Involuntary Treatment of Patients With Life-Threatening Anorexia Nervosa

Patricia Westmoreland, MD, Craig Johnson, PhD, Michael Stafford, JD, Richard Martinez, MD, MH, and Philip S. Mehler, MD

Anorexia nervosa has the highest mortality rate of any psychiatric illness. Predictors of mortality include chronicity of the illness, critically low body weight, and binging and purging behavior. Delusional beliefs body image, coupled with impaired judgment and cognition caused by starvation, often result in these patients adamantly resisting efforts to treat them. Guardianship, although useful in assisting with medical treatment decisions for patients with anorexia nervosa who are critically medically ill, is usually an inadequate intervention with respect to psychiatric treatment for these patients. Despite the severity and risk of the illness, there is often reluctance among providers to initiate involuntary treatment for patients with anorexia nervosa. Recent legal cases involving patients with anorexia nervosa have addressed the role of the committing court in authorizing treatment decisions and, in one case, opining that a patient was best served by receiving treatment in another state. Other related concerns addressed by the courts include ensuring that appropriate criteria are used for hospital admission, clarifying that the definition of grave disability as it pertains to anorexia does not require that the patient be close to death and that medications are often warranted in treating patients with the disease.

J Am Acad Psychiatry Law 45:419–25, 2017

Anorexia nervosa is a severe mental illness with a high rate of mortality and morbidity. The crude mortality rate is 5.1 percent per decade, and the standardized mortality ratio is 6 percent.[1,2] The mortality rate 10 years after hospitalization is 10 times greater than in an age- and gender-matched population, and half of deaths occur in the first three years after hospitalization. Medical complications arise as a direct result of weight loss and malnutrition, but there are no studies that define which body mass index is associated with a particular medical complication.[3] Suicide and medical complications directly related to the illness are the most common causes of death, and the average age at death is 34 years. This makes anorexia nervosa the most lethal psychiatric illness.[4–7] Treatment effectiveness is mixed, with only 50 percent of patients reporting full recovery, 30 percent achieving partial recovery, and 20 percent remaining severely ill. Anorexia nervosa primarily affects adolescent and young adult females, and the mean duration of illness until recovery with treatment, is seven years.[8–10] Early intervention and normalization of weight are positive prognostic indicators that suggest a full course of treatment early in the course of the illness bodes well for recovery.[11,12]

Despite the severity and risk of the illness, there is often reluctance to subject patients with anorexia nervosa to civil commitment. However, given the high mortality associated with anorexia nervosa, this permissive approach may have direct adverse consequences. Patients with a very low body mass index, those with critically abnormal electrolytes or EKG findings, and those who continue to engage in life-threatening behaviors while eschewing voluntary treatment constitute a subset of patients for whom involuntary treatment may be life saving.[13] Land-

Dr. Westmoreland is an attending psychiatrist, Dr. Johnson is Chief Science Officer and Director of the Family Institute, and Dr. Mehler is Chief Medical Officer, Eating Recovery Center, Denver, CO. Dr. Westmoreland is an consulting psychiatrist and Dr. Mehler is Executive Medical Director, ACUTE Center for Eating Disorders, Denver Health, Denver, CO. Mr. Stafford is City Attorney and Director of Mental Health Division, City and County of Denver, Denver, CO. Dr. Martinez is Professor of Psychiatry and Law and Director of Forensic Training, Department of Forensic Psychiatry, University of Colorado, Denver School of Medicine, Dr. Mehler is Professor of Internal Medicine, Department of Medicine, University of Colorado, Denver, CO and Dr. Westmoreland is an adjunct assistant professor, University of Colorado, Denver, CO. Address correspondence to: Patricia Westmoreland, MD, Eating Recovery Center, 1830 Franklin Street, Suite 500, Denver, CO 80218. E-mail: patricia.westmoreland@eatingrecovery.come.

