowing the withdrawal of compulsory treatment.

5.4: Compulsory Treatment and Bodily Integrity

This paradox is compounded by the fact that compulsory treatment for anorexia nervosa is an infringement of bodily integrity. Bodily integrity is the right of all individuals not to have their body touched or interfered with without their consent; to exclude all other people from their body.[331] David Feldman defines bodily integrity as 'a right to be free from physical interference', including 'physical assaults, torture, medical or other experimentation, immunization and compelled eugenic or social sterilization, and cruel or degrading treatment or punishment'.[332] Jill Marshall has shown that the right to bodily integrity is protected by Articles 3 and 8 of the ECHR.[333] This protection extends to unwanted medical interventions, including force-feeding. In *Herczegfalvy v Austria*, the European Court of Human Rights found that Articles 3 and 8 were applicable to, but had not been breached in the case of a prisoner and psychiatric patient who had been force-fed while on a hunger strike.[334] The Court held that it was for the medical authorities to decide 'on the basis of the recognised rules of medical science, on therapeutic methods to be used if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves'.[335] To

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[331] J Herring and J Wall, 'The Nature and Significance of the Right to Bodily Integrity' (2017) 76 Cambridge Law Journal 566, 568.

[332] David Feldman, *Civil Liberties and Human Rights in England and Wales* (2nd edn, Oxford, 2002), 241.

[333] Jill Marshall, 'Bodily and Moral Integrity Rights' in Viens (ed), *The Right to Bodily Integrity* (2016 Routledge).

[334] *Herczegfalvy v Austria* (1992) 15 EHRR 437.

[335] ibid.

use this outdated language, anorexia nervosa patients who are deemed to lack capacity are, from a legal perspective, ‘entirely incapable of deciding for themselves’ which medical treatment should be used to treat them. Therefore, compulsory feeding is not inherently a breach of Article 3 or Article 8 ECHR.

Additionally, Pugh argues that the right to bodily integrity includes a negative claim that third parties not physically interfere with our bodies.[336] The provision of autonomous, informed consent waives this claim; it allows third parties to intrude upon our bodies.[337] This provides the first insight into how bodily integrity is distinct from autonomy. This is a crucial distinction; even where incapacitous individuals lack the autonomy required to provide informed consent, they retain the right to bodily integrity.[338] Herring and Wall add that autonomy differs from bodily integrity because, whilst our decision-making capacity can be ‘abstracted’ out of the body, ‘the remaining relevant moral properties of the subject remain as embodied properties’.[339] That is, our ‘subjectivity’—in the form of well-being, pain, pleasure, flourishing, communicating, and relating—is located in the body. The authors provide the example of the difference between having one’s eyebrows waxed against one’s will and a refusal of a request for an eyebrow wax. The waxing is experienced in the body for the former, but not the latter, marking the difference between an infringement of bodily integrity and the denial of a positive autonomous claim.[340] Compulsory treatment for anorexia nervosa is

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[336] Jonathan Pugh, ‘The Child’s Right to Bodily Integrity and Autonomy: A Conceptual Analysis’ (2024) 19(4) Clinical Ethics 307.

[337] ibid.

[338] ibid.

[339] Herring and Wall, ‘The Nature and Significance of the Right to Bodily Integrity’ (n 331) 578.

[340] ibid.

experienced in the body, making it an interference with the right to bodily integrity. Therefore, patients with anorexia nervosa who are deemed to lack capacity, or who lack the ability to autonomously refuse medical treatment, still have a right to bodily integrity that is being infringed.

The severity of compulsory feeding as an interference with bodily integrity is best illustrated by drawing out the parallels between force-feeding and rape, which is universally understood to be an exceptionally grave infringement of the right to bodily integrity. First, in both scenarios there is an imbalance of power. Survivors of rape and anorexia nervosa patients are 'at the mercy' of third parties—the rapist and medical staff. This imbalance manifests in rape survivors being held down while the rape occurs, just as anorexia nervosa patients are often restrained or sedated for compulsory feeding. The second parallel is penetration. Feeding tubes and phalluses both penetrate the body. As Herring and Wall point out, under the Sexual Offences Act 2003, the definition of 'penetration' includes the act of entering the body and the ongoing presence within it.[341] Similarly, in *Airedale NHS Trust v Bland,* Lord Browne-Wilkinson held that the case depended 'on the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent'.[342] This suggests that the feeding tube's presence in Anthony's body was an ongoing interference with his bodily integrity. Thus, the presence of NG and PEG tubes in the bodies of anorexia nervosa patients is a *continuous* infringement of their bodily integrity, often for very long periods of time. Finally, the goal of the penetration is the same in that something exits the penetrating object and enters the penetrated body: semen or liquid food. The rape survivor and the

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[341] Herring and Wall, 'The Nature and Significance of the Right to Bodily Integrity' (n 331) 572.

