

MG Karels & H Oosthuizen

Dying to starve: A comparative analysis of legal aspects relating to consent in force-feeding of both minor and adult anorexic patients

Summary

The authors explore the legal complexities surrounding the force-feeding of anorexic patients. Due to the myriad of difficulties relating to *anorexia nervosa*, treatment is intricate. The aim of this exposition is to clarify legal issues of consent and self-determination, with regard to both adult and minor patients. In addition, the distinction between 'irrational' and 'incompetent' refusal will be discussed, with the authors maintaining that the 'irrational' refusal of an adult patient should be respected by the law. To come to an informed conclusion, the authors will first analyse the medical and psychological aspects of *anorexia nervosa*. Secondly, the South African position as shaped by the *Mental Health Care Act*, the *Children's Act* and the *National Health Act* will be contrasted with the position in Great Britain in order to determine the international perspective and its contrast, or not, to South African law.

Sterf deur verhongering: 'n Vergelykende ontleding van die wetlike aspekte van toestemming in gedwonge voeding van beide minderjarige en volwasse anoreksiese pasiënte

Die outeurs ondersoek hoe ingewikkeld die wetlike aspekte van gedwonge voeding van anoreksiese pasiënte is. Die problematiek rondom *anorexia nervosa* bemoeilik die behandeling daarvan. Die oogmerk van hierdie bespreking is om helderheid te bied ten opsigte van die regsaspekte van toestemming en selfbeskikking by kinders en volwasse pasiënte. Voorts sal die verskil tussen irrasionele en onbevoegde weiering van toestemming tot behandeling bespreek word. Die outeurs is van mening dat irrasionele weiering deur 'n volwassene deur die reg gerespekteer moet word. Ten einde 'n ingeligte gevolgtrekking te kan maak, sal die outeurs eerstens die geneeskundige en psigologiese aspekte van *anorexia nervosa*, ontleed. Bykomend daartoe sal die *Mental Health Care Act*, die *Children's Act* en die *National Health Act* van Suid-Afrika vergelyk word met soortgelyke wetgewing in Groot-Brittanje om internasionale perspektiewe te bepaal.

Miss Michelle G Karels, Senior Lecturer, Department of Criminal Law and Procedure, University of South Africa.

Prof. Hennie Oosthuizen, Head of Department of Criminal and Medical Law, University of the Free State.

Section One

Brief exposition of *anorexia nervosa* and the cause and treatment thereof

1. Preface

I have days, now, when I don't think much about my weight. I have days, at least, when I see properly, when I look in the mirror and see myself as I am – a woman – instead of as a piece of unwanted flesh, forever verging on excess.¹

The above attitude can be viewed from two perspectives: first, as the lament of an overly theatrical victim of self-hate or, secondly, as the sentiments of a disordered mind. Psychologically embedded pathology relating to *anorexia nervosa*² speaks towards a fascinating, complex disorder which does not appear to fit into acceptable norms of human thinking. *Anorexia nervosa*, bulimia and obesity³ are as familiar as our own skin and yet totally incomprehensible to the average person of normal (or not disordered) self-perception. Statistically *anorexia nervosa* can no longer be considered a 'white Westerner's' disease, but is on the rise in the African society and is affecting men on an increasing scale.⁴

Society (especially minors) is bombarded by a plethora of media images of emaciated women (and more recently men) that are said to have attained flawlessness through their physical dimensions.⁵ In the case of impressionable minors, the fact that these images are airbrushed and electronically manipulated to portray a reality which does not exist, is often not recognised. This manipulated 'reality' is, however, embraced, adored and emulated by countless millions who seek to attain a perceived perfection through mass. Perfection is a road strewn with many obstacles and the anorexic soon discovers that death is often the end product of these obstacles. The pursuit of weight control is not solely isolated to those emulating a trend, but can occur subsequent to a trigger such as sexual abuse, divorce or depression (to name but a few). Whether in the pursuit of fashion or as a result of a psychological trigger the inevitable deterioration in health amounts to the same result.

1 Hornbacher 1999:60.

2 The terms *anorexia* and *anorexia nervosa* are used interchangeably in this article – refer to footnote 11 for an explanation of the difference between the terms.

3 All classified as eating disorders in terms of the *Diagnostic and Statistical Manual /IV* (obesity is not yet classified in the DSM-IV 2005:541).

4 Buckroyd 2002:7. See further in this regard the Cultural Features under the DSM-IV 2005:542.

5 See also the DSM-IV Gender Features 2005:543.

Owing to the immense quantity of research available on the subject of eating disorders the authors think it prudent to discuss one in particular which appears to be the most prevalent and the most intricate to treat, namely *anorexia nervosa*.

Anorexia can be treated symptomatically or, as a last resort, by force-feeding.⁶ Currently, the South African *Mental Health Care Act* 17 of 2002⁷ requires that a patient give informed consent to treatment but anorexics are not capable of giving consent or of refusing treatment, as they are deemed unable to direct their own affairs owing to the nature of their pathology.⁸ The aim of this exposition is to clarify the issues of consent, with regard to majors and minors, and the right to refuse medical treatment for *anorexia nervosa*. From the South African perspective, the *Mental Health Care Act* 17 of 2002 will be examined as well as a specific section of the *Children's Act*⁹ and the *National Health Act*.¹⁰ The South African position will be contrasted with the legal position in Great Britain. The authors will examine the issue of self-determination and the impact of *anorexia nervosa* on the ability of the patient to refuse feeding and the subsequent issue of force-feeding. The authors will argue that in the case of minors the informed consent of the patient is not essential and that force-feeding will be in the child's best interest, but that the issue in adults is not as clear-cut as it first appears. The authors will argue that there is a difference between 'irrational refusal' and incompetent refusal and that 'irrationality' of decision-making in an adult anorexic should be respected by the law. For the purpose of clarity this submission is divided into two sections – the first will deal with the medical and psychological aspects of *anorexia nervosa* and the second will examine the legal aspects relating to consent to treatment and involuntary medical treatment.

6 Through the insertion of a naso-gastric tube which provides liquid sustenance directly into the stomach of the patient. http://search.medicinenet.com/search/search_results/default.aspx?navState=4294924268&sourceType=all&query=nasogastric (accessed on 2 March 2011).

7 Section 9 specifically.

8 This incapacity will be dissected and discussed at a later point in this article.

9 Act 38/2005.

10 Act 61/2003.

2. Defining *anorexia nervosa* in psychological terms

Anorexia¹¹ nervosa¹² is an eating disorder defined as severe, self inflicted starvation and a loss in body weight to at least 15% below that expected for the individual's sex and height.¹³

2.1 Diagnostic criteria for *anorexia nervosa*

According to the *Diagnostic and Statistics Manual-IV-TR*¹⁴ the diagnostic criteria for *anorexia nervosa* are:

- a) Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85 per cent of that expected or failure to make expected weight gain during period of growth, leading to body weight less than 85 per cent of that expected).
- b) Intense fear of gaining weight or becoming fat, even though underweight.
- c) Disturbance is the way in which one's body weight or shape is experienced; undue influence of body weight or shape on self-evaluation, or denial of seriousness of the current low body weight.
- d) In post-menarchal females, amenorrhoea, that is, the absence of at least three consecutive menstrual cycles.¹⁵

Anorexia nervosa is then further classified into two distinct types¹⁶ or subsets:¹⁷

11 According to the *Dictionary of Psychology*, Reber 2001:38, "anorexia means lacking in appetite. The term is most commonly used with respect to eating although appetite is occasionally extended to cover other desires such as sex". The same author describes *anorexia nervosa* as "an eating disorder characterized by intense fear of becoming obese, dramatic weight loss, obsessive concern with one's weight, disturbances of body image such that the patient 'feels fat' when of normal weight or even when emaciated ... The shortened term anorexia, use of which is widespread, is actually somewhat misleading in that the real loss of appetite does not occur until late in the course of the disorder – at the outset the patient is typically hungry like anyone on a sharply reduced food-intake regime."

