Society of Medical Education & Research

2025, Volume 5, Page No: 25-35
ISSN: 3108-5059

Asian Journal of Ethics in Health and Medicine

# Ethical Concerns in Managing Anorexia Nervosa: A Content Analysis of Ethics Consultation Records

**Hadi M Salem[1]*, Satoshi Watanabe[2,3], Ai Hua Chang[4]**

[1] Department of Public Health, Faculty of Health, Education, & Life Sciences, Birmingham City University, Edgbaston, Birmingham B15 3TN, UK.
[2] Department of Rehabilitation & Sport Sciences, Faculty of Health & Social Sciences, Bournemouth University, Bournemouth BH8 8GP, UK.
[3] Centre for Wellbeing and Long-Term Health, Faculty of Health & Social Sciences, Bournemouth University, Bournemouth BH8 8GP, UK.
[4] Centre for Midwifery and Women's Health, Faculty of Health & Social Sciences, Bournemouth University, Bournemouth BH8 8GP, UK.

***E-mail** ✉ aichanghua@gmail.com

## Abstract

Providing care for patients with anorexia nervosa (AN) often generates significant moral distress for healthcare professionals. Central to this distress is the ethical tension between enforcing treatment to prevent severe outcomes, such as premature death, and honoring patients' refusals of care. Despite its relevance, empirical research on this moral conflict remains limited. We examined all 19 documented ethics consultations (ECs) related to AN from a single clinical ethics support service in Switzerland. Using a sequential deductive-inductive coding approach, we analyzed the documentation and interpreted the resulting code system on a case-by-case basis. This report focuses on patient characteristics and the ethical issues raised. The ECs predominantly involved extremely underweight AN patients with extensive prior treatment histories who posed serious risks to themselves by refusing recommended interventions. Beyond questions regarding the ethical justification of coercion, frequent concerns included whether further coercive measures to achieve weight gain might be ineffective or even harmful, highlighting conflicts between the principles of beneficence and non-maleficence. Potential strategies considered included harm-reduction approaches (e.g., psychotherapy without mandatory weight gain) and palliative measures (e.g., initiating end-of-life care), each carrying its own ethical dilemmas. Across cases, we identified nine distinct types of conflicts or uncertainties between ethical principles, with a median of eight per case. Caring for individuals with AN involves multifaceted and intricate ethical challenges. To navigate the tension between respecting autonomy and promoting beneficence while avoiding harm, clinicians sometimes consider non-curative approaches. However, their broader implementation is limited by ongoing uncertainty about general justification, eligibility criteria, and standardized protocols.

**Keywords:** Palliative psychiatry, Anorexia nervosa, Clinical ethics, Eating disorders, Harm reduction, Ethical concerns

## Introduction

Access this article online https://smerpub.com/

**Received:** 05 December 2025; **Accepted:** 11 March 2025

**How to cite this article:** Salem HM, Watanabe S, Chang AH. Ethical Concerns in Managing Anorexia Nervosa: A Content Analysis of Ethics Consultation Records. Asian J Ethics Health Med. 2025;5:25-35.https://doi.org/10.51847/oHEI6FgL3V

Anorexia nervosa (AN) affects between 1% and 4% of females in high-income countries at some point in their lives [1, 2]. Its core behavioral manifestation is the restriction of energy intake, which leads to marked underweight [3] and a range of potential medical complications [4]. Evidence-based treatments have demonstrated efficacy at the group level [5], with approximately 80% of patients achieving at least partial remission over the course of the disorder [6]. Despite this, a substantial number of patients either do not seek treatment, discontinue it prematurely, fail to respond, or experience relapse shortly thereafter [7–9], resulting in roughly 20% developing chronic AN. Mortality in AN is estimated at 5% [6], representing a fivefold higher risk compared to healthy individuals of the same age [10]. To avert death or severe medical complications, formal coercive measures—such as involuntary hospitalization or tube feeding—are applied in 13–44% of inpatients [11]. Patients also frequently report experiences of informal coercion and procedural injustice within inpatient care [12–14].

Healthcare professionals working with AN patients often experience negative emotions, self-criticism, adverse judgments toward patients, and moral distress due to poor outcomes, limited treatment efficacy, and the need for coercion [15]. Matusek and Wright [16] suggest that the primary ethical conflict in this setting lies between employing coercion to prevent serious complications or death (aligning with the principle of beneficence as outlined by Beauchamp and Childress [17]) and respecting a patient's refusal of treatment (following the principle of autonomy). This dilemma has been extensively debated in clinical ethics literature. Geppert [18] contended that treatment should not be withheld on grounds of futility, as clinical recovery can occur even after decades [19–21]. She further argued that patient refusals often cannot justify forgoing treatment, as starvation-related neurocognitive impairments undermine autonomous decision-making. Similarly, Charland [22] and Giordano [23] maintained that even when patients meet standard decision-making capacity criteria, coercive life-sustaining interventions may be ethically defensible (hard paternalism per Dworkin [24]), given the reversibility of AN symptoms and the absence of a clear desire for death in most patients.