Disclosures of financial or other potential conflicts of interest: None.

mark cases involving patients with anorexia nervosa have addressed the role of the committing court in authorizing treatment decisions and, in one case, opining that a patient was best served by receiving treatment in another state. Other related concerns addressed by the courts include insuring that appropriate criteria are used for hospital admission, clarifying that the definition of grave disability does not necessitate that the patient be close to death and that medications are often warranted for these patients.[14,15] In the following sections, we will review how case law has informed clinical decision-making regarding anorexia nervosa and what the modest outcome literature about compulsory treatment has demonstrated.

Types of Involuntary Treatment

In general, patients incapacitated because of medical illnesses, in the absence of an available proxy decision-maker, are often appointed legal guardians who are authorized to make medical decisions for their incapacitated wards. If, however, a proxy decision-maker is available, that individual usually has the authority to make medical decisions for the incapacitated patient. In general, guardianship is a useful mechanism for decision-making regarding medical care for a ward, but it is not an adequate mechanism when it comes to psychiatric treatment of patients with eating disorders. For example, when medically compromised, patients with severe life-threatening anorexia may be forcibly tube-fed, based on the decision of a court-appointed guardian. This authority usually does not extend to continued feeding or to psychiatric care once patients become more medically stable. In addition, a guardian may not initiate the commitment of a ward to a mental health institution or facility except in accordance with the respective state's procedure for involuntary civil commitment and use of emergency and involuntary psychiatric medications.

For individuals with mental illness, states have carved out separate legal and procedural mechanisms for providing psychiatric care to the incompetent patient who refuses potentially beneficial treatments. Civil commitment usually requires psychiatrists to establish that an individual is dangerous to self or others and is gravely disabled, to hospitalize an individual involuntarily. Although procedures and criteria vary across jurisdictions, providing involuntary medications to those with mental illness, in many jurisdictions, is an additional step beyond commitment. In Colorado, for example, for treatment to begin over a patient's objection, the state requires that the person not only be mentally ill and incompetent to participate in rational choices for psychiatric care, but the treatment must be necessary to prevent harm to others or to the patient or to prevent deterioration in the patient's mental health.[16] In addition, most jurisdictions require that it be established that there are no less intrusive treatment alternatives. In Colorado, for example, involuntary tube-feeding is designated a special procedure, much like electroconvulsive therapy, and requires a separate hearing.

There is a growing awareness that some patients with anorexia nervosa may indeed need involuntary treatment, and thus medical providers may have a professional obligation to pursue mechanisms that result in such treatment. As with all medical and surgical interventions, ethics-related dilemmas are inevitable. The question of involuntary treatment of those with eating disorders presents some unique challenges, but challenges that are subject to the ethics balancing of benefits and harms. Further complicating challenges in involuntary treatment of those with eating disorders are ambiguities about what defines competency to refuse treatment in the patient with an eating disorder, how the clinician weighs the benefit of involuntary treatment against the harm of refused treatment, and the potential harm of invading the liberty interests and privacy of the patient who refuses treatment. Although there are no clear answers that can be applied to all cases where involuntary treatment should be considered, these basic principles of ethics should guide clinicians and should be considered in a transparent and analytic manner. Consultation with hospital-based ethics committees is strongly recommended in all of these cases.

We reviewed the literature on PubMed from 1980 to 2015, using the key words "anorexia nervosa," "eating disorder," and "involuntary treatment," and included publications that addressed involuntary treatment in adolescent or adult patients with eating disorders. We excluded publications regarding the pediatric population, and those that were not written in English (unless a translated version was available). We also searched Westlaw, a legal database, for cases pertaining to anorexia nervosa and involuntary treatment. In addition, the Colorado cases were available through a limited-access search of the public records.