[342] *Airedale NHS Trust v Bland* [1993] AC 789 (HL), 883.

anorexic patient are both powerless to control the effects of the ejaculated substance on their bodies. Whilst semen can lead to pregnancy or sexually transmitted infections, liquid food leads to unwanted absorption of calories. As indicated by the life sentence it carries, the law recognises rape as one of the most extreme infringements of the right to bodily integrity imaginable. The parallels between rape and compulsory feeding are very strong indicators that the latter, too, is an extreme invasion of the body.

The obvious counterargument is that compulsory feeding takes place in a controlled environment with the aim of making it a tolerable process for the patient, whereas rape is typically carried out in a violent manner with the aim of inflicting pain on the victim. However, it is the act of intrusion that produces the distress, not necessarily the environment in which it takes place. As Thomas Douglas argues, 'most people attach great symbolic value to their bodies and experience nonconsensual interference with their bodies as highly intrusive and often disrespectful'.[343] Therefore, even if rape were carried out in a 'safe' manner with no pain, risk of pregnancy, or disease, it would still be 'experienced as intrusive, degrading and humiliating'.[344] Likewise, the motives behind any interference with the body are irrelevant to determining whether the right has been infringed.[345] Douglas uses the example of Smith, a man who severs Jones' hand despite Jones' protests. Whether Smith does this to prevent the spread of a deadly infection in Jones' hand or on a whim is irrelevant to the question of whether Smith has violated Jones' right to bodily integrity. It is relevant

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[343] Thomas Douglas, 'Criminal Rehabilitation Through Medical Intervention: Moral Liability and the Right to Bodily Integrity' (2014) 18 Journal of Ethics 101, 114.

[344] ibid.

[345] ibid 107.

only to the question of whether Smith is justified in doing so.[346] Thus, the fact that clinicians administer compulsory feeding in a medically safe environment with the aim of improving the health of anorexia nervosa patients does not negate the fact that they are engaging in a grave infringement of those patients' rights to bodily integrity. It is relevant only to the question of whether they are justified in doing so, which will be addressed below.

Further, and crucially, the right to bodily integrity is closely connected to the idea of control. This has already been shown to be essential to the justifiability of compulsory treatment for anorexia patients. As Margaret Brazier argues, 'unwanted intrusion on the body hurts, not just the flesh, but the ability to control your own life'.[347] Our experience of the world is shaped by our bodies. The ability of anorexia nervosa patients to control their lives—as they so desperately want to—depends on the ability of their bodies to move, speak, and eat (or not eat) free from interference. Our bodies are the only things in the entire world that are indisputably, exclusively our own. They are private, safe spaces that belong to us. That inviolability is what gives rise to the right to bodily integrity. In direct contrast, compulsory treatment puts the ability of the body to flourish, interact, and execute agency into the hands of third parties. Once subject to compulsory treatment, one's sense of privacy and control over the body disappears. The most dramatic example of this is the use of general anaesthetic in refeeding. Being anaesthetized and waking up 10 or 20 kilograms heavier is akin to transplantation; so severe an invasion that one is no longer in one's own body. In such

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[346] ibid.

[347] Margaret Brazier, 'Introduction: Being Human: Of Liberty and Privilege' in Stephen Smith and Ronan Deazley (eds), *The Legal, Medical and Cultural Regulation of the Body: Transformation and Transgression* (Routledge 2009) 10.

cases, the right to bodily integrity is entirely overridden. So, too, is the ability of the anorexic patient to control her body. Once again, the treatment is precisely the thing that harms the patient.