12 Barlow *et al.* 2005:261 posit that " ... anorexia nervosa (which literally means 'nervous loss of appetite'), [is] an incorrect definition because appetite often remains healthy".

13 According to generally accepted medical thought, but the exact definition is open to interpretation.

14 Hereinafter referred to as the DSM-IV.

15 In terms of the DSM-IV 2005:550, if the patient does not exhibit the absence of menstruation, then the eating disorder is classified as an eating disorder not otherwise specified and not as *anorexia nervosa*.

16 According to the DSM-IV-TR.

17 Barlow *et al.* 2005:263.

- **Restricting type:** during the episode of *anorexia nervosa*, the person does not regularly engage in binge eating or purging¹⁸ behaviour.¹⁹
- **Binge eating/purging type:**²⁰ during the episode of *anorexia nervosa*, the person has regularly engaged in binge eating or purging behaviour.²¹

The medical symptoms of *anorexia nervosa* generally include amenorrhoea,²² *lanugo*,²³ hair loss, intolerance of cold temperature, low heart rate, low blood pressure, poor circulation, dry skin, brittle nails, insomnia and electrolyte imbalance²⁴ especially if the patient is engaging in bingeing and purging behaviour which results in cardiac and kidney problems.²⁵ According to Davidson,²⁶ *anorexia nervosa* slows, or in some instances prevents, growth and further halts pubertal development.²⁷ The adult patient, due to hormonal fluctuations, will have a minimal interest in sexual activity and tends to have no libido.²⁸ Once starvation has progressed, the internal organs will begin to cease functioning in an effort to maintain energy which eventually results in heart failure.

Psychologically the patient will have an obsessive focus on food and eating habits and will frequently exercise excessively. Coupled with this is an inability to concentrate, social isolation, low self-esteem and a high degree of self-hatred.²⁹ The patient often finds concentrating on tasks, academic or not, difficult due to low energy levels and interfering obsessive thoughts focused on food.³⁰ *Anorexia nervosa* patients usually present with depression and obsessive compulsive disorder which complicates the diagnosis and treatment further.³¹

18 For example, self-induced vomiting or the misuse of laxatives or diuretics which is often the mark of a bulimia sufferer.

19 Barlow *et al.* 2005:263.

20 According to Barlow *et al.* 2005:270, *anorexia nervosa* is often associated with bulimia and mood disorders.

21 According to Herbert 1991:141: "Patients in the advanced stage of *anorexia nervosa* are more difficult to categorize. Their competence may be subtly impaired, and although their lack of nutrition may be life-threatening they are not thought of as terminally ill. As a result they normally receive some form of involuntary feeding."

22 The cessation of menstruation. http://search.medicinenet.com/search/search_results/default.aspx?Searchwhat=1&query=amenorrhea (accessed on 2 March 2011).

23 The growth of fine, downy hair on the limbs and cheeks. http://search.medicinenet.com/search/search_results/default.aspx?sourceType=all&query=lanugo (accessed on 2 March 2011).

24 Barlow *et al.* 2005:263.

25 Buckroyd 2002:5-7.

26 Davidson 2002:202.

27 Usually, as a result of this, the female *anorexia nervosa* patient, will not develop hips, buttocks or breasts and will, for all intents and purposes, remain a child. In this regard see also Barlow *et al.* 2005:260.

28 Davidson 2002:202.

29 Buckroyd 2005:5. See also Barlow *et al.* 2005:263.

30 Davidson 2002:202.

31 Barlow *et al.* 2005:261.

2.2 Incidence of *anorexia nervosa*

A conservative estimate puts the incidence of *anorexia nervosa* at about 1% of the female population between the ages of 15 and 30.³² The incidence has increased steadily since World War Two. Men appear to make up 1 in 20 reported cases.³³ Mortality rates³⁴ vary between 5 per cent and 18 per cent.³⁵ Recent reports³⁶ put the incidence in the United States of America at 0.1 per cent of adults and 0.5-3.7 per cent of adolescents with the prevalence translating into 1 in 1000 people or 272 000 people in the United States of America.³⁷

Traditionally, *anorexia* affected predominantly white middle-class females, but recently there has been a surge in incidence in all races and sexes.³⁸ In South Africa a group of 40 black females were interviewed at the University of Natal and over 50 per cent indicated that they used laxatives and diet pills in order to attain a below-average weight. The same group indicated that there was a definite pressure on young black women to conform to traditional Western standards of weight and beauty.³⁹

2.3 Course of *anorexia* and its effects

Anorexia usually develops over a period of time during which the person will alter his/her eating patterns from normal to grossly restrictive.⁴⁰ The process may take months or years and often starts with the sufferer going on a diet. This, in itself, is not unusual, but the anorexic seems to enjoy the feeling of starvation and finds it unusually easy to lose the initial weight (bear in mind that the true anorexic is usually of a normal weight to begin with and not overweight in the least). Once the diet is completed the sufferer will continue to follow restrictive dieting practices and cut out all fat, and will become anxious at the sight of fat or fatty food. Slowly the sufferer will begin to restrict the consumption of other types of food, for example sugar. It has been noted that most anorexics will become vegan or vegetarian. Eventually the anorexic will arrive at the point where insufficient food is consumed to maintain weight, which results in progressive starvation. At this point a neurochemical reaction

32 Hearnden 2002:2. See also the Diagnostic Features in the DSM-IV 2005:539.

33 Buckroyd 2002:6-7.

34 The mortality rate in the United States of America is 1 in 200 or 10 per cent. <http://www.anorexia.com/eflpgg/anorexia+treatment/pid4623/D110146/C21937/provGOOD> (accessed on 24 June 2009).

35 Hearnden 2002:1-2.

36 <http://www.anorexia.com/eflpgg/anorexia+treatment/pid4623/D110146/C21937/provGOOD> (accessed on 24 June 2009).

37 <http://www.anorexia.com/eflpgg/anorexia+treatment/pid4623/D110146/C21937/provGOOD> (accessed on 24 June 2009).

38 See Barlow *et al.* 2005:265 for a discussion of cross-cultural considerations in *anorexia nervosa*.

39 Buckroyd 2002:6-7. See also the DSM-IV Cultural Features 2005:543.

40 Buckroyd 2002:7.

occurs and the anorexic is unable to see her⁴¹ (females are the predominant sufferers) true body image reflected in a mirror. She will see herself as grossly over-weight⁴² and out of proportion.⁴³

This restrictive practice of limiting food intake is disturbing from the outset, but is typically worsened by a compulsive need to exercise. Often the anorexic will exercise in secret, hoping to maintain the appearance of normalcy to those around her.⁴⁴ The average duration for the course of the illness is 1 to 8 years.⁴⁵

2.4 Aetiology of *anorexia nervosa*

There are many theories⁴⁶ as to why people abuse food. Several of the theories advanced are nothing but a superficial analysis of the disorder and a few are in-depth psychological analyses of specific mental/psychological components of the disorder.⁴⁷

The psychoanalytical school holds that self-starvation is caused by the inability of the sufferer to cope with the developmental crisis of adolescence, possibly because of an unresolved oedipal⁴⁸ conflict. Another theory blames *anorexia* on a disordered mother-child relationship, dating from the pre-oedipal stage.⁴⁹

Most schools of thought attempt to find blame in the family, most particularly the mother.⁵⁰ This theory hinges on the assumption that the sufferer does not receive enough reassurance from the mother. Typically it is the mother who first places the child on a diet. The child will, in most cases, emulate the mother's dietary habits and so it follows that, if the mother is constantly on diet, the child will learn that this behaviour is normal and in fact expected.⁵¹

As stated earlier, there are many theories advanced as to the causes of *anorexia*, but for the sake of brevity the following will suffice.