Andersen wrote, "If a patient's clinical condition meets common legal criteria for petition for involuntary admission to hospital and treatment, there is no reason the category of eating disorders should be excluded from consideration for life-saving treatment" (Ref. 17, p 10). Authors noted that the literature largely endorses involuntary treatment for patients with eating disorders when the patients do not meet criteria for capacity to consent to their own treatment, and when the outcome of involuntary treatment may be lifesaving.[18]

Civil commitment of a patient with anorexia nervosa may be less commonly pursued than commitment of a patient with other forms of severe mental illness. In part, this discordance may exist because patients with anorexia nervosa are usually very intelligent and self-disciplined.[19] They present themselves well, and, in court proceedings, portray themselves as credible witnesses when providing rational explanations for their aberrant eating behavior, while being cautious not to express the intent to die of their illness. There are also persistent myths regarding eating disorders such as anorexia nervosa, that mandated treatment is futile, chronicity is inevitable, and anorexia is indistinguishable from culturally normative weight concerns.[17]

Anorexia nervosa is a chronic illness, and the patients are typically young. Thus, the danger of death may not be thought to be imminent by the courts. Per a review of guidelines for assessing and presenting subtle forms of patient incompetence, clinicians who present evidence citing the need for commitment of patients with severe eating disorders should carefully document the distortions of body image and food-related concerns inherent in these disorders.[19] In discussing the cognitive distortions related to anorexia, it is useful to trace the genesis of the illness. In general, cultural ideals of beauty and thinness may incite the development of disordered eating in vulnerable individuals who have a genetic predisposition toward anxiety and perfectionism.[20] Starvation and purging may initially calm these feelings of anxiety and reduce obsessions and compulsions via a serotonergic neuronal pathway.[21,22] Prolonged caloric deprivation leads to impaired cognition, which may result in patients' becoming frankly delusional regarding their food intake and body size.

Although patients with anorexia nervosa who are treated involuntarily have lower admission weights, longer illness duration, and require a longer hospitalization to achieve a healthful discharge weight,[23] there is no difference in the rate of weight restoration for patients treated on a voluntary versus involuntary basis.[23–25] Almost half of patients treated involuntarily (who previously did not endorse needing admission), agreed in hindsight and after just two weeks of treatment, that they had indeed needed treatment.[26] A recent review of compulsory treatment in patients with anorexia nervosa also demonstrated that, in the short term, compulsory refeeding may be beneficial.[14] However, notwithstanding the aforementioned similarity in the rate of weight restoration and short-term benefits of compulsory refeeding, patients with an eating disorder who are treated involuntarily may have a less favorable long-term outcome.[14,24] According to the study by Ramsey and colleagues,[24] this is not a result of the involuntary treatment itself. It appears that selection factors associated with the severity of their illness (such as a history of physical or sexual abuse and self-harm) were responsible for the less favorable long-term outcome in this study.[24]

In a recent follow-up study, Ward *et al.*[27] compared the mortality outcome of 81 patients, who had been admitted voluntarily, to the mortality rate of the same number of patients who were admitted involuntarily. The mortality rate of the patients treated involuntarily was significantly higher than for those treated voluntarily in the first five years after admission. However, there was no significant difference in mortality between the two groups 20 years after admission. Thus, the elevated mortality rate associated with involuntarily treatment is attenuated over time. The initial excess mortality in involuntary patients may be caused by their more weakened state of physical health, or may have more associated comorbidities than those who do not require involuntary treatment. The attenuation of mortality over time found by Ward *et al.* is in line with that in another study[28] citing the risk of premature death in anorexia nervosa as being highest in the first ten years of follow-up.