Conversely, some authors suggest that in severely ill individuals, the likelihood of meaningful recovery or a satisfactory quality of life may be so diminished that the burdens of repeated invasive coercion outweigh potential benefits [25–27]. Additionally, competent treatment refusals in long-standing AN may warrant respect, as patients with extensive experience of the disorder often possess insight into their quality of life and treatment burdens [23, 28–31]. Palliative care approaches have been proposed as alternatives for these patients [27, 29, 32-35], and neglecting such options may reinforce mind–body dualism and perpetuate stigma around severe mental disorders [31].

To date, much of the ethical discourse has relied on theoretical analysis and single-case reports, leaving the broader relevance to routine AN care uncertain. The current study seeks to address this gap by providing a detailed, structured account of ethical concerns arising in everyday clinical care for patients with AN, as well as the situations that precipitate them. These findings aim to support both mental health professionals providing care and clinical ethicists assisting them, thereby contributing to more informed ethical decision-making in mental healthcare.

## Methods

### *Approach, context and reflexivity*

To examine how healthcare teams identify and interpret ethical issues in the care of patients with AN, we adopted a constructivist perspective [36]. Our focus was on understanding which clinical situations are perceived as ethically significant and why, acknowledging that there is no single "correct" moral assessment of any scenario. The aim was to systematically map the variety of ethical concerns that emerge in this setting. For this descriptive purpose, qualitative content analysis provided a suitable methodological framework [37], a strategy previously applied to analyzing ethics consultation (EC) documentation in somatic medicine [38–41].

This study draws on prior work analyzing psychiatric ECs [42] and reviews documents from the Clinical Ethics Support Service (CESS) in Basel, Switzerland, across multiple hospital contexts. Established in 2012, CESS currently serves four tertiary hospitals, applying a principle-based approach [17] enriched with structured perspective-taking techniques [43, 44]. After each consultation, a written protocol is generated, verified by the clinician who requested the consultation, and archived both in the patient's record and the service database.

Notably, some of the authors (ALW, SRT, MT), all trained in mental health care, directly participated in the ECs included in this study. Their professional experience and personal ethical perspectives influenced the consultation discussions, documentation, and interpretation of coded material. They share the clinical view that for patients with severe and persistent AN, shifting from traditional curative goals (e.g., weight restoration) to non-curative care goals can sometimes serve the patient's best interests [27, 45].

### *Selection strategy*

We searched the CESS database for entries containing “anorexia” or “eating disorder” from July 2012 through June 2022. We included all ECs that addressed individual patients diagnosed with anorexia nervosa (ICD-10 F50.x; [3]). Consultations were excluded if they did not focus on individual patients—such as those supporting guideline development—or if they concerned anorexia related to conditions other than AN, such as restricted intake due to dysphagia in pharyngeal cancer. No exclusions were made based on consultation depth or format (e.g., brief vs. full ECs [46]). An overview of included consultations and details on data processing are provided in Supplementary Material S1.

### *Coding and analysis*

To examine the ethics consultation (EC) documentation, ALW applied a sequential approach combining deductive and inductive coding, following Kuckartz [47] (see Supplementary Material S2 for illustrative examples). Because documentation standards at CESS evolved over the study period and not all records adhered strictly to them, we initially organized the materials into predefined categories based on the key components of EC documentation outlined by Pearlman *et al.* [48]. For this study, we focused on three main areas: (a) information specific to each consultation, including medical details and patient preferences, (b) ethical issues identified during the consultation, and (c) analyses of these ethical concerns. Our definition of “ethical concern” was deliberately broad, encompassing challenges in providing care that is normatively justified, difficulties in implementing ethical decisions, and the perspectives of both clinical ethicists and consultation participants [49].

Next, inductive coding captured specific content from the text. Examples included factual codes, such as sociodemographic information, and thematic codes, such as questions about the patient’s decision-making capacity. These detailed codes were then grouped into higher-order categories, forming a hierarchical code system. Each code was characterized and differentiated from similar codes through memos. MAXQDA 2022® facilitated the assignment of deductive categories, the creation and application of inductive codes, extraction of coded segments for higher-level coding, memo documentation, and frequency analysis.

Although only a limited number of ECs were available, the final five cases did not yield new insights, suggesting that data saturation had been reached according to the definition provided by Saunders *et al.* [50]. Coding quality was strengthened through a consensual process [50], with five documentations (EC11_1 to EC15_1) independently coded by SRT. Any discrepancies or ambiguities were resolved through discussion among ALW, SRT, and the methodological consultant SW, and decisions were recorded in the code memos.

Cases, rather than individual EC documents, were treated as the unit of analysis because multiple ECs for the same patient occurred in close temporal proximity (ranging from eight days to under eight months) and referenced prior consultations, reflecting an ongoing deliberative process. All coding and analysis were conducted in German, and findings were later translated into English by ALW, with MT verifying translation accuracy. For readability, all results are reported in the simple past tense, irrespective of the ECs being prospective or retrospective. Reporting follows SRQR guidelines where applicable [51].