41 <http://www.anorexia.com/eflpgg/anorexia+treatment/pid4623/D110146/C21937/provGOOD> (accessed on 24 June 2009). See also Reber 2001:38.

42 Hence the inclusion of disturbed body perception and image in the diagnostic criteria.

43 Davidson 2002:201.

44 According to Buckroyd 2002:17-19, sufferers will often attempt to hide their behaviour or condition from friends and family.

45 Barlow *et al.* 2005:271.

46 See the work of Barlow *et al.* 2005:267-273 for an overview of the biological, psychological and social dimensions of the causes of *anorexia nervosa*. See also www.eatingdisorders.about.com and <http://www.anorexia.com/eflpgg/anorexia+treatment/pid4623/D110146/C21937/provGOOD> (accessed on 24 June 2009) for a discussion of cause.

47 Buckroyd 2002:19.

48 Psychological phenomena in which a female child is attracted to her father or a father figure. <http://www.allpsych.com/dictionary/o.html> (accessed on 3 February 2011).

49 Greer 1999:60-61.

50 Greer 1999:59.

51 Greer 1999:61.

2.4.1 Pre-Freudian⁵²

Prior to the advent of the psychoanalytical way of thinking, it was acknowledged that *anorexia* was an illness whose origins lay in feelings and in the mind rather than being biologically determined. It was only in the 18th century that *anorexia nervosa* was explained in terms of its psychological origin. From the late 18th century, the psychological influence of the mother was viewed as a major, but mysterious, part of the crisis.⁵³

2.4.2 Classical Freud⁵⁴

Freud considered *anorexia nervosa* as a form of hysteria created by the divergence of nourishment and sexual response. This is abundantly clear in the classic quote from Freud's *Three essays on the Theory of sexuality*:

Does the taking in of nourishment remain for eating disorder patients as a sexually driven activity, or is it a prototype of a way of object relating based on introjective identification, or is it both?

Freud went as far as to suggest that anorexics identify food with the male sex organs and the refusal to eat is in response to a fear of becoming pregnant.⁵⁵

2.4.3 Post-Freud⁵⁶

Lewin⁵⁷ suggested that anorexic sufferers are attempting to avoid being classified fully as a specific sex. *Anorexia nervosa* is perceived as a response to puberty and the indefinite realisation and identification with a specific sex.⁵⁸

Modern scientists are investigating the possibility that *anorexia* is genetically determined as well as the theory that anorexic patients seem to have the inability to manufacture as well as absorb zinc⁵⁹ into their systemic systems.⁶⁰

Anorexia is a disorder which seems to create or pre-determine obsessive compulsive behaviour.⁶¹ Sufferers become obsessive about food, preparation of food and caloric content of food. Clinically *anorexia* seems to begin after certain experiences or trauma situations including, but not limited to, the death

52 Farrel 2002:4-5.

53 Nandea 1789.

54 Farrel 2002:5-6.

55 Buckroyd 2002:19.

56 Farrel 2002:6-13.

57 Farrel 2002:15.

58 Farrel 2002:15.

59 Researchers have found that low levels of zinc appear to affect the efficiency of neurotransmitters in the brain of an *anorexia nervosa* patient – <http://www.about.com/health> (accessed on 2 March 2011).

60 Farrel 2002:15.

61 Barlow *et al.* 2005:263.

of a parent, death of a sibling, divorce of the parents, sexual abuse and rape, leaving home, teasing and bullying.⁶²

In establishing the cause of *anorexia nervosa* it is evident that no one factor seems sufficient to shoulder the blame.⁶³ Social, biological, cultural, genetic and psychological factors all appear to play a part in causing *anorexia nervosa* and, as is the nature of any psychological disease, there is little consensus in this regard.

2.5 History of *anorexia*

In Western civilisation instances of self-starvation (outside of religious practices and protest actions) do not appear until the Hellenistic era.⁶⁴ Many of these early abstainers were male hermits who renounced the material world as part of a general asceticism.⁶⁵ The independent city states began to decline⁶⁶ at this time and many citizens lost their sense of public usefulness and so divested their desire for control to the private sphere, including their corporal selves. Eastern religion became popular and the majority of these religions taught that the body was evil and the moral, pure soul was trapped within it. Many women adopted the idea of the depreciation of the body.

During the Dark Ages⁶⁷ there were three reported cases of death as a result of starvation. Two involved women who were supposedly possessed by the devil while the third involved a princess who fasted over her arranged marriage.⁶⁸

During the Renaissance era⁶⁹ death as a result of *anorexia* reached epidemic proportions.⁷⁰ Many of the fatalities were religious martyrs who chose to fast and eventually die as a form of sacrifice and religious penance.

During the Victorian era⁷¹ *anorexia* continued to cause a high rate of mortality among women, but declined in prevalence in the immediate period before the First World War.⁷²

It has been noted that starvation was also used as a form of political protest. Emily Davidson was a suffragette who campaigned for a woman's right to vote. She regularly went on hunger strikes to call attention to her crusade.⁷³

62 Buckroyd 2002:39-40.

63 Barlow *et al.* 2005:273.

64 Ranke-Heinemann 1900:3.

65 Ranke-Heinemann 1900:5.

66 From the 15th century onwards. www.babylon.com (accessed on 2 March 2011).

67 Period between the fall of Rome and the Renaissance. www.babylon.com (accessed on 2 March 2011).

68 Ranke-Heinemann 1900:5.

69 Between 15th and 17th century. www.babylon.com (accessed on 2 March 2011).

70 Ranke-Heinemann 1900:6.

71 1837-1901. www.babylon.com (accessed on 2 March 2011).

72 Ranke-Heinemann 1900:5.

73 www.umanitoba.com (accessed on 20 November 2003).

A few years ago, a British prisoner chose to starve himself to death rather than face a 30-year prison sentence.⁷⁴ An Irish prisoner, Bobby Sands, starved himself to death to avoid prison and became a martyr⁷⁵ for the Irish republican cause.⁷⁶

2.6 Treatment of *anorexia nervosa*

Treatment for *anorexia nervosa* is complex and often unsuccessful.⁷⁷ Failure in treatment is most commonly due to the patient's refusal to participate in treatment programmes. This is exacerbated by the fact that anorexics are often manipulative and deceitful and will go to great lengths to hide their behaviour. Add to this the fact that the patient is so malnourished that his/her mind is unable to recognise the effects of his/her behaviour and you have a recipe for the failure of medical treatment.

Traditional treatments⁷⁸ generally include family therapy, group therapy, psychoanalysis, hypnotherapy, shock treatment and antidepressant drug therapy. The above treatments usually occur while the patient still lives at home and is treated on an out-patient basis.⁷⁹

When the disease has progressed to the point that the patient is admitted to hospital, the patient will usually be fed intravenously.⁸⁰ The aim of such treatment is to allow the patient to gain weight steadily.⁸¹ Clinically anorexic patients will gain ½ a kilogram per week.⁸²

74 BBC online network 1999:1-17.

75 A person who undergoes death or great suffering in support of a cause, belief or principle. www.babylon.com (accessed on 2 March 2011).