In a study of five patients who died of their eating disorders, Holm and colleagues suggested[13] that respect for patients' autonomy contributed to the fatal outcome. Because of the known neuropsychiatric disturbances and cognitive impairments that result from prolonged and severe starvation, the "reasonableness" of treatment refusal is questionable. They pointed out that increased chronicity is a risk factor for death in anorexia nervosa and emphasized the

need to treat early and, if needed, to force treatment early in the course of the illness. This would prevent patients from becoming more chronically ill and thus at a higher risk of death. Recently, other authors have noted that there is a point at which treatment of anorexia nervosa is futile, and patients with a severe and enduring form of the illness should be allowed to die with dignity.[29–31] This approach may be necessary for a select number of patients who are chronically ill and in whom treatment has failed multiple times. However others have argued that futility is a concept "whose time has not yet come" for patients with anorexia nervosa.[32]

When physicians pursue involuntary treatment, they are likely to find themselves in opposition to the patient or family, who are angry that the patient is being forced to endure the indignity of involuntary treatment. The treating psychiatrist often bears the brunt of their anger, and psychiatrists have to be aware that countertransference may result from these situations. If a treating psychiatrist leans toward palliative care, he might expect a barrage of criticism for allowing a patient to die of an illness that has a strong volitional component, especially if that patient is relatively young. This outcome may provoke strong responses in the treating psychiatrist, who may feel unjustly criticized for allowing such a death when involuntary treatment is available.

There is some agreement that rigorous criteria are needed for involuntary treatment of patients with eating disorders. Suggested guidelines for involuntary treatment include the presence of cardiac arrhythmias, severe blood chemistry abnormalities, acute psychiatric or ominous medical symptoms, suicidal ideation, a body mass index (BMI) <13, or a poor response to prior interventions.[33,34] Further refinement of these criteria may assist in formulating a better definition of parameters for involuntary treatment. Moreover, an understanding of how the legal system has heretofore dealt with cases involving eating disorders may make it possible to elucidate ways to approach involuntary treatment for these patients.

Court Cases Involving Eating Disorders

Each state has its own laws concerning civil commitment and involuntary treatment of patients with psychiatric disorders. Courts in several states have applied these statutes with respect to treatment of patients with eating disorders, and a consideration of some of those decisions may be helpful.

In the Matter of Joanne Kolodrubetz

Ms. Kolodrubetz presented to the facility where she was committed with an extensive history of severe anorexia, to the degree that her life was repeatedly endangered by her behaviors when she was not in treatment. Ms. Kolodrubetz did not agree with the treatment modality at the facility and pursued the administrative process. After that process had run its course, the findings and recommendations were unsatisfactory to her, and she petitioned the committing court for relief. The district court denied her relief, and she appealed.[35]

The appellate court determined that the Minnesota statutory process provided for court action only to the extent of making the initial legal determination of whether the patient met legal criteria for involuntary committal. Then, the administrative process was available to the patient to review the efficacy of one treatment modality versus another. The appellate court noted the court had repeatedly stressed that the committing court may not involve themselves in treatment decisions.[35]

The appellate court noted that the remedy for a patient who disagreed with the findings and recommendations generated by the administrative process was for the patient to file a lawsuit, seeking damages. The appellate court noted in dicta that legal standard in such a lawsuit was whether the treatment pursued by the facility was within accepted professional standards[35] and that there was no indication that the facility's treatment of Ms. Kolodrubetz fell outside of that standard.

Of interest is the appellate court's statements in the form of dicta recognizing several of the behaviors that make anorexia nervosa such a difficult disorder to treat.

In the Matter of Molly Kellor

In *Kellor*,[36] the People appealed a Minnesota District Court case authorizing the patient to receive treatment in an out-of-state facility. In Minnesota, the committing court only makes the initial legal determination as to whether the patient meets statutory criteria for commitment. Once that judicial determination is made, the court will not review specific treatment modalities.

Ms. Kellor was initially committed to the University of Minnesota Hospital for a period of six months. She was subsequently committed to the University of Minnesota Hospital for a period of 12

months, to be transferred to Willmar State Hospital when medically stable. Ms. Kellor was transferred to Willmar where her weight was partially restored through tube feeding, but she gained little if any insight into her eating disorder and had a conflictual relationship with the treatment staff.

