Refusing to Eat: Assessment, Management, and Ethical Implications for Consultation-Liaison Psychiatry

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Introduction

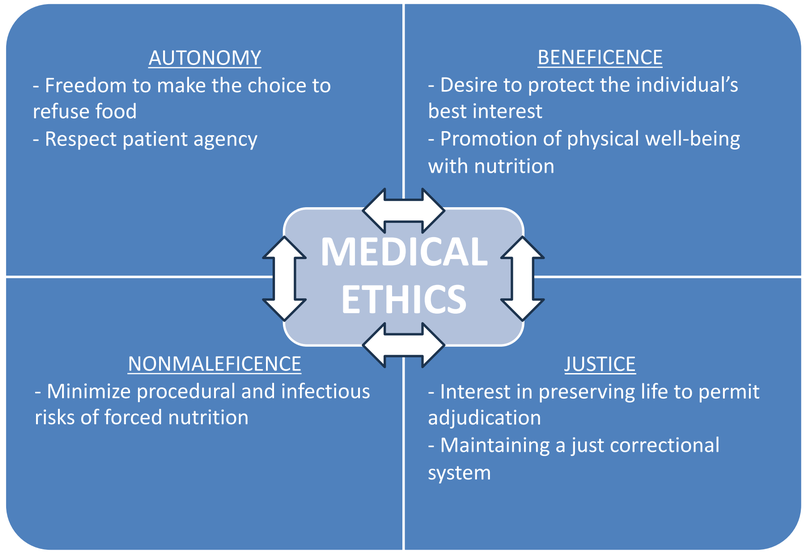
Refusal to Eat:

Diagnostic challenge:

- Several Etiologies:
  - General Medical Conditions
    - Delirium
    - Dementia
    - Gastrointestinal disorders
- Psychiatric Conditions
  - Psychosis
  - Depression
  - Catatonia
  - Eating disorders
- Volitional in specific populations
  - Outlet to express anger and reduce tension in restrictive environments
  - As form of protest
  - Religious beliefs
- Inability/refusal to communicate reasoning of food refusal complicates diagnosis
- Medical-legal barriers can impede obtaining collateral to clarify diagnosis

Therapeutic Challenge:

- Potentially responsive to observation and counseling
- Treatment response and cooperation are highly dependent on establishment of
- trust and alliance between patient and provider
- Difficult to establish therapeutic alliance within prison system or involuntary psychiatric hold, where the physician may be viewed as a part of the establishment
- Psychiatric illness does not automatically pronounce a patient to lack capacity to refuse food
- In practice, complicated to force nutrition on patients: forced feeding tube or IV nutrition



Case Presentation

One Liner: Ms. X is a 29 year old female with a chart history of bipolar disorder, borderline personality disorder, stimulant use disorder (cocaine, methamphetamine), and sinus tachycardia admitted to Internal Medicine from jail for dehydration, hypokalemia, and palpitations due to reduced oral intake.

History of Present Illness:

- Largely did not provide much history
- Brought in by EMS for sinus tachycardia; given IV adenosine x2
- Reported urinary incontinence and numbness in the bilateral lower extremities

Initial Psychiatry Evaluation:

- CC: "I don't want my private records to be sold"
- Initially concerned about her heart condition, referring to the tachycardia
- Progressed to explaining she was having difficulty coping with her anxiety
- Reported feeling "forsaken" due to limited support system
- Attributed lack of intake to dietary preferences: dairy allergy, does not eat pork
- Stated she did not want psychotropics because she believed they worsen mental health conditions
- Requested second opinion from Internal Medicine physician
- Denied SI/HI/AVH

Psychiatric History:

- Bipolar I Disorder with psychotic features requiring prior hospitalizations for manic episodes
- Substance induced psychotic disorder
- Substance use disorder (cocaine, methamphetamines, marijuana, nicotine)
- Borderline personality disorder
- Has required 3 inpatient psychiatric hospitalizations

Family History: no history of mental illness, substance use or suicide attempts

Social History:

- Substance use:
  - Currently smoking 0.5 packs/day
  - Denies alcohol use
  - Prior history of cocaine, methamphetamines, marijuana and cocaine