## Findings

The search identified 19 EC documentations covering 14 patients, accounting for 5.7% of all ECs recorded during the study period. Two consultations were brief, and 17 were full ECs (following Tapper *et al.* [46]), with each patient having at least one full consultation (see Supplementary Material S1). Brief ECs consisted of telephone or email exchanges between a clinician and a clinical ethicist, whereas full ECs involved either in-person or virtual meetings of multiple healthcare professionals and at least two clinical ethicists. Family members participated in three of the full ECs; patients did not attend any consultation. Across all documented ECs, 130 participants were involved, some attending more than one session. Of the 19 consultations, 15 were prospective, one was retrospective, and three addressed both retrospective and prospective ethical concerns. Metadata for the full ECs are summarized in **Table 1.**

**Table 1.** Metadata on the full ECs included in the analysis

| | | |
|---|---|---|
| requester | count | 13 different requesters from 7 different institutions |
| | profession | 9 physicians<br>2 psychologists<br>(1 relative) |
| | medical specialty | 8 mental healthcare<br>2 pediatrics<br>1 internal medicine<br>1 oral and maxillofacial surgery |
| | work setting | 9 university hospital<br>1 general hospital<br>2 private practice |
| participants | count | Median = 9 participants (range [3; 12]) |
| | professions | Median = 3 different professions (range [1; 6]) |
| | medical specialties | Median = 2 different medical specialties (range [1; 3]) |
| | institutions | Median = 2 different institutions (range [1; 5]) |
| EC | duration | Median = 85 min (range [30; 135]) |
| Protocol | Word count | Median = 2123 words (range [530; 3368]) |

*Notes*: The specialty "mental healthcare" comprises psychiatry including child and adolescent psychiatry, psychosomatic medicine, and clinical psychology. EC = ethics consultation

The consultations most often involved AN patients with extensive prior treatment who were currently severely underweight and considered at high risk due to their refusal of recommended interventions. Other aspects of the patients' backgrounds and clinical histories differed considerably across cases **(Figure 1)**.

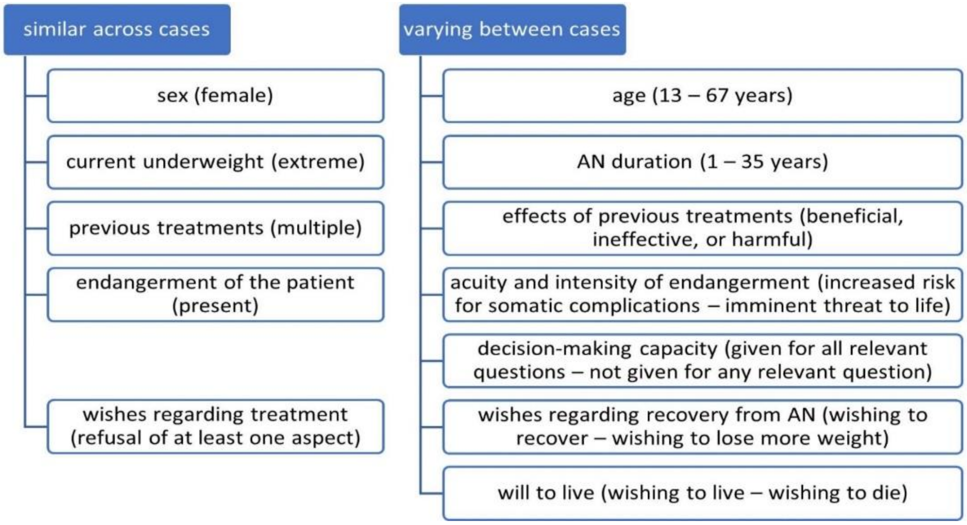

**Figure 1.** Patient Characteristics and Histories

*Certain features of patients and their clinical histories were consistent across the majority of cases (i.e., the same or similar in at least twelve cases), whereas other aspects showed considerable variability. For characteristics that varied, the range of observed expressions is provided in brackets. A more detailed account of patient characteristics and histories is available in Supplementary Material S2.

### *Ethical concerns*

Ethical issues were identified in several ways: they were reported by the clinicians requesting the EC as reasons for involving CESS, raised during consultations by participants as morally challenging, or highlighted by the clinical ethicists themselves. Across individual cases, between three and 13 distinct ethical concerns were identified, with a median of 8 per case. These concerns encompassed patient suffering and risk, patient preferences, decision-making capacity, involvement of surrogate decision-makers, and aspects of ongoing treatment **(Figure 2)**.