Ms. Kellor sought to go to eating disorder–specific treatment at an out-of-state facility, Laureate Psychiatric Clinic and Hospital, in Oklahoma. The district court granted her request, finding that there was no in-state facility that offered eating disorder–specific treatment in Minnesota and that under Minnesota statute, the patient was entitled to receive appropriate treatment in the least restrictive setting.

The appellate court applied the "clearly erroneous" standard of review. If there was support in the testimony for the trial court's findings, the judgment would not be set aside, given that the trial court is afforded discretion as to how much weight to attach to the evidence presented at hearing.

The appellate court finally held that the trial court had wide discretion in determining the least restrictive setting.

In re S.A.M.

In this case,[37] S.A.M. appealed an Iowa District Court case determining that she met the definition of a person with a serious mental impairment and as a result, was likely to inflict physical injury upon self or others if allowed to remain at liberty. When filing the appeal, S.A.M. admitted that she had a mental illness, anorexia nervosa, and therefore did not challenge the trial court's findings that she had a serious mental impairment. S.A.M. challenged the trial court's finding that there was clear and convincing evidence that she was likely to inflict physical harm to self if she were allowed to remain at liberty.

The reviewing court first examined the term "likely" in the statutory language and found that likely has been construed to mean probable or reasonably to be expected. Given that S.A.M. had been able to maintain a stable body weight while in outpatient treatment just before being rehospitalized and had never experienced metabolic abnormalities, even at a lower body weight, the reviewing court determined that there was not clear and convincing evidence that it was probable or reasonably expected that S.A.M. was likely to inflict physical injury upon herself if she was allowed to remain at liberty. Therefore, the trial court's ruling was reversed.

In re P.A.

In *In re P.A.*, 12CA1024, 13CA1350, not published pursuant to C.A.R. 35(f),[38,39] P.A., who was well known to the legal system, had been certified several times for involuntary mental health treatment, including medications and feeding tubes.

Under the Colorado statutory scheme, the professional person associated with a facility designated for mental health treatment initiates the involuntary treatment process by filing certification paperwork with the district court in the appropriate venue.

In the underlying cases in 12CA1024 and 13CA1350, the respondent requested a trial. In both instances, the trial court upheld the short-term certification for the statutory three-month period, determining that P.A. was a danger to self and gravely disabled. The trial court also granted both involuntary medication administration authority to the designated facility and authority to place a feeding tube involuntarily. Of note is that the respondent presented with a low body weight of 43 lb upon one admission and maintained persistently low body weights that were clinically unacceptable.

P.A. appealed both decisions, alleging that because her weight had been partially restored in the facility, she was no longer gravely disabled or a danger to self, as she was no longer near death. The appellate court found that "the definition of gravely disabled does not require that respondent be near death. Instead, it only requires that respondent be in danger of serious physical harm because of an inability or failure to provide one's self with the essential human needs of food and medical care" (*In re P.A.*, p 7) The appellate court specifically did not entertain whether P.A. was a danger to herself.

Conclusion

Anorexia nervosa is a psychiatric illness with formidable rates of morbidity and mortality. Not understanding this ominous reality, mental health professionals are often reluctant to treat these patients on an involuntary basis, either via guardianship laws or civil commitment. However, this respect for a patient's autonomy may lead to a fatal outcome in patients with eating disorders.[13] In addition, patients who are initially resistant to treatment may later realize they needed treatment.[26] Furthermore, the rate of weight gain appears to be equivalent in patients treated on a voluntary versus an involuntary basis.[23]

Advocates of palliative care for life-threatening anorexia nervosa cite chronicity of illness (and futility of further treatment) as a reason to favor palliative care for these individuals as opposed to involuntary treatment.