76 BBC online network 1999:1-17.

77 Buckroyd 2002:19.

78 Dawson 2001:38-46.

79 Dawson 2001:38-46.

80 Dawson 2001:38-46.

81 According to Hsv & Lee 1990:136, "Weight restoration occurs in conjunction with other treatments, such as individual and family therapy, so that the patient does not feel that eating and weight gain are the only goals of treatment. The patient trusts the treatment team and believes that she will not be allowed to become overweight. The patient's fear of loss of control is contained; this may be accomplished by having her eat frequent, smaller meals ... so as to produce a gradual but steady weight gain. A member of the nursing staff is present during mealtimes to encourage the patient to eat and to discuss her fears and anxiety about eating and weight gain. Gradual weight gain rather than the amount of food eaten is regularly monitored, and the result is made known to the patient; thus the patient should be weighed at regular intervals and she should know whether she has gained weight or lost weight ... The patient's self-defeating behaviour, such as surreptitious vomiting or purging, is confronted and controlled. The dysfunctional conflict between the patient and the family about eating and food is not reenacted in the hospital; or if the pattern is to be reenacted in a therapeutic lunch session, the purpose is clearly defined."

82 Dawson 2001:38-46.

As a last resort a patient will be tube-fed.⁸³ This involves the insertion of a tube into the nose. The tube goes down the throat and directly into the stomach. Liquid food is then fed into the tube. This usually only occurs in emergency situations and is considered a last possible resort. Normally medical treatment cannot be administered without consent of the patient.⁸⁴ However, in the case of mentally ill patients, their perceptions of reality may render them unable to make these decisions. Despite the fact that chronic anorexics do not have the necessary capacity to refuse treatment, force-feeding, without a patient's consent, is often criticised by medical ethics groups as well as human rights groups.⁸⁵ This quandary then brings us to the legal aspect of this discussion. Should patients suffering from *anorexia nervosa* be allowed to refuse treatment, especially in cases where they appear intellectually capable? In terms of which provisions of the South African law may force-feeding occur? Are there differences between forced treatment in the case of minors and adults and what role does self-determination play in medical treatment? Is there a difference between incompetence and 'irrational' refusal and, if so, should 'irrational' refusal be protected?

83 Dawson 2001:38-46.

84 Medical personnel that pursue treatment without the consent of the patient are guilty of assault. In Great Britain assault is termed 'battery'.

85 Hearnden 2002:3.

Section Two

Force-feeding – Legal aspects in relation to consent in minor and adult patients

1. Preface

In an article by a British barrister, Alexis Hearnden,⁸⁶ the advantages and disadvantages of force-feeding are laid out as a starting point for legal discourse. At the risk of duplication the authors deem it prudent to reproduce these points.

1.1 Advantages of force-feeding of anorexic patients⁸⁷

- a) Anorexics, in the United Kingdom, are typically treated under mental health legislation.⁸⁸ They do not make a free choice because they are not rationally able to weigh up decisions and consequences. The patient is not capable of forming unimpaired and rational judgments concerning consequences.⁸⁹
- b) Life is more important than dignity; many medical treatments are unpleasant or painful, but are necessary to preserve life.⁹⁰ Psychological problems can only be treated if the person is alive.
- c) A healthier body weight is necessary to be able to treat the patients' psychological problems.⁹¹ Studies in Minnesota show that when normal volunteers were starved, they began to develop anorexic patterns. They overestimated the size of their faces by 50 per cent. This shows the impact of starvation on the brain.
- d) Medical ethics dictate that a doctor has a responsibility to keep the patient alive in order to administer treatment.⁹² In the United Kingdom, Diana Pretty was denied the right to die by the House of Lords.⁹³ The Israeli Courts ordered the force-feeding of political hunger strikers arguing that in

86 www.debate.co.uk (accessed on 20 June 2005).

87 Hearnden 2002:1-3. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

88 This position is mirrored by South Africa in terms of the *Mental Health Care Act 17/2002*.

89 According to the British Medical Association report concerning life-prolonging treatment.

90 Hearnden 2002:1. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

91 Hearnden 2002:2. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

92 Hearnden 2002:2. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

93 Hearnden 2002:2. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

a conflict between life and dignity, life must always win. India prosecuted a physician who allowed a hunger striker to die.⁹⁴

- e) Palliative⁹⁵ care is defeatist and does not attempt to cure the problem. Doctors do not often have to deal with severe or chronic *anorexia*. Just because it is a very long treatment schedule that can be harrowing to a doctor, this is not a reason to settle for palliative care.

1.2 Disadvantages of force-feeding of anorexic patients⁹⁶

- a) Force-feeding is undignified.⁹⁷ The European Convention on Human Rights prohibits degrading treatment in article 3.⁹⁸ The patients' right to refuse treatment should be respected even if they are mentally ill.⁹⁹
- b) An anorexic's fear of weight gain, especially forced weight gain in hospital, is an obstacle to treatment. If an anorexic sufferer thinks that s/he will be force-fed s/he may be less likely to seek treatment or advice.¹⁰⁰
- c) Compulsory treatment may only be successful in the short term.¹⁰¹ In the long term it does nothing to reduce the fear of food. Suicide accounts for 27 per cent of anorexic deaths.¹⁰² Compulsory treatment may make the patient more depressed and at greater risk of self-harm.
- d) Force-feeding has negative consequences. If the patient is dangerously thin and is force-fed, it can lead to hypophosphataemia.¹⁰³ Anorexics are characterised by self-denial and often do not come forward voluntarily. They are even less likely to do so if faced with the prospect of force-feeding.¹⁰⁴

94 Hearnden 2002:2. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

95 Palliative care refers to the service of medical treatment with the aim to relieve the symptoms of the illness, but not the cause. http://search.medicinenet.com/search/search_results/default.aspx?sourceType=all&query=palliative%20care (accessed on 2 March 2011).

96 Hearnden 2002:1-3. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

97 This disadvantage can be considered in the same light in South Africa due to the rights protected in the South African Bill of Rights.

98 Article 5 of the African Charter on Peoples Rights contains a similar provision.

99 Article 20 of the African Charter on Peoples Rights dictates that all people have the right to self-determination.

100 Hearnden 2002:3. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

101 Hearnden 2002:3. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

102 Hearnden 2002:3. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

103 Refers to the reduction of phosphates in the blood which inevitably causes heart failure. http://search.medicinenet.com/search/search_results/default.aspx?sourceType=all&query=hypophosphatemia (accessed on 2 March 2011).

104 Hearnden 2002:3. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

- e) Some doctors advocate focusing on palliative care due to the low recovery rate of anorexic sufferers. Research shows that over a 10-year period, only approximately 20 per cent of patients recover. Those patients who have suffered for more than 12 years are unlikely to recover.¹⁰⁵

And thus we arrive at the focal point of this discussion: regardless of its effectiveness, is force-feeding (which logically is against the will of the patient), in South Africa, legally permissible under existing legislation and in line with basic human rights as set out in relevant legislation and the Constitution?¹⁰⁶ In order to solve the problem statement posed, reference will be made to the issue of consent to treatment and the legislative provisions pertaining to minor and adult sufferers. Certain stipulations of the South African *Mental Health Care Act*¹⁰⁷ which affect the issue of consent to medical intervention, in an incapable patient, will be referred to. A comparative analysis will be drawn between Great Britain and South Africa.