Therefore, the question for the judge is whether such a serious infringement of bodily integrity can be justified because it is in the patient's best interests. Vera Tesink and others argue that the right to bodily integrity can be infringed to different degrees, and the more severe the interference the more 'substantial' the reasons for justifying it must be.[348] Interference with the body through compulsory feeding is particularly grave not only for the reasons above, but also because anorexia nervosa is *about the body.* Patients with anorexia nervosa think about, grapple with, and seek control over their bodies far more than the average individual does. Their experience of the world is shaped by their bodies in a more explicit and substantial way than non-anorexic people. Thus, one might argue that these patients should have a stronger right to bodily integrity than the average person. At the very least, the connection between anorexia nervosa and the body means that authorising an infringement of bodily integrity through force-feeding demands very substantial justification. Prolonging the patient's life is clearly the strongest reason. And yet, it is not clear that this goal is sufficiently robust in all cases. Indeed, empirical evidence suggests that preservation of life is not even a definite outcome of compulsory treatment. There are other, undesirable outcomes that can be of great relevance to the case at hand.

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[348] Vera Tesink and others, 'Neurointerventions in Criminal Justice: On the Scope of the Moral Right to Bodily Integrity' (2023) 16(26) Neuroethics 25.

5.5: Outcomes and (In)effectiveness

In *LV,* Morgan J held:

> In a sense most troublingly of all it may be that [LV] goes through this risky, invasive and perhaps frightening process in which all control is taken from her - a person for whom control is of enormous importance - and at the end [of] it all, it may be for nothing. It may still be that she cannot break the cycle and move on to the next therapeutic stage and start to recover.[349]

This is the risk that all judges face in these cases: that they deprive patients of control over their bodies and subject them to a severe invasion of bodily integrity, to no avail. Logically, for compulsory feeding to be in a patient's best interests the judge must believe that the treatment will be effective. It will prolong the patient's life, allowing them to engage in the psychotherapies that can lead to recovery. And yet, in some cases there are strong indications that this will not occur. Given that the treatment is what harms the patient, there are circumstances in which the evidence points to the conclusion that force-feeding will lead to greater suffering rather than physical or psychological improvement. In other words, recovery is by no means guaranteed simply because the patient's life may be prolonged.

One undesirable outcome of compulsory feeding is the strain it puts on patient-clinician relationships. Some nurses believe that force-feeding under restraint can hinder the development of a meaningful and lasting relationship with the patient or prevent one from developing at all.[350] Moreover, Stephen Touyz and co-authors found that the 'human connection' required for a good therapeutic relationship was not always

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[349] *LV* (n 113) [56].

[350] Berit Støre Brinchmann, Mette Spliid Ludvigsen, and Tove Godskesen, 'Nurses' Experience of Nasogastric Tube Feeding Under Restraint for Anorexia Nervosa in a Psychiatric Hospital' (2024) 25 BMC Medical Ethics 111.

present during compulsory treatment, and that ‘feelings of anger, betrayal and abandonment often came to the fore’.[351] Giordano offers an explanation for those findings, arguing that the use of coercive intervention erodes the trust between patient and clinician that is necessary to reach a clinically successful outcome.[352] Evidence of patient/clinician tension can be seen in the cases. ER had ‘little confidence’ in her GP and did not feel comfortable disclosing important symptoms.[353] The relationship between Miss W and Dr X had also become ‘strained’.[354] These dysfunctional therapeutic relationships have profound implications given that one of the most important factors for patients undergoing treatment for anorexia nervosa is their relationships with their carers.[355] That is, patients’ trust in their carers is central to their decision to accept and engage in treatment.[356] In this way, compulsory feeding can threaten one of the key requirements of recovery. The goal of prolonging life to facilitate recovery is not a wholly convincing reason to authorise compulsory feeding, considering the treatment can facilitate precisely the opposite outcome.

Moreover, the long-term effectiveness of compulsory treatment for anorexia nervosa is generally unclear. One study found that the benefits of compulsory hospitalisation for anorexia nervosa patients were inconclusive, and that the treatment

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[351] Stephen Touyz and others, ‘Clinical, Legal and Ethical Implications of Coercion and Compulsory Treatment in Eating Disorders: Do Rapid Review Findings Identify Clear Answers or More Muddy Waters?’ (2024) 12 Journal of Eating Disorders 1, 10.

[352] Giordano, ‘Understanding Eating Disorders’ (n 211211) 229.

[353] *ER* (n 32) [24].