We believe that civil commitment is warranted on occasion and clinically prudent for patients whose lives are threatened by severe eating disorders. Case law has demonstrated that the courts, although stringent regarding the correctness of the data presented for commitment, are also willing to accept the manifestations of eating disorders as overvalued ideas/beliefs that may require treatment with psychotropic medication. What appears to be missing are specific criteria that could be used in deciding whether a patient with a severe, life-threatening eating disorder should be civilly committed and treated on an involuntary basis. Such criteria may include the presence of medical conditions, such as dangerous cardiac arrhythmias and severe hypoglycemia; chronicity of the illness, failed prior voluntary treatments; and criteria such as danger to self or others that are already in use for patients with other psychiatric disorders. In addition, weight-related criteria may be useful.

Criteria may exist for deciding not to commit a patient with a severe life-threatening eating disorder. Thought must be given to the duration and chronicity of the illness, the number of prior treatments, and whether there has ever been any meaningful degree of freedom from illness.[29] Although civil commitment could be pursued in a patient with a critically low BMI and abnormalities in blood work results or their EKG, it does not mean that it should be pursued automatically. Doing so may ultimately be more harmful than helpful, especially in patients who have a history of multiple prior treatments with little to no time spent in remission. Even though anorexia nervosa has the highest mortality rate of any psychiatric illness, most patients survive and thankfully such cases are rare. Appropriate treatment options should always be fully explored before summarily deciding on palliative or hospice care for a patient with a severe and enduring eating disorder.

References

1. Arcelus J, Mitchell AJ, Wales J, *et al*: Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. Arch Gen Psychiatry 68:724–31, 2011
2. Crow SJ, Peterson CB, Swanson SA, *et al*: Increased mortality in bulimia nervosa and other eating disorders. Am J Psychiatry 166: 1342–6, 2009
3. Westmoreland P, Krantz MJ, Mehler PS: Medical complications of anorexia nervosa and bulimia nervosa. Am J Med 129:30–7, 2016
4. Sullivan PF: Mortality in anorexia nervosa. Am J Psychiatry 152: 1073–4, 1995
5. Hoek HW: Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. Curr Opin Psychiatry 19:389–94, 2006
6. Haus C, Caille A, Godart N, *et al*: Factors predictive of ten-year mortality in severe anorexia nervosa patients. Acta Psychiatr Scand 123:62–70, 2011
7. Emborg C: Mortality and causes of death in eating disorders in Denmark 1970–1993: a case register study. Int J Eat Disord 25:243–51, 1999
8. Keel PK, Brown TA: Update on course and outcome in eating disorders. Int J Eat Disord 43:194–204, 2010
9. Strober M, Freeman R, Morrell W: The long-term course of severe anorexia nervosa in adolescents: survival analysis of recovery, relapse, and outcome predictors over 10–15 years in a prospective study. Int J Eat Disord 22:339–60, 1997
10. Steinhausen HC, Seidel R, Winkler Metzke C: Evaluation of treatment and intermediate and long-term outcome of adolescent eating disorders. Psychol Med 30:1089–98, 2000
11. Accurso EC, Ciao AC, Fitzsimmons-Craft EE, *et al*: Is weight gain really a catalyst for broader recovery? The impact of weight gain n psychological symptoms in the treatment of adolescents anorexia nervosa. Behav Res Ther 56:1–6, 2014
12. LeGrange D, Fitzsimmons-Craft EE, Crosby RD, *et al*: Predictors and moderators of outcome for severe and enduring anorexia nervosa. Behav Res Ther 56:91–8, 2014
13. Holm JS, Brixen K, Andries A, *et al*: Reflections on involuntary treatment in the prevention of fatal anorexia nervosa: a review of five cases. Int J Eat Disord 45:93–100, 2012
14. Elzakkers IFFM, Danner UM, Hoek HW, *et al*: Compulsory treatment in anorexia nervosa: a review. Int J Eat Disord 47:845–52, 2014
15. Clausen L, Jones A: A systematic review of the frequency, duration, type and effect of involuntary treatment for people with anorexia nervosa, and an analysis of patient characteristics. J Eating Disord 2:29–38, 2014
16. Colo. Rev. Stat. § 27-65-101 (2013)
17. Anderson AE: Eating disorders and coercion. Am J Psychiatry 164:9–11, 2007
18. Bryden P, Steinegger C, Jarvis D: The Ontario experience of involuntary treatment of pediatric patients with eating disorders. Int'l J L & Psychiatry 33:138–43, 2010
19. Gutheil TG, Bursztajn H: Clinicians' guidelines for assessing and presenting subtle forms of patient incompetence in legal settings. Am J Psychiatry 143:1020–3, 1986
20. Lulé D, Schulze UME, Bauer K, *et al*: Anorexia nervosa and its relation to depression, anxiety, alexithymia and emotional processing deficits. Eat Weight Disord 19:209–216, 2014
21. Kaye WH, Fudge JL, Paulus M: New insight into symptoms and neurocircuit function in anorexia nervosa. Nat Rev Neurosci 10: 573–84, 2009
22. Zink CF, Weinberger DR: Cracking the moody brain: the rewards of self- starvation. Nat Med 16:1382–3, 2010
23. Watson TL, Bowers WA, Anderson AE: Involuntary treatment of eating disorders. Am J Psychiatry 157:1806–10, 2000
24. Ramsey R, Ward A, Treasure J, *et al*: Compulsory treatment in anorexia nervosa: short-term benefits and long-term mortality. Br J Psychiatry 175:147–53, 1999
25. Brunner R, Parzar P, Resch F: Unfreiwillige Hospitalisierung von Patienten mit Anorexia nervosa: Klinische Aspekte und empirische Befunde. [Involuntary hospitalization of patients with anorexia ner-