2. Legal position in the United Kingdom

2.1 Refusal of treatment with regard to minors and decision-making by competent minors

In the United Kingdom a minor who has sufficient competence and understanding of a proposed procedure or medical treatment may give valid consent regardless of age.¹⁰⁸ The refusal of treatment by a young person under the age of 18, however, may not be determinative. British mental health legislation requires that any person below 18 have a sufficient level of competence and understanding in order to seek medical attention and consent to treatment (and presumably to refuse such treatment).¹⁰⁹

In English law there is no automatic assumption of competence in young people below 16 and a proper assessment must be made on a case-by-case basis.¹¹⁰ The assessment must take into account the individual's understanding of the condition, the proposed treatment and the possible consequences of the said treatment.¹¹¹

However a minor's refusal of treatment is not determinative and parental consent may override a minor's refusal of treatment. The legal jurisprudence concerning refusal of treatment, to which we will now refer, has evolved differently in differing parts of the United Kingdom.

105 Hearnden 2002:3. www.idebate.org/debatabase/topic_details.php?topicID=161 (accessed on 20 June 2009).

106 *Constitution of the Republic of South Africa*, 1996.

107 *Mental Health Care Act* 17/2002.

108 See *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 AllER 402 and *British Medical Association* 1999:1-5.

109 *British Medical Association* 1999:1-5.

110 *British Medical Association* 1999:1-5.

111 *British Medical Association* 1999:1-5.

2.1.1 The legal position in England, Wales and Northern Ireland

A minor may give consent to treatment if competent; still, it does not necessarily follow that s/he would have the same right to refuse treatment.¹¹² In cases before the British courts it was made clear that parents and the courts did not lose their right to give consent on behalf of a young person below the age of 18. In the case of *Gillick v West Norfolk and Wisbech Area Health Authority*¹¹³ Lord Donaldson held:

A competent child can consent, but if he or she declines to do so or refuses, consent can be given by someone else who has parental rights or responsibilities. The refusal or failure of the competent child is a very important factor in the doctor's decision whether or not to treat, but does not prevent the necessary consent being obtained from another competent source.¹¹⁴

In an unreported case dealing with the issue of refusal of medical treatment, W was 16 years old and a ward of the state. Her health deteriorated, due to *anorexia nervosa*, to the point that the authorities wished to transfer her to a treatment centre. W appeared capable of understanding the information given to her and the consequences of refusing intervention, yet she refused treatment. Her refusal was overridden on the basis that it was a symptom of her illness which involved a desire not to be treated. The decision seems to indicate that a young person is not capable of refusing treatment. Nevertheless, the court indicated that, even if W were to have been deemed fully competent, they would still have authorised treatment as it was in her best interest.

Since refusal of treatment does not determine care, advance refusal¹¹⁵ of young people will not carry the same weight as the advance refusal of a competent adult.¹¹⁶ It has, however, been stated that advance refusal may play a part in the decision-making process.

It would thus appear that in England, Wales and Northern Ireland an anorexic minor will be subjected to force-feeding regardless of his/her refusal. A competent parental authority will then give the necessary consent and if they refuse, are deceased or are incapable, the court will give the necessary consent.

2.1.2 The legal position in Scotland

As in England, Wales and Northern Ireland, the presumption of competence over 16 years of age is enshrined in statute. In Scotland, legislation also makes specific provision to allow people below 16 to validly consent provided

112 British Medical Association 1999:3.

113 *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 AllER 402.

114 According to Manley *et al.* 2001:150, this has also become known as the Gillick principle which deals with a child's ability to understand and appreciate what treatment is necessary and why and the implications of receiving or not receiving treatment.

115 Such as in the case of a living will.

116 British Medical Association 1999:5.

they are “capable of understanding the nature and possible consequences of the procedure or treatment”.¹¹⁷ The *Children’s Act 1995* provides that a major person may be appointed as a child’s legal representative to give consent to medical intervention if the child is incapable of doing so on his/her own behalf. Thus in Scottish law parental authority and court authority in the case of a competent minor is absent.¹¹⁸

It would thus appear that in Scottish law an anorexic minor may validly refuse treatment if deemed competent; on the other hand, if the said minor cannot meet the required competency, a legal representative would be appointed to give consent on the minor’s behalf.¹¹⁹

In England, Wales, Northern Ireland and Scotland a minor is competent to refuse medical treatment if s/he has “a full understanding and appreciation of the consequences both of the treatment in terms of the effects and equally important, the anticipated consequences of the failure to treat”.¹²⁰

Specific guidelines for young people in determination of competence were given by the British Medical Association¹²¹ and Law Society in 1995 which may be summarised as follows. The following should be considered:

- a) Assessment of competence should take into consideration a person’s age.
- b) Ability to understand that there is a choice and that each choice has specific consequences.
- c) Willingness and ability to make a choice.
- d) Understanding of nature and purpose of the procedure or treatment.
- e) Understanding of risks and side effects.
- f) Understanding of alternatives to the procedure and the risks and consequences involved in the refusal of treatment.
- g) Freedom from pressure.

In conclusion we may examine the opinions of Shaw *et al.*¹²² with regard to consent and refusal of medical treatment, in the case of a minor, in Great Britain:

- a) There can be no single test for competency.¹²³
- b) Withholding consent usually has consequences of greater importance and potential danger than giving consent.¹²⁴

117 British Medical Association 1999:4.

118 British Medical Association 1999:1-5.

119 British Medical Association 1999:1-5.

120 *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 AllER 402.

121 *Withholding and withdrawing life-prolonging medical treatment: A guide for decision-making*, 3rd ed, 2007, British Medical Association.

122 Shaw 2001:11-12.

123 Roth *et al.* 1977.

124 Pearce *et al.* 1994.

- c) By a 'catch 22', patients whose competence is in doubt are deemed rational if they accept a doctor's proposal, but incompetent if they reject it.¹²⁵
- d) The consent of a person with parental responsibility overrides a young person's refusal: thus, a competent minor cannot refuse treatment.¹²⁶
- e) In logic there can be no difference between an ability to consent to treatment and an ability to refuse it.¹²⁷
- f) The *Children's Act* has no specific safeguards for young people whose refusal of treatment is overruled; their only recourse is to instruct a solicitor to seek a specific court order.
- g) The *Mental Health Act*¹²⁸ better protects the rights of young people treated against their wishes than does the *Children's Act*, but detention under the *Mental Health Act* is stigmatising.

Since *anorexia nervosa* is treated as a psychiatric disease in the United Kingdom,¹²⁹ it is likely that minor sufferers would be mentally incapable, as a result of the disease, to give competent refusal to treatment and would therefore be force-fed on the consent of a capable parental figure or the consent of a competent court.

2.2 Refusal of treatment by adults in the United Kingdom

In the case of *Re T*,¹³⁰ Lord Donaldson set out the position as follows:

An adult patient who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it, or to choose one rather than another of the treatments being offered. This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.¹³¹

A competent adult has the right to refuse treatment "for reasons which are rational or irrational, or for no reason".¹³² It is thus apparent that in Great Britain an anorexic major would not be force-fed if s/he were considered competent

125 Devereux *et al.* 1993.

126 Shaw 2001:11-12.

127 Lord Justice Balcombe 'in *Re W* [1993] 4 ALLER 177, CA.

128 *British Mental Health Act* 1983.

129 Shaw 2001:11-12

130 *Re T* [1992] 9 BMLR 46.