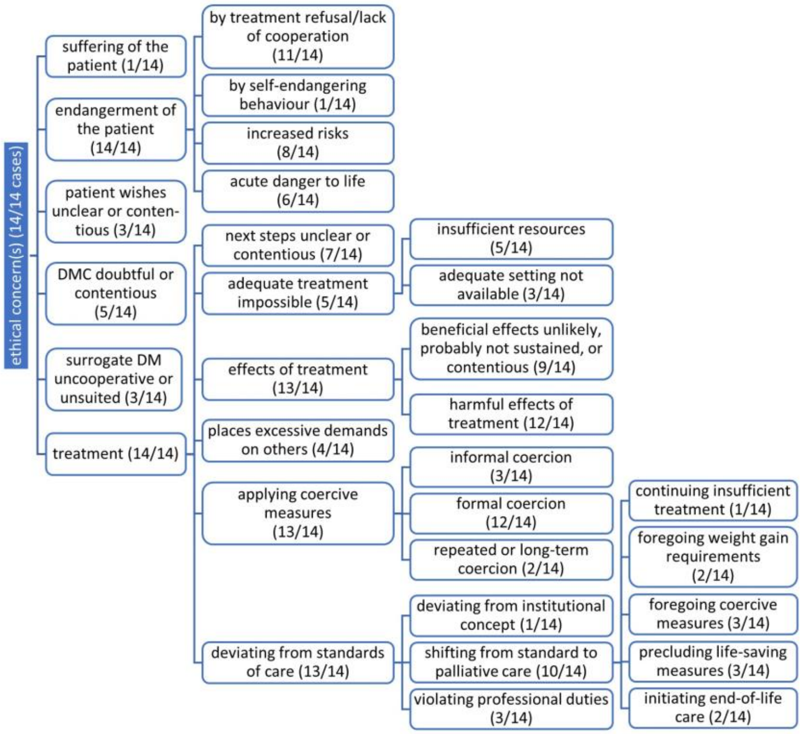

**Figure 2.** Ethical Concerns in the Care of Patients with AN

*The occurrence of ethical concerns is reported as the number of cases (out of 14) in which each issue was noted. DM = decision maker, DMC = decision-making capacity.

In every case, a primary ethical issue involved the patient putting herself at risk. This typically arose when the patient refused recommended interventions, such as tube feeding (EC5_1) or hospitalization (EC9_1). These refusals either increased the likelihood of serious medical complications—like an underweight patient declining routine check-ups (EC3_2)—or posed immediate life-threatening dangers, such as severe iron-deficiency anemia combined with overexertion, leading to critically elevated heart enzymes (EC9_1). In three cases, ambiguity or conflict regarding patient preferences generated ethical concern (e.g., EC7_1), while in five cases, decision-making capacity was questionable or contested (e.g., EC6_3, EC9_1). Surrogate decision-makers also raised ethical questions, either due to lack of cooperation, such as refusing consent for proposed interventions, or concerns about their suitability for the role (EC5_1).

All cases also involved doubts about the current treatment plan. In five cases, adequate care was considered unachievable because of resource limitations—such as insufficient nursing support (EC12_1)—or the unavailability of appropriate specialized settings (e.g., a closed ward providing combined psychiatric and medical care; EC7_1). In four cases, treatment demands were perceived as excessive for staff, for example, repeated aggressive behavior toward nursing personnel (EC7_1). Nine cases raised uncertainty about whether further treatment aimed at symptom reduction would actually be effective, including whether any benefits would persist post-discharge (EC1_1). This uncertainty extended to the use of coercion—informally pressuring a patient to attend emergency care (EC5_1), or formally restraining a patient for tube feeding (EC7_1)—with additional worry that such measures could harm the therapeutic relationship (EC8_1).

Participants often considered departures from standard care, either by bending professional obligations (e.g., withholding information about planned coercion; EC11_1) or by shifting away from curative goals like weight restoration toward palliative strategies. These palliative approaches included continuing psychotherapy even if insufficient for weight gain (EC8_1), providing therapy without requiring commitment to weight gain (EC3_2), forgoing coercion when benefit-burden ratios were unfavorable (EC12_1), respecting patient decisions to refuse life-saving interventions such as resuscitation (EC2_1), and initiating end-of-life care, including hospice referral (EC10_1).

### *Analysis of ethical concerns*

When interpreted through a principlism lens [17], these ethical issues revealed nine distinct types of conflicts or uncertainties among ethical principles, ranging from three to seven per case (see Supplementary Material S3). Most conflicts revolved around beneficence **(Figure 3)**. In 13 of 14 cases, tension arose between beneficence and respect for autonomy, specifically regarding whether to honor a patient's refusal of treatment or to apply coercion to prevent serious harm. In nine of these cases, uncertainty further complicated the situation. Concerns about autonomy included doubts about patient preferences, decision-making capacity, or the appropriateness of surrogate decision-makers, as well as the dilemma of respecting present autonomy versus promoting future autonomy through coercive interventions aimed at enhancing decision-making capacity.

Uncertainty regarding beneficence appeared in 12 of 14 cases, stemming from concerns about whether suitable treatment was possible or effective and whether deviations from standard care could better serve the patient. Concerns about potential harm from treatment, such as pain or trauma, were identified in 11 of 14 cases, reflecting non-maleficence uncertainty. Overall, these combined concerns led participants to question whether further symptom-focused interventions might produce more harm than benefit (11 of 14 cases), highlighting a conflict between beneficence and non-maleficence.