[354] *Miss W* (n 326) [14].

[355] Jacinta Tan and others, ‘Attitudes of Patients with Anorexia Nervosa to Compulsory Treatment and Coercion’ (2010) 33(1) International Journal of Law and Psychiatry 13.

[356] ibid.

was associated with 'significant stress and potentially negative outcomes'.[357] Another study found that higher levels of perceived coercion—not even formal coercion through the MCA or Mental Health Act 1983—were associated with a significantly higher drive for thinness, body dissatisfaction, neuroticism, and depression scores.[358] Patients who experienced higher perceived coercion were also less likely to successfully transition to a partial hospitalisation program.[359] Further, there is little evidence on how patients who do achieve recovery come to regard their experience of compulsory feeding. In the one study that was found, the patient's attitude towards compulsory feeding was torn; she stated that it was 'traumatising' but also acknowledged that it her saved her life.[360] In her words, it was a 'confusing legacy of care to be left with'.[361] These findings cast doubt on the effectiveness of compulsory treatment as a means of helping patients achieve long-term recovery, and the lasting impact on patients if treatment is successful. Evidently, when contemplating whether to authorise compulsory treatment, judges cannot cite the goal of prolonging the patient's life to facilitate recovery in full confidence that this goal will be realised.

It is also important to analyse the 'cycle' of treatment that Morgan J identifies in her statement. Crucially, the patients in cases arising before the court will almost certainly have SE-AN. They will have passed the critical window for intervention of

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[357] Agnese Minuti and others, 'Coercion and Compulsory Treatment in Anorexia Nervosa: A Systematic Review on Legal and Ethical Issues' (2023) 35(2) Psychiatria Danubina 206, 214.

[358] Colleen C Schreyer and others, 'Perceived Coercion in Inpatients with Anorexia Nervosa: Associations with Illness Severity and Hospital Course' (2016) 49(4) International Journal of Eating Disorders 345, 401.

[359] ibid.

[360] Fuller, Tan, and Nicholls (n 289) 166.

[361] ibid.

three years, greatly reducing the likelihood that they will achieve recovery.[362] Moreover, Stephen A. Wonderlich and co-authors found that:

> Patients with [SE-AN] are particularly likely to report having experienced extreme or coercive efforts to increase body weight, typically in higher levels of care, only to be followed by "weight relapse" and a revolving door pattern of admission and discharge…Repeat attempts at refeeding that include limitations of privileges, intrusive observation, forced bed rest, and involuntary treatment measures can become unproductive and even traumatic for the patient, increasing the likelihood of them refusing future interventions.[363]

This 'revolving door' pattern of treatment is a recurring theme in the cases. Moor J recognised that RD's 'cycle of compulsory admissions' improved her BMI only by causing her distress, and that any weight restoration was lost upon returning to the community.[364] Patricia, too, immediately lost any weight gained through compulsory feeding.[365] Additionally, Cobb J described Ms X's treatment as an 'increasingly predictable and immensely damaging cycle'.[366] As Wonderlich and co-authors found, these patterns of treatment can be harmful to the patient. Not only is the treatment torturous, but the outcome—a higher BMI—is torturous as well. This intensifies patients' desire for control over their diet, causing weight loss and the restart of the cycle. When such patterns are present, the likelihood of recovery lowers drastically, making the goal of recovery a far less convincing reason to continue compulsory

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[362] Zipfel and others (n 94).

[363] Stephen A Wonderlich and others, 'Severe and Enduring Anorexia Nervosa: Update and Observations About the Current Clinical Reality' (2020) 53(8) International Journal of Eating Disorders 1303, 1309.

[364] *RD* (n 25) [34].

[365] *Re Patricia* (n 129) [3].

[366] *Ms X* (n 20) [2].

treatment. Tellingly, these treatment cycles are frequently present when judges deem compulsory feeding to be futile.