131 According to the spring 1994-edition of the *Medical Law Review*, "... *prima facie* every adult has the right and capacity to refuse medical treatment, even if such refusal may risk his death or permanent injury to his health; and that such refusal may take the form of a declaration never to consent in the future or never to consent in some future circumstance".

132 *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871.

enough to refuse medical treatment. In the case of *Re C*,¹³³ elements for determining competence were explained as follows:

- a) The patient must be able to take in and retain the information material to the decision and understand the likely consequences of having or not having the treatment.
- b) The patient must believe the given information, albeit 'in his own way'. A compulsive disorder, delusion or phobia may stifle the belief in the information. Confusion or drugs may erode the capacity.
- c) The patient must then be able to weigh the associated risks and make an informed choice.

Once a decision is the clear product of a patient's unimpaired reasoning, it will be accepted even though the choice may result in the patient's death. Therefore, as the British law stands in this area, only severe kinds of psychiatric illnesses will rob a patient of his/her ability to make his/her own medical decisions.¹³⁴

It is however evident that due to the effects of *anorexia nervosa* a sufferer is habitually in such a state of illness that a functional level of competency cannot be expected. In cases of *anorexia nervosa* the patient characteristically has an obsessive fear of food and treatment which involves feeding. Anorexics in Britain are typically treated under the *Mental Health Act 1983* as they are incapable of giving informed consent or of refusing treatment. The requirements of detention under the *Mental Health Act 1983* are:

- a) A second opinion from a state psychiatrist.
- b) A time-limited application procedure.
- c) The opportunity for an independent review of the patient.

There has been much debate in Britain regarding the use of the *Mental Health Act* in detaining and treating anorexic sufferers without their consent. However, the Mental Health Act Commission decided that the *Act* can be used to treat anorexics, regardless of age, if the disease has the result of putting the patient's health and safety at risk.¹³⁵

In the case of *B v Croydon Health Authority*,¹³⁶ the issue of force-feeding was addressed at length. The case involved an adult, B, who was suffering from borderline personality disorder, coupled with post-traumatic stress disorder (referred to psychologically as co-morbidity of disorders) and a desire to inflict self-harm. In January 1993, B was admitted to hospital in terms of the

133 *Re C* (1997) FLR 180. The applicant was a 68-year-old man suffering from paranoid schizophrenia and confined to a psychiatric unit. He developed gangrene on one of his feet which necessitated amputation. The applicant refused to consent. The applicant sought an injunction to prevent the hospital from amputating his foot despite their claims of the applicant's incompetence.

134 Shaw 2001:11-12.

135 According to the Institute of Psychiatry at Kings College, London 2001.

136 *B v Croydon Health Authority* (1994) ALL ER.

Mental Health Act 1983 under section 3 which permits compulsory admission for treatment. Whilst in the treatment facility, B began to starve herself and was ultimately classified as anorexic. The hospital withdrew psychotherapy until B gained weight. B did gain weight as a result of nasogastric feeding. In May 1994, her weight again dropped and force-feeding was threatened. In June, B sought an injunction to prevent the Croydon Health Authority from force-feeding her. The court eventually declared that B could be force-fed under section 63 of the *Mental Health Act*.¹³⁷ The questions with which the court was faced were briefly as follows:

- a) Does tube-feeding constitute medicine under the *Mental Health Act* 1983, in terms of section 58?

Counsel for the appellant argued that tube-feeding was a medicine within the meaning of section 58 and could not therefore be administered without patient consent. Section 58 requires that the provision of specific medical treatment is dependent on the patient giving valid consent to the proposed treatment and the certification by a registered medical practitioner that the treatment is necessary and should be given. Counsel's argument was not accepted by the courts who felt that the crucial factor in defining a substance as a medicine is its chemical composition. The manner of administration is irrelevant. Since food is not a medicine within the meaning of section 5 the patient's consent is not a requirement for administration of treatment. B therefore could be treated.

- b) Does tube-feeding constitute treatment for a mental disorder under section 63 of the *Mental Health Act*?

Counsel submitted that tube-feeding did not treat B's psychiatric disorder but rather treated the symptoms of it. The court found that tube-feeding did constitute treatment for a mental disorder in terms of section 63 as it complemented the core treatment of psychotherapy.

It appears that under British law an adult may be force-fed in two instances, namely:

- In terms of the *Mental Health Act* 1983.
- The second instance has been determined by case law and states that doctors can force feed a patient if s/he has become mentally incapacitated, the feeding is in his/her best interest and will save the patients' life.

Treatment is in a patient's best interest if it is "necessary to preserve the life, health or well-being of the patient".¹³⁸ An example of the courts authorising force-feeding when it's in the patients' best interest is in the case of prisoners who embark on a hunger strike.¹³⁹

137 *B v Croydon Health Authority*; paragraphs C-F.

138 *A. London Borough v BS* 2003 EWHC 1909 (FAM).

139 As discussed by Keywood in the *Web Journal of Current Legal Issues* in association with Blackstone Press Ltd, 1995.

The concept of best interests gives rise to human rights considerations. It is of the utmost importance to treat patients in a non-degrading way which would not breach article 3 of the European Convention on Human Rights.¹⁴⁰

In *Herczegfalvy v Austria*,¹⁴¹ the European Court of Human Rights stated:

While it is for the medical authorities to decide, on the basis of recogni[z]ed rules of medical science, on the 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 and for whom they are therefore responsible, such patients nevertheless remain under the protection of article 3, the requirements of which permit no derogation.

If the patient gave advanced directives, whilst competent, a doctor may not treat against these directives. This includes force-feeding the patient to save the life of the said patient¹⁴² (whether such situation would apply to *anorexia nervosa* is debatable and the intention of the legislature will need to be examined to determine the intention, for example, such as the application to non-resuscitation orders).¹⁴³

In conclusion: In terms of British law an adult anorexic may be force-fed in terms of a court directive or the provisions of mental health legislation, provided all the requirements are complied with and no advance directive exists which expressly refuses force-feeding. The directive must have been made when the patient was capable. The question of whether the refusal to take nourishment, in the absence of an advance directive, boils down to euthanasia has yet to be answered by the courts.

3. Legal position in South Africa

3.1 Introduction

The Constitution grants protection, specifically in section 12, to the right to bodily security and integrity. This right encompasses the right to refuse medical treatment and/or surgical intervention.

Similarly, in *Stoffberg v Elliot*¹⁴⁴ recognition is given to the patient's free will and personality. The presiding officer states as follows:

140 www.eidohealthcare.com/consent/module2/section2.html (accessed on 28 June 2008).

141 *Herczegfalvy v Austria* 1992 15 EHRR.

142 According to Draper 2000:31, "... anorexia nervosa results in the death of between 20-30 patients per year in the UK and the death rates internationally are reported to be between 4-20%".

143 *Herczegfalvy v Austria* 1992 15 EHRR.

144 *Stoffberg v Elliot* 1923 CPD 148. See also in this regard *Castell v De Greef* 1994 (4) SA 408 which provides support and an extension of the principle in *Stoffberg v Elliot*.

In the eyes of the law every person has certain absolute rights which the law protects. These are not dependant on statute or on contract, but they are rights to be respected, and one of these rights is absolute security of person¹⁴⁵ Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law or consented to, is a wrong

Where exceptions to the above stated premise exist, they pertain to compulsion by statute, emergency situations and where the patient is incapable due to youth or mental incapacity.

For the purpose of this discussion the exception which exists in the case of those considered mentally incompetent to give consent shall be examined.