VS: Temp: 37.3C (99.1F), HR 148, RR 18, BP 141/89, Sat: 98% on room air

Labs:

140	104	4	92
3.3	20	0.49	

	13.5	
7.88		288
	39.9	

- Liver Panel: within normal limits
- Lactate: 1.9; VBG: 7.45/31/97
- Nutrition Labs:
  - B12: 1290
  - Copper: 87
  - B-hydroxybutyrate: 2.4 (elevated)
- TSH: 1.37
- Urine: notable for ketonuria, small blood, 500 large leukocyte esterase, and 27 WBC
- Ingestion Labs:
  - Acetaminophen level: <5
  - Salicylate level: <0.3
  - Ethanol: <10
  - Urine Tox Screen: negative
- Infectious:
  - Syphilis: RPR negative
  - HIV: NR

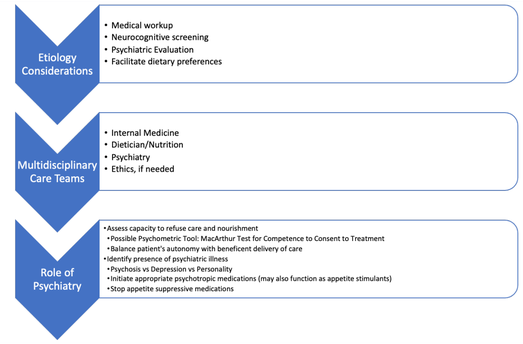
Imaging:

- CXR: no acute abnormality
- MR lumbar spine w/wo IV contrast: unremarkable

Clinical Course

- Psychiatry consulted to help determine whether psychiatric decompensation was driving her refusal to eat
- Patient continued to decline being interviewed, and declined most medications and therapies, repeatedly claiming she was being harassed
- Due to the patient's refusal to engage in the interview, she could not demonstrate capacity to refuse to eat
- No overt evidence of agitation, depression, anxiety, mania, or psychosis, but unable to rule out
- A multidisciplinary approach was taken to attempt increasing her oral intake:
  - Hydration with IV fluids and electrolyte repletion
  - Clarification of dietary preferences
  - Encouragement from the primary team
  - Empiric trial of olanzapine
- While the patient's lab derangements improved, she continued to refuse to eat
- Ethics Consult: Since she was not emergently ill, ethically, the team could not force nutritional treatment.
- Transferred back to jail for further psychiatric evaluation in the jail mental health unit
- Ultimately readmitted and found to have acute inflammatory demyelinating polyneuropathy treated with IVIG
- Course complicated by catatonia requiring treatment, which resolved. Now admitted currently with rapidly cycling bipolar disorder, in current depressive episode.

Suggested Therapeutic Approach



DEI Correlate

Conclusions

- Important to not anchor on psychiatric illness as primary etiology in patients with history of serious mental illness
- Proactive involvement of consultants early to facilitate wholistic delivery of care
- Crucial to determine if refusal to eat is emergent or life-threatening as it would change management
- Not a large evidence base for patients who present in this way
  - Avenues for future research:
    - Development of diagnostic algorithm, perhaps as suggested here today
    - Evidence for antipsychotic/psychotropic management in these cases
    - Development of ethical guidelines to facilitate care delivery

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References

1. Brockman B. (1999). Food refusal in prisoners: a communication or a method of self-killing? The role of the psychiatrist and resulting ethical challenges. *Journal of medical ethics*, 25(6), 451–456. https://doi.org/10.1136/jme.25.6.451
2. Dresser RS, Boisaubin EV Jr. Psychiatric patients who refuse nourishment. *Gen Hosp Psychiatry*. 1986 Mar;8(2):101-6. doi: 10.1016/0163-8343(86)90093-9. PMID: 3082715.
3. Gillon R. (1994). Medical ethics: four principles plus attention to scope. *BMJ (Clinical research ed.)*, 309(6948), 184–188. https://doi.org/10.1136/bmj.309.6948.184
4. Harris JC. Anorexia Nervosa and Anorexia Mirabilis: Miss K. R— and St Catherine of Siena. *JAMA Psychiatry*. 2014;71(11):1212–1213. doi:10.1001/jamapsychiatry.