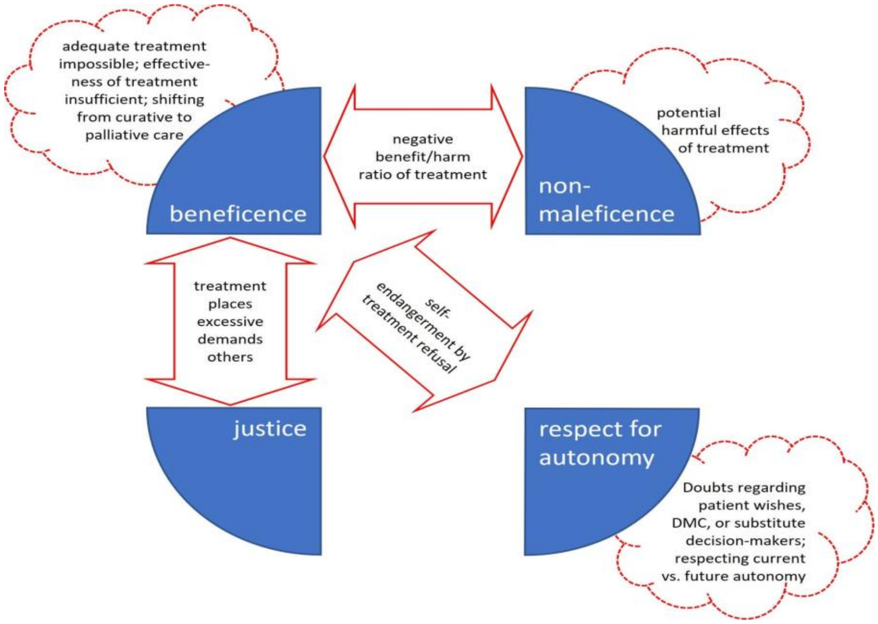

**Figure 3.** Analysis of Ethical Concerns in the Care of Patients with AN

*In the figure, conflicts between ethical principles are illustrated with double-headed arrows, while uncertainties regarding principles are depicted as clouds. The text within these symbols summarizes the main ethical issues associated with each conflict or uncertainty. For clarity, only conflicts or uncertainties that appeared in more than two cases are displayed. A full overview of the analysis of ethical concerns can be found in Supplementary Material S3. DMC = decision-making capacity.

## Discussion

The ECs examined in this study predominantly involved AN patients who had undergone extensive prior treatment, were currently extremely underweight, and were considered at risk due to refusing recommended interventions. These clinical scenarios were further complicated by ambiguities regarding the patients' preferences and decision-making capacity.

Each case prompted multiple ethical considerations, which, when analyzed, revealed nine distinct types of conflicts or uncertainties among ethical principles. Beyond the recurring question of whether coercion should be applied to prevent serious AN-related complications—highlighting the tension between respect for autonomy and beneficence—participants frequently deliberated on whether further interventions targeting symptom reduction were likely to succeed, could cause harm, or might produce a net negative outcome. These deliberations reflected uncertainties surrounding beneficence and non-maleficence, as well as a conflict between these principles **(Figure 3)**. Such complexity mirrors the lack of robust empirical evidence on long-term outcomes of AN treatment, particularly coerced interventions in patients with longstanding illness [52], as well as the absence of validated staging models or prognostic tools for AN [53]. Normatively, this raises the question of how prognostic uncertainty should factor into ethical decision-making.

A key insight from this study is that ethical issues in AN care cannot be reduced to a simple conflict between autonomy and beneficence. Rather, EC participants frequently wrestled with a three-way dilemma: whether to employ coercion to avert severe complications and potential death—acknowledging that this could cause harm—or to respect treatment refusal, with its inherent risks to the patient. This illustrates a complex interplay between beneficence, non-maleficence, and respect for autonomy, further compounded by uncertainty about how these principles should be prioritized.

Recent ethical discussions emphasize the relevance of non-maleficence, particularly in justifying harm reduction strategies for both adults [54] and adolescents with AN [55]. However, harm reduction alone is often insufficient to meet the needs of patients with severe or longstanding AN [27]. Consistent with this, some strategies discussed in the ECs, such as allowing psychotherapy without weight-gain requirements or foregoing coercion despite risk, can be viewed as harm-reduction approaches. Others, however, extended beyond harm reduction and entered the realm of end-of-life care, including withholding life-saving measures or initiating hospice care. End-of-life care in AN remains ethically complex and controversial. A recent review identified two central challenges: (a) key concepts such as "futility" are inconsistently defined, often value-laden, and sometimes circular; and (b) fundamental normative questions—like whether diagnosis-based ethico-legal exceptions are justified—remain unresolved [56]. Reflecting this, the appropriateness of non-curative interventions was itself a source of ethical concern in the ECs, highlighting uncertainty about whether beneficence and non-maleficence could be better served by deviating from standard care. Currently, guidance for clinicians in such situations is limited, which likely exacerbates moral distress and may adversely affect patient care. Some preliminary recommendations for addressing potential futility in mental healthcare have been proposed [57], but substantial work remains.

Further research is needed to develop reliable methods for evaluating decision-making capacity in AN, establish validated staging models and prognostic tools, and define alternative care options. With such evidence, healthcare professionals and clinical ethicists could receive more structured guidance and recommendations for ethical decision-making in these highly complex and morally challenging scenarios.

## Strengths and Limitations

While this study represents the largest collection of published clinical ethics cases related to AN to date, the total number of cases remains relatively small. This may reflect (a) the low prevalence of severe eating disorders and (b) the fact that a specialized treatment program for severe eating disorders was only recently implemented at one of the hospitals served by the CESS. Nevertheless, coding reached saturation, suggesting that the findings capture the majority of ethical concerns encountered by healthcare professionals caring for patients with AN in Switzerland.

It is possible that certain ECs—particularly brief consultations conducted by telephone—were not recorded due to time constraints, potentially resulting in selective documentation bias [38]. Moreover, EC participants were largely self-selected, limiting the study's ability to capture the concerns of those who did not seek ethics support, for instance due to negative perceptions of the CESS. This limitation is partially mitigated by the diversity of EC requesters and participants, representing multiple professions, specialties, and institutions. The retrospective document analysis design strengthens confirmability, as neither the behavior of EC participants nor CESS members could have been influenced by awareness of the study or its objectives [38].