3.2 Consent and refusal of medical treatment in the case of a minor in South Africa

Section 129(2) and (3) of the *Children's Act* 38 of 2005 states in essence that a person of 12 years and older can consent to medical treatment without the assistance of a parent or guardian¹⁴⁶ and that a person of 12 years and older may consent to the performance of a surgical procedure with the assistance of a parent or guardian.¹⁴⁷ The application of logic dictates that a person of 12 years and older can therefore refuse medical treatment and a person of 12 and older can also refuse surgical intervention.¹⁴⁸ The 'right' to refuse must, however, be viewed within the confines of the court's power as the 'upper guardian of minors'. The high court may overrule a minor's refusal but may be loath to do so if the child is close to the age of majority.¹⁴⁹

It stands to reason that a child who is capable of giving consent to medical treatment may also refuse medical treatment. This refusal is still not definitive as a parent or guardian may overrule the child's refusal and give the necessary consent. A parent is obliged in law to ensure that his/her child receives the proper medical treatment. Refusal by the parents or guardian may be rejected by the Minister of Health who may then give substitute consent. In certain instances substituted consent may be sought from the superintendent of the hospital.¹⁵⁰

The physician treating the minor is entitled to accept the parent's consent over the minor's refusal. Nonetheless, if the child is capable of forming an

145 Now guaranteed by section 12 of the *Constitution of the Republic of South Africa*, 1996.

146 Section 129(2) of the *Children's Act* 38/2005.

147 Section 129(3) of the *Children's Act* 38/2005.

148 Section 129 of the *Children's Act* has reduced the required age of consent to 12 years in cases of both medical treatment and surgical procedures which changed the position stipulated in the *Child Care Act* 74/1983 which stipulated the age of 14 for medical treatment and 18 for surgical intervention.

149 McQuoid Mason 2010:646.

150 Similar to the provisions of section 39(1) and (2) of the repealed *Child Care Act* 74/1983.

intention, it is advisable to allow the parent and child to come to an agreement. Should both the parent and the child refuse treatment, section 129(7)¹⁵¹ can be used by the physician to make application to the minister for his/her consent to the minor's treatment.

Due to the psychological nature of the disorder, complicated by youth, the anorexic minor would not be capable of forming an intention and therefore it is unlikely that s/he could refuse force-feeding. The parent's or guardian's consent overrides that of the minor. In the last resort the Minister may give his/her permission to force-feed the minor should the parents withhold consent.

3.3 Refusal of medical treatment by adults in South Africa

As stated above in the case of *Stoffberg v Elliot*,¹⁵² a competent adult has a right to refuse or accept medical treatment. This right is protected in the Bill of Rights by the stipulations of sections 10 (human dignity) and 12 (freedom and security of person) and the *National Health Act*.

An adult patient may give valid consent to any medical treatment and, logically, may refuse any form of treatment offered even if that refusal will result in his/her death. If the adult in question is mentally capable to refuse treatment the physician may not intervene to save the sufferer's life. *Anorexia nervosa* is, however, a psychological disorder and the patient may be, due to the disorder, emotionally and mentally incapable of refusing treatment. This incapacity is a result of the starvation that the body is experiencing. Often these patients will present as mentally clouded and incapable of any decision-making. These patients will be treated under the auspices of the *Mental Health Care Act 17 of 2002*.

According to section 1 of the *Mental Health Care Act*, an incapable person can receive involuntary care which is defined as:

[I]nvoluntary care, treatment and rehabilitation means the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others and 'involuntary care, treatment and rehabilitation services' has a corresponding meaning.

Section 9 of the *Mental Health Care Act* pertains to the issue of consent: it states that a patient may only be treated in a mental health facility with his/her consent. However, section 9(1)(b) and (c) states that a patient may be treated without consent when so authorised by a court order or review board or when, due to mental illness, the delay in such treatment would result in death or irreversible harm¹⁵³ to the patient or serious harm to the patient or others.¹⁵⁴

151 Act 38/2005.

152 *Stoffberg v Elliot* 1923 CPD 148.

153 Act 17/2002:section 9(1)(c)(i).

154 Act 17/2002:section 9(1)(c)(ii).

Section 26 of the *Mental Health Care Act* deals with treatment of patients incapable of making informed decisions. It states as follows:

Subject to section 9(1)(c), a mental health care user may not be provided with assisted care, treatment and rehabilitation services at a health establishment as an outpatient or inpatient without his or her consent, unless –

(a) a written application for care, treatment and rehabilitation services is made to the head of the health establishment concerned and he or she approves it; and

(b) at the time of making the application –

(i) there is a reasonable belief that the mental health care user is suffering from a mental illness or severe or profound mental disability, and requires care, treatment and rehabilitation services for his or her health or safety, or for the health and safety of other people; and

(ii) the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services.

Section 27 of the *Mental Health Care Act* deals with the application referred to in section 26.

From section 26 of the *Mental Health Care Act* it is clear that a patient may be treated without consent if s/he is endangering him-/herself. An *anorexia* sufferer, in the extreme cases, is in danger of starving to the point that the heart will fail, and is clearly incapable of giving consent or refusing medical treatment. An anorexic may be force-fed under the *Mental Health Care Act* provided the provisions of sections 26 and 27 are complied with.

Although force-feeding and forced treatments appear to violate the constitutional right to freedom and security of a person and to self-determination, they may be justified by section 36 of the Constitution.¹⁵⁵ Force-feeding of an anorexic limits his/her right to freedom and security of person in an attempt to save his/her life. A rational connection exists between the limitation and the purpose. In advanced *anorexia* there is no other viable alternative but to force-feed the patient. It would thus appear that the limitation fulfils the requirements of section 36 of the Constitution.¹⁵⁶

155 *Constitution of the Republic of South Africa*, 1996:section 36. Also called the limitation clause.

156 *Constitution of the Republic of South Africa*, 1996.

4. The case for 'irrational' refusal of medical treatment and the protection thereof in adult patients

The authors submit that, in the case of a minor, force-feeding should take place even if the minor refuses¹⁵⁷ under the necessary legislation, especially when considering the immaturity of a minor patient and the standard of the best interest of the child.¹⁵⁸ In the case of an adult, however, the question of the acceptance or refusal of treatment in the case of *anorexia nervosa* is intriguing, especially in light of the views expressed in *Stoffberg v Elliot*.¹⁵⁹ The presiding officer¹⁶⁰ states that:

[B]y going into a hospital the patient does not give up his right to absolute security of person; he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purpose of vivisection; he remains a human being, and he retains his rights of control and disposal of his own body; he still has a right to say what operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong ...

The South African courts and Constitution appear intent on protecting the right to self-determination and protection of person¹⁶¹ and yet the right to refuse treatment is not absolute. The limitations are understandable in certain situations and yet there is a case to be made here for the protection of the refusal of force-feeding in an adult patient in certain circumstances. The authors further submit that involuntary treatment in terms of mental health legislation is stigmatising¹⁶² and not always the best available option to an adult person suffering from *anorexia nervosa*. A line must obviously be drawn between those patients who fulfil the guidelines of incompetence and those whose refusal is simply 'irrational' to those around them. Irrationality is not a ground to rob a person of his/her fundamental rights, and the law should not attempt to control actions and decisions which are simply out of the ordinary

157 According to Manley *et al.* 2001:144, "The younger person with anorexia nervosa can often deteriorate quickly, therefore the child who is in denial with respect to the seriousness of her condition and/or markedly ambivalent regarding renourishment is at grave risk. Involuntary treatment is likely to be considered during such a medical crisis."

