COMMENTARY

The Competency Paradox in Somatic Disease

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Westmoreland *et al.* have reviewed factors associated with provider reluctance to initiate and judicial reluctance to authorize civil commitment and involuntary treatment for persons with severe anorexia nervosa. Their analysis of the legal, medical, and psychiatric elements that affect treatment outcomes contributes to professional understanding of a complex topic. Although their proposal to create guidelines for involuntary treatment for persons with eating disorders may be of clinical utility, guidelines should not be promulgated for the purposes of reaching judicial findings of law.

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Westmoreland *et al.*[1] provide a valuable contribution to the literature in describing the clinical and legal challenges in obtaining involuntary treatment for persons with anorexia nervosa. They review the medical severity and high mortality rate of anorexia nervosa, the limitations to obtaining meaningful treatment via guardianship, and case law that has shaped treatment determinations in some case proceedings. They also propose developing specific criteria to determine whether a person with severe anorexia nervosa should be civilly committed or involuntarily treated, although doing so could be problematic because of the paradigm differences between the law and medicine.

Each state has its own laws regarding when and how an individual can be required to receive treatment for mental illness. All state civil commitment statutes are predicated on an individual's posing a danger to self or others as a result of mental disorder.[2] Commitment standards may include being unable to care for one's basic needs because of the grave disability that the mental disorder creates.

In the 1970s and 1980s, two different approaches evolved regarding the right to refuse treatment: the treatment-driven professional judgment model and the rights-driven model.[3] Treatment-driven professional judgment allows clinical judgment to determine whether treatment refusal can be overridden, while still recognizing the patient's privacy interest. In this model, a medical expert or panel reviews a patient's objection to treatment, often independent of the treating clinician. In contrast, the rights-driven model requires external judicial review and focuses more on formal due process rights and court procedures.

Voluntary patients cannot be treated against their will unless found to lack decision-making capacity, and involuntary patients must similarly be found incompetent. Involuntary hospitalization because of danger to self or others, or grave disability does not establish a determination of incompetence. Rights-driven models require a formal evaluation of the refusing patient's competence. While states vary in procedures and oversight, a key feature is determination of incompetency to justify involuntary treatment that is carried out by a nonclinician, typically by a judge. States fall along a continuum from primarily medically oriented to primarily legally oriented civil commitment and involuntary treatment models.

Regardless of the legal models used in a particular jurisdiction, hearings on civil commitment and treatment refusal can often be informal and inquisitorial and can be conducted in a nonadversarial manner.[4] As Westmoreland *et al.* discuss, however, civil commitment and treatment determination proceedings for a person with anorexia nervosa can be particularly challenging and adversarial. Such individuals can present well in court, their cognitive distortions of

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their eating patterns may sound convincingly acceptable to a nonmedical audience, and the danger of mortality in a young population may not be perceived as imminent and life-threatening.

The review of the scientific literature by Westmoreland *et al.* supports the idea that treating clinicians should initiate civil commitment and involuntary treatment proceedings in extreme cases. The severity of the disease process of anorexia nervosa and its high mortality rate, especially in persons with very low body mass index, critically abnormal electrolytes, and cardiac conduction problems can create grave disability, which in most jurisdictions must translate into a legal determination made by a judge.[5]

Westmoreland *et al.* recommend developing specific criteria to aid civil commitment and involuntary treatment determinations. However, there are paradigmatic disciplinary differences between medicine and the law: conceptualizing and finding facts in the law should not be equated with clinical findings and treatment recommendations. Well-crafted clinical guidelines are designed to frame existing medical knowledge to assist health care providers in delivering high-quality care.[6] For example, practice guidelines are applied in court, but their use is generally discouraged and can be problematic.[7] Devising clinical guidelines specifically to make legal determinations on civil commitment and involuntary treatment is antithetical to the use of traditional evidentiary principles to render a judicial determination of the ultimate issue. Clinicians should provide useful testimony on grave disability and need for compulsory treatment of persons with severe anorexia nervosa in jurisdictions that require it, but scientific expertise is not the only element that goes toward legal determinations pertaining to individual rights and autonomy. That said, the medical and case law review in Westmorland *et al.* suggests that, when the behavior of anorexic patients endangers their lives, they should be committable under grave-disability standards. In such instances, clinicians should petition for civil commitment and treatment orders, and ordering commitment and treatment should be reasonable determinations made by a judge under certain circumstances.

Westmoreland *et al.* discuss other treatment interventions for anorexia nervosa as appropriate, including voluntary treatment in inpatient and outpatient settings and consideration of palliative care. They note that advocates of palliative care for life-threatening anorexia nervosa as opposed to involuntary treatment cite the illness's chronicity and the futility of continued treatment. Although palliative care encompasses a broad range of treatment goals and interventions, it can also include end-of-life care. In some states, end-of-life care options include physician-assisted death.

Arguments concerning physician assisted death for psychiatric disorders have historically focused on otherwise healthy persons with severe treatment-refractory depression.[8] For persons with depression, the desire to die is part of the disorder. However, the use of physician-assisted death in other psychiatric conditions, including eating disorders such as anorexia nervosa, also raises ethics-related concerns. The patient with anorexia's stoicism, cognitive distortions, and weakened physical state can hasten death in the absence of suicidal ideation, and response to additional treatment can be less certain. This can make assessing decision-making competence and understanding the nature of their suffering more difficult.

Physician assistance to help people end their lives is currently legal in some form in four American states, Canada, and four European countries.[8] The expansion of physician-assisted death within the United States is almost certain, so the question of its use for psychiatric disorders will inevitably arise. Understanding how the process works in other countries is therefore of utility. A review of euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands shows that most patients who choose euthanasia and assisted suicide have depressive disorders. However, other conditions represented were psychosis, posttraumatic stress or anxiety and somatoform, neurocognitive, and eating disorders. Patient characteristics include being mostly women, having concomitant personality disorders, significant physical problems, and social isolation.[9] Persons with anorexia nervosa can fit this profile, which raises serious concerns about implementing physician-assisted death for persons with severe eating disorders. These concerns circle back to ethics-based arguments supporting involuntary treatment in lieu of palliative care, so that all appropriate treatment options are pursued before deciding on palliative or hospice care.

The main problem is that persons with anorexia nervosa may be mentally competent to refuse care, even in the face of significant somatic disease. Hence, the task is how to decide whether and how such individuals

should be treated involuntarily when they are answering correctly all the competency questions posed to them. Although Westmoreland's proposal to create guidelines for involuntary treatment for persons with eating disorders may be of clinical utility, guidelines should not be promulgated for the purposes of reaching judicial findings of law. It is the province of the courts to weigh clinical and nonclinical factors and then determine whether to authorize involuntary treatment in such complicated dilemmas.

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