It is important to note that the study analyzed routine, pre-structured, and selective documentation from a single CESS rather than the ECs themselves. Consequently, the depth and type of information varied across cases, and certain potentially relevant details could not be reconstructed—for example, specific procedures used to assess decision-making capacity or which participant raised a particular ethical concern. Furthermore, the coding primarily focused on ethical issues, with less attention to psychosocial factors (e.g., patient–clinician communication) and legal aspects (e.g., Swiss guardianship law).

The generalizability of these findings is limited by the focus on a single CESS operating under a principlism framework and primarily serving tertiary care healthcare professionals in Switzerland. ECs conducted within other ethical frameworks, different levels of care, or healthcare systems without universal coverage may reveal different ethical concerns. For instance, a study of predominantly US-based outpatient psychologists highlighted ethical issues primarily around access to affordable, evidence-based care [58]. Additionally, because few informal caregivers and no patients participated in the ECs analyzed, the findings are unlikely to reflect the perspectives of these stakeholders. The absence of patient input may have contributed to a predominantly biomedical framing of AN, reducing attention to sociocultural factors influencing judgments of decision-making capacity and treatment refusal [59].

To gain a more comprehensive understanding, ethnographic research examining not only the EC itself but also the interactions leading up to a request (or decision against requesting) an EC would be valuable. Such studies could also explore whether participants' professional role or hierarchical position influences their ethical perspectives.

## Conclusions

Ethical concerns in the care of patients with AN are multifaceted and complex. To navigate the tensions and uncertainties between respect for autonomy, beneficence, and non-maleficence, healthcare professionals sometimes consider non-curative approaches. However, the lack of clear guidance regarding their general justification, eligibility criteria, and standardized protocols currently limits the implementation of these approaches.

**Acknowledgments:** None

**Conflict of Interest:** None

**Financial Support:** None

**Ethics Statement:** None

## References

1. van Eeden AE, van Hoeken D, Hoek HW. Incidence, prevalence and mortality of anorexia nervosa and bulimia nervosa. Curr Opin Psychiatry. 2021;34:515–24. https://doi.org/10.1097/YCO.0000000000000739
2. Keski-Rahkonen A, Mustelin L. Epidemiology of eating disorders in Europe: prevalence, incidence, comorbidity, course, consequences, and risk factors. Curr Opin Psychiatry. 2016;29:340–5. https://doi.org/10.1097/YCO.0000000000000278
3. World Health Organization. International statistical classification of diseases and related health problems. 10th ed. Geneva: World Health Organization; 2016.
4. Westmoreland P, Krantz MJ, Mehler PS. Medical complications of anorexia nervosa and bulimia. Am J Med. 2016;129:30–7. https://doi.org/10.1016/j.amjmed.2015.06.031
5. Zeeck A, Herpertz-Dahlmann B, Friederich HC, Brockmeyer T, Resmark G, Hagenah U, et al. Psychotherapeutic treatment for anorexia nervosa: a systematic review and network meta-analysis. Front Psychiatry. 2018. https://doi.org/10.3389/fpsyt.2018.00158
6. Steinhausen HC. The outcome of anorexia nervosa in the 20th century. Am J Psychiatry. 2002;159:1284–93. https://doi.org/10.1176/appi.ajp.159.8.1284
7. Khalsa SS, Portnoff LC, McCurdy-McKinnon D, Feusner JD. What happens after treatment? A systematic review of relapse, remission, and recovery in anorexia nervosa. J Eat Disord. 2017. https://doi.org/10.1186/s40337-017-0145-3
8. Gregertsen EC, Mandy W, Kanakam N, Armstrong S, Serpell L. Pre-treatment patient characteristics as predictors of drop-out and treatment outcome in

individual and family therapy for adolescents and adults with anorexia nervosa: a systematic review and meta-analysis. Psychiatry Res. 2019;271:484–501. https://doi.org/10.1016/j.psychres.2018.11.068