vosa: clinical issues and empirical findings.] Fortschr Neurol Psychiatr [Modern Neurology and Psychiatry] 73:9–15, 2005
26. Guarda AS, Pinto AM, Coughlin JW, *et al*: Perceived coercion and change in perceived need for admission in patients hospitalized for eating disorders. Am J Psychiatry 164:108–14, 2007
27. Ward A, Ramsey R, Russell G, *et al*: Follow-up mortality study of compulsorily treated patients with anorexia nervosa (published correction in Int J Eat Disord 49:435, 2016). Int J Eat Disord 48:860–5, 2015
28. Franko DL, Keshaviah A, Eddy KT, *et al*: A longitudinal investigation of mortality in anorexia and bulimia nervosa. Am J Psychiatry 170:917–25, 2013
29. Lopez A, Yager J, Feinstein RE: Medical futility and psychiatry: palliative care and hospice care as a last resort in the treatment of refractory anorexia nervosa. Int J Eat Disord 43:372–7, 2010
30. McKinney C: Is resistance (n)ever futile? A response to "Futility in chronic anorexia nervosa: a concept whose time has not yet come" by Cynthia Geppert. Am J Bioethics 15:53–4, 2015
31. McKenzie R: Ms. X: A promising new view of anorexia nervosa, futility, and end-of-life decisions in a very recent English case. Am J Bioeth 15:57–8, 2015
32. Geppert CMA: Futility in chronic anorexia nervosa: a concept whose time has not yet come. Am J Bioeth 15:34–43, 2015
33. Thiel A, Paul T: Compulsory treatment in anorexia nervosa. Psychother Psychosom Med Psychol 57:128–35, 2007
34. Thiels C: Forced treatment of patients with anorexia. Curr Opin Psychiatry 21:495–48, 2008
35. In the Matter of Kolodrubetz, 411 N.W.2d 528 (Minn. Ct. App. 1987)
36. In the Matter of Kellor, 520 N.W.2d 9 (Minn Ct. App. 1994)
37. In re. S.A.M., 695 N.W.2d 506 (Iowa Ct. App. 2005)
38. In the interest of P.A., No. 12CA1024 (Col. App. 2012), unpublished
39. In the interest of P.A., No. 13CA1350 (Col. App. 2013), unpublished