158 According to Manley *et al.* 2001:147, "Child and adolescent often feel a marked time urgency with respect to the effective treatment due to the importance of critical periods of growth. For example, intervening early on and aggressively may be necessary to prevent permanent stunting of growth and the development of osteopenia, as well as the indeterminate longer effects of the eating disorder on infertility."

159 1923 CPD 148.

160 1923 CPD 148:149.

161 Section 12 of the *Constitution of the Republic of South Africa*, 1996.

162 Draper 2000:121 reasons that "Sectioning for force feeding should ... only be considered as an adjunct to other therapies if it is justified by appeals to best interest ... a repeat episode of force feeding decreases the chances of long term recovery and it is doubtful if it is in the best interest of the patient ...".

realm of human acceptance. The law should nonetheless protect those individuals who make 'irrational' decisions from being stripped of their right to self-determination even if such refusal results in the death of the patient.¹⁶³

Medical health care workers should not assume that a patient is incompetent to consent or refuse treatment by virtue of the illness alone as competence depends on a variety of factors.¹⁶⁴ It is especially disconcerting to consider that anorexic patients are often trapped in a "damned if you do and damned if you don't situation" in that if they consent to re-nourishment they are deemed competent and yet if they refuse they are deemed incompetent. This situation further exacerbates the paternalistic stereotype of medical practitioners.¹⁶⁵

The authors concede that the refusal of treatment in anorexic patients is not analogous to the refusal of treatment in a cardiac failure or HIV-positive patient due to the fact that denial of illness and resistance to treatment in *anorexia nervosa* is a symptom of the disorder.¹⁶⁶ Despite this fact the determination of incompetence in anorexic patients should not be automatic upon diagnosis, but should rather be determined on a case-by-case basis. It is possible for an anorexic patient to live a normal (or not disordered life) and function competently in his/her work, home and social life. The DSM-IV stipulates that the diagnosis can only be made once the patient fulfils the criteria stipulated and such behaviour is having a marked effect on their occupation, social or personal functioning.¹⁶⁷ There is no empirical evidence to suggest that incompetence can be determined solely on the basis of low body weight, and other factors besides body mass must be taken into account.¹⁶⁸

The notions of narrow and broad incompetence need to be taken into account.¹⁶⁹ Those who are on the point of starving to death can be safely assumed to be broadly or globally incompetent and yet those who are functioning in society can be argued to be competent enough to make a rational decision and therefore narrowly incompetent. The danger lies in confusing the concept of incompetence with irrational decisions with which the majority of society would not agree.¹⁷⁰ In *Re C*¹⁷¹ the test for competence was threefold. One, the patient can comprehend and retain treatment information; two, the patient believes the information and, three, the patient can weigh the information in a balance to arrive at a decision. Applying this test to an adult anorexic it is possible to conclude that in certain cases the patient may arrive

163 According to Draper 2000:31, "... at least some of those who suffer from eating disorders should have their refusal respected, even if they may die as a result."

164 Manley *et al.* 2001:150.

165 Draper 2000:130 posits "This questioning [of competence] itself highlights the ease with which assessments about a patient's competence can be muddled by disagreements over the relative value of deep-seated beliefs".

166 Manley *et al.* 2001:151.

167 1994:539.

168 Manley *et al.* 2001:155.

169 Draper 2000:122.

170 Draper 2000:126.

171 *Re C* (refusal of medical treatment) [1994] 1 ALL ER 819 (FD).

at an irrational refusal of treatment, but that incompetence cannot be shown in every case and that irrationality is not akin to incompetence. A competent decision to refuse treatment can be made on a ground which is irrational, rational or absent and yet it is usually respected; why then should this rule be any different in the case of an adult anorexic¹⁷² that passes the test for competence as determined in *Re C*?¹⁷³

The South African case law concerning the issue of consent is very clear in *Castell v De Greef*¹⁷⁴ where the presiding officer determined:

It is clearly for the patient, in the exercise of his or her fundamental right to self-determination, to decide whether he or she wishes to undergo an operation, and it is in principle wholly irrelevant that the patient's attitude is grossly unreasonable in the eyes of the medical profession: the patient's right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment.

Although it is legitimate to override refusal in certain cases it cannot be argued that the refusal of treatment should be overridden in every case of *anorexia nervosa*¹⁷⁵ especially those cases in which the individual is a long-term sufferer who has insight into the condition and has previously been force-fed to no avail. There is no question that the decision of a woman diagnosed with breast cancer to refuse a mastectomy would be respected (and would indeed attract sympathy), so why then the distinction with the refusal to eat? Cancer patients often refuse therapy due to the side effects and suffering attached thereto and yet they are not considered incompetent. In the case of force-feeding or re-nourishment a patient may just as well decide that the risks (including discomfort, deepening of psychological illness, curtailment of liberty, sepsis, air embolism and death from line manipulation, pneumonia, infection, dehydration and equipment failure)¹⁷⁶ are too heavy to carry and refuse treatment.¹⁷⁷

172 Draper 2000:129 argues: "As has already been indicated, whether it is a sufficiently irrational obsession to be categorized as a mental illness cannot be taken for granted, but even if it is, it is far from obvious that simply being classed as suffering from mental illness is necessarily an indication that one is an incompetent individual. Nor is it obvious that anorexics refusing therapy are sufficiently irrational to be classed as incompetent to make decisions regarding their food intake."

173 *Re C* (refusal of medical treatment) [1994] 1 ALL ER 819 (FD).

174 1994 (4) SA 408 (C); 420 I/J – 421 C/D – D/E.

175 Draper 2000:123 argues that "in these cases [of anorexia nervosa] the decision to refuse therapy is on par with other decisions to refuse life prolonging therapy made by sufferers of debilitating chronic or acute onset terminal illnesses ..."

176 Herbert 1991:142. See also Neiderman *et al.* 1995:471.

177 In *Re C* (refusal of medical treatment) Judge Thorp reiterated the decision in *Re R* [1992] Fam.11 CA: "patients who hold beliefs, however irrational, for example that surgery may kill them or, accepting they are ill, that they would be better off without treatment, are not incompetent ... Providing however that their views do not affect their understanding of treatment or the consequences of non-treatment, the law should respect their right to decide."

5. Conclusion

Whilst South African law allows a capable person to refuse medical treatment it does not allow the same right, and understandably so in many cases, to those who are incapable for one reason or another. A capable person may refuse treatment even if that refusal results in death but the test for 'allowing' such decision is competence. It is clear that an anorexic patient, who is mentally unfit, is not capable of refusing treatment and the patient will be force-fed against his/her will under the provisions of South Africa's mental health legislation. The laws of Great Britain, Wales and Scotland mimic this position. Despite this, most sufferers will relapse and eventually die of the disease. Minors are robbed of their ability to refuse or consent due to their youth and incompetence, although age alone is sufficient to override refusal. Adults, on the other hand, are allowed to refuse but such refusal will not be determinative based on the supposed incompetence of the patient. The authors submit that the application of the diagnostic criteria and the general paternalistic attitude of medical health care workers should not be the only factors in determining that such a patient is indeed incompetent. There is a difference between irrational refusal and blatant incompetence and the adult patient's right to integrity and dignity should be protected and respected if s/he refuses treatment for *anorexia nervosa*. Only when a patient, taking into account the individual merits of the case, is determined to be globally incompetent should the interference of a third party to give consent, be allowed. There is a definite clash between the intention of the medical profession and the law in this regard which creates gaps which threaten fundamental rights.

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