9. Zipfel S, Giel KE, Bulik CM, Hay PJ, Schmidt U. Anorexia nervosa: aetiology, assessment, and treatment. Lancet Psychiatry. 2015;2:1099–111. https://doi.org/10.1016/S2215-0366(15)00356-9
10. Keshaviah A, Edkins K, Hastings ER, Krishna M, Franko DL, Herzog DB, et al. Re-examining premature mortality in anorexia nervosa: a meta-analysis redux. Compr Psychiatry. 2014;55:1773–84. https://doi.org/10.1016/j.comppsych.2014.07.017
11. Clausen L. Perspectives on involuntary treatment of anorexia nervosa. Front Psychiatry. 2020. https://doi.org/10.3389/fpsyt.2020.533288
12. Guarda AS, Pinto AM, Coughlin JW, Hussain S, Haug NA, Heinberg LJ. Perceived coercion and change in perceived need for admission in patients hospitalized for eating disorders. Am J Psychiatry. 2007;164:108–14. https://doi.org/10.1176/ajp.2007.164.1.108
13. Hillen S, Dempfle A, Seitz J, Herpertz-Dahlmann B, Bühren K. Motivation to change and perceptions of the admission process with respect to outcome in adolescent anorexia nervosa. BMC Psychiatry. 2015. https://doi.org/10.1186/s12888-015-0516-8
14. Schreyer CC, Coughlin JW, Makhzoumi SH, Redgrave GW, Hansen JL, Guarda AS. Perceived coercion in inpatients with anorexia nervosa: associations with illness severity and hospital course. Int J Eat Disord. 2016;49:407–12. https://doi.org/10.1002/eat.22476
15. Graham MR, Tierney S, Chisholm A, Fox JRE. The lived experience of working with people with eating disorders: a meta-ethnography. Int J Eat Disord. 2020;53:422–41. https://doi.org/10.1002/eat.23215
16. Matusek JA, Wright MO. Ethical dilemmas in treating clients with eating disorders: a review and application of an integrative ethical decision-making model. Eur Eat Disord Rev. 2010;18:434–52.
17. Beauchamp TL, Childress JF. Principles of biomedical ethics. 8th ed. New York: Oxford University Press; 2019.
18. Geppert CMA. Futility in chronic anorexia nervosa: a concept whose time has not yet come. Am J Bioeth. 2015;15:34–43. https://doi.org/10.1080/15265161.2015.1039720
19. Dobrescu SR, Dinkler L, Gillberg C, Råstam M, Gillberg C, Wentz E. Anorexia nervosa: 30-year outcome. Br J Psychiatry. 2020;216:97–104. https://doi.org/10.1192/bjp.2019.113
20. Eddy KT, Tabri N, Thomas JJ, Murray HB, Keshaviah A, Hastings E, et al. Recovery from anorexia nervosa and bulimia nervosa at 22-year follow-up. J Clin Psychiatry. 2017;78:184–9. https://doi.org/10.4088/JCP.15m10393
21. Löwe B, Zipfel S, Buchholz C, Dupont Y, Reas DL, Herzog W. Long-term outcome of anorexia nervosa in a prospective 21-year follow-up study. Psychol Med. 2001;31:881–90. https://doi.org/10.1017/s003329170100407x
22. Charland LC. Ethical and conceptual issues in eating disorders. Curr Opin Psychiatry. 2013;26:562–5.
23. Giordano S. Anorexia nervosa: a case for exceptionalism in ethical decision making. Philos Psychiatry Psychol. 2019;26:315–31. https://doi.org/10.1353/ppp.2019.0047
24. Dworkin G. In: Zalta EN, editor. Paternalism. The Stanford Encyclopedia of Philosophy; 2020.
25. 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 Bioeth. 2015;15:53–4. https://doi.org/10.1080/15265161.2015.1042991
26. Giordano S. Anorexia and refusal of life-saving treatment: the moral place of competence, suffering, and the family. Philos Psychiatry Psychol. 2010;17:143–54. https://doi.org/10.1353/ppp.0.0286
27. Westermair AL, Buchman DZ, Levitt S, Trachsel M. Palliative psychiatry for severe and enduring anorexia nervosa includes but goes beyond harm reduction. Am J Bioeth. 2021;21:60–2. https://doi.org/10.1080/15265161.2021.1926594
28. Draper H. Anorexia nervosa and respecting a refusal of life-prolonging therapy: a limited justification. Bioethics. 2000;14:120–33.
29. Yager J. Managing patients with severe and enduring anorexia nervosa: when is enough enough? J Nerv Ment Dis. 2020;208:277–82. https://doi.org/10.1097/NMD.0000000000001124
30. Gans M, Gunn WB Jr. End stage anorexia: criteria for competence to refuse treatment. Int J Law Psychiatry. 2003;26:677–95. https://doi.org/10.1016/j.ijlp.2003.09.004