The grim reality is that, as Cynthia Geppert, Joel Yager, and Jeanne Kerwin state, the likelihood of complete recovery for patients with SE-AN can be ‘slim’.[367] The often-lifelong battles experienced by the patients who come before the Court of Protection demonstrate the ‘unremitting’ nature of SE-AN.[368] Where the patient, family, and all clinicians agree that compulsory treatment should be withdrawn—usually because every possible treatment has been attempted and no progress has been made—it is perhaps not a misuse of the word ‘terminal’ to describe the patient’s illness. To avoid subjecting individuals to purposeless harm, there can come a stage at which the cycle should be stopped. This is necessary to avoid reaching a point at which patients feel, as Ms X did, that ‘rather than helping me, [treatment] is actually making me worse’.[369] As such, a consensus between the parties like that seen in *BG* and *Re E,* or a medical history of many years of unsuccessful cycles of treatment, weakens the goal of prolonging life as a justification for compulsory treatment.

Even if Kong were correct to suggest that protecting a patient’s ‘thick’ sense of autonomy would justify overriding her refusal of medical treatment, that reasoning cannot also justify the consequences of that decision: the unique torture of compulsory feeding. Force-feeding precipitates trauma by depriving patients of *precisely* the thing

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[367] Cynthia MA Geppert, Joel Yager, and Jeanne Kerwin, ‘Futility’ in Patricia Westmoreland (ed) *Tipping the Scales: Ethical and Legal Dilemmas in Managing Severe Eating Disorders* (American Psychiatric Association Publishing 2020) 167.

[368] ibid.

[369] *Ms X* (n 20) [51].

they want most: control. It is also one of the most severe infringements of bodily integrity imaginable, a harm that is intensified by the fact that anorexia nervosa patients experience a far more sensitive connection with their bodies than the average person. The justification for authorising that level of suffering must be concrete and substantial. The goal that Kong identifies is certainly insufficient. Given that the outcomes of long-term compulsory feeding are at best uncertain and at worst a source of further physical and psychological harm to the patient, even the goal of prolonging life to facilitate recovery will not always be sufficiently robust. Thus, judges' decisions in these cases are immensely complicated by the nature of treatment for anorexia nervosa. Whilst withdrawal of compulsory treatment bears the risk of harm and death, *so too* does the authorisation of compulsory treatment. What in other circumstances is a decision that could have a very strong justification—continue compulsory treatment to prevent suffering and enable recovery—becomes extraordinarily complex in these scenarios.

CONCLUSION

This thesis has attempted to deconstruct a category of cases which, although once quite obscure, is arising far more frequently in the Court of Protection. The consequences of such cases are immense, regardless of which course of action the judge finds to be in the patient's best interests. Indeed, one of the defining features of these cases is that the decision is likely to have an undesirable outcome in the short or long-term, or both. This research has shown why this is so, using the clinical features of anorexia nervosa, theories of personal autonomy, and bioethical studies on compulsory feeding to elucidate how the quandary is created.

Anorexia nervosa is a severe mental disorder that is associated with intense fear of weight gain and the persistent belief that one is 'fat' despite extremely low body weight. Although these symptoms undoubtedly have an impact on patients' experiences of the world, a diagnosis of anorexia nervosa is not sufficient evidence that patients lack the ability to autonomously refuse medical treatment. On the contrary, patients with anorexia nervosa can engage in complex, articulate reasoning that meets the criteria for autonomy about many aspects of their lives, if not in relation to food. This is the first confounding factor in these best interests assessments. Authorising compulsory feeding ignores the possibility that patients may be making an autonomous decision to refuse medical treatment—a right that is legally protected. Yet, honouring the patient's autonomy will very likely lead to her death. Judges are faced with an impossible choice: resist paternalistic impulses and respect the patient's autonomy at the cost of her life, or prolong the patient's life at the cost of overriding her autonomy.

The nature of treatment for anorexia nervosa creates a second conundrum. Compulsory feeding through NG or PEG tubes, often under restraint or sedation, can be an intensely traumatic experience for patients. One of the key attributes of anorexia nervosa is the need for control, and the defining feature of compulsory feeding is the deprivation of control over one's body. In this way, compulsory feeding produces the exact harm from which patients are attempting to escape. This is compounded by the fact that compulsory feeding is a severe infringement of the right to bodily integrity. Once again, judges are at an ethical impasse: they must decide between authorising death or authorising a treatment that generates and perpetuates enormous suffering.

These two confounding factors explain why it is so difficult to determine whether a judge has reached the correct conclusion in this type of case. Very often, there is no decision that can be deemed correct from a legal, ethical, and medical standpoint. It is unsurprising, therefore, that judges so often refer to the 'difficulty', the 'gravity', and the 'burden' of these decisions.

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