31. Campbell AT, Aulisio MP. The stigma of mental illness: end stage anorexia and treatment refusal. Int J Eat Disord. 2012;45:627–34. https://doi.org/10.1002/eat.22002
32. Trachsel M, Wild V, Biller-Andorno N, Krones T. Compulsory treatment in chronic anorexia nervosa by all means? Searching for a middle ground between a curative and a palliative approach. Am J Bioeth. 2015;15:55–6. https://doi.org/10.1080/15265161.2015.1039730
33. Westermair AL, Perrar KM, Schweiger U. Ein palliativer Ansatz für schwerste anorexia nervosa? [A palliative approach for severest anorexia nervosa?]. Nervenarzt. 2020;91:411–6. https://doi.org/10.1007/s00115-020-00875-3
34. Trachsel M, Irwin SA, Biller-Andorno N, Hoff P, Riese F. Palliative psychiatry for severe persistent mental illness as a new approach to psychiatry? Definition, scope, benefits, and risks. BMC Psychiatry. 2016. https://doi.org/10.1186/s12888-016-0970-y
35. 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. 2010;43:372–7. https://doi.org/10.1002/eat.20701
36. Kelly M, Dowling M, Millar M. The search for understanding: the role of paradigms. Nurse Res. 2018;25:9–13. https://doi.org/10.7748/nr.2018.e1499
37. Liamputtong P, Ezzy D. Qualitative research methods. 2nd ed. Oxford: Oxford University Press; 2006.
38. Bowen GA. Document analysis as a qualitative research method. Qual Res J. 2009;9:27–40. https://doi.org/10.3316/QRJ0902027
39. Opel DJ, Wilfond BS, Brownstein D, Diekema DS, Pearlman RA. Characterisation of organisational issues in paediatric clinical ethics consultation: a qualitative study. J Med Ethics. 2009;35:477–82.
40. Wasson K, Anderson E, Hagstrom E, McCarthy M, Parsi K, Kuczewski M. What ethical issues really arise in practice at an academic medical center? A quantitative and qualitative analysis of clinical ethics consultations from 2008 to 2013. HEC Forum. 2016;28:217–28. https://doi.org/10.1007/s10730-015-9293-5
41. Johnson LM, Church CL, Metzger M, Baker JN. Ethics consultation in pediatrics: long-term experience from a pediatric oncology center. Am J Bioeth. 2015;15:3–17. https://doi.org/10.1080/15265161.2015.1021965
42. Montaguti E, Schürmann J, Wetterauer C, Picozzi M, Reiter-Theil S. Reflecting on the reasons pros and cons coercive measures for patients in psychiatric and somatic care: the role of clinical ethics consultation. A pilot study. Front Psychiatry. 2019. https://doi.org/10.3389/fpsyt.2019.00441
43. Reiter-Theil S. Initiating and maintaining clinical ethics support in psychiatry: ten tasks and challenges – and how to meet them. Clin Ethics. 2016;11:45–53. https://doi.org/10.1177/1477750916649119
44. Reiter-Theil S, Schürmann J. The big five in 100 clinical ethics consultation cases. Bioethica Forum. 2016;9:60–70. https://doi.org/10.24894/bf.2016.09013
45. Westermair AL, Buchman DZ, Levitt S, Perrar KM, Trachsel M. Palliative psychiatry in a narrow and in a broad sense: a concept clarification. Aust N Z J Psychiatry. 2022;56:1535–41. https://doi.org/10.1177/00048674221114784
46. Tapper EB, Vercler CJ, Cruze D, Sexson W. Ethics consultation at a large urban public teaching hospital. Mayo Clin Proc. 2010;85:433–8. https://doi.org/10.4065/mcp.2009.0324
47. Kuckartz U. Qualitative inhaltsanalyse [Qualitative content analysis]: methoden, praxis, computer-unterstützung [methods, practice, computer assistance]. 4th ed. Weinheim: Beltz Juventa; 2018.
48. Pearlman RA, Foglia MB, Fox E, Cohen JH, Chanko BL, Berkowitz KA. Ethics consultation quality assessment tool: a novel method for assessing the quality of ethics case consultations based on written records. Am J Bioeth. 2016;16:3–14. https://doi.org/10.1080/15265161.2015.1134704
49. Salloch S, Ritter P, Wäscher S, Vollmann J, Schildmann J. Was ist ein ethisches problem und wie finde ich es? Theoretische, methodologische und forschungspraktische fragen der identifikation ethischer probleme am beispiel einer empirisch-ethischen interventionsstudie [What is an ethical problem and how do I find it? Theoretical, methodological and practical questions to identify ethical problems in an empirical–ethical intervention study]. Ethik Med. 2016;28:267–81. https://doi.org/10.1007/s00481-016-0384-x
50. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research:

exploring its conceptualization and operationalization. Qual Quant. 2018;52:1893–907. https://doi.org/10.1007/s11135-017-0574-8

51. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89:1245–51. https://doi.org/10.1097/ACM.0000000000000388
52. Wonderlich SA, Bulik CM, Schmidt U, Steiger H, Hoek HW. Severe and enduring anorexia nervosa: update and observations about the current clinical reality. Int J Eat Disord. 2020;53:1303–12. https://doi.org/10.1002/eat.23283
53. Maguire S, Surgenor LJ, Le Grange D, Lacey JH, Crosby RD, Engel SG, et al. Examining a staging model for anorexia nervosa: empirical exploration of a four stage model of severity. J Eat Disord. 2017. https://doi.org/10.1186/s40337-017-0155-1
54. Bianchi A, Stanley K, Sutandar K. The ethical defensibility of harm reduction and eating disorders. Am J Bioeth. 2021;21:46–56. https://doi.org/10.1080/15265161.2020.1863509
55. Tsiandoulas K, McSheffrey G, Fleming L, Rawal V, Fadel MP, Katzman DK, McCradden MD. Ethical tensions in the treatment of youth with severe anorexia nervosa. Lancet Child Adolesc Health. 2023;7:69–76. https://doi.org/10.1016/S2352-4642(22)00236-X
56. Westermair AL, Weber S, Westmoreland P, Mehler PS, Elsner F, Trachsel M. Scoping review of end-of-life care for persons with anorexia nervosa. Ann Palliat Med. 2024;13:685–707. https://doi.org/10.21037/apm-23-522
57. Westermair AL, Trachsel M. Moral intuitions about futility as prompts for evaluating goals in mental health care. AMA J Ethics. 2023;25:E690–702. https://doi.org/10.1001/amajethics.2023.690
58. Walker DC, Heiss S, Donahue JM, Brooks JM. Practitioners' perspectives on ethical issues within the treatment of eating disorders: results from a concept mapping study. Int J Eat Disord. 2020;53:1941–51. https://doi.org/10.1002/eat.23381
59. Kendall S. Anorexia nervosa: the diagnosis. A postmodern ethics contribution to the bioethics debate on involuntary treatment for anorexia nervosa. J Bioeth Inq. 2014;11:31–40. https://doi.org/10.1007/s11673-013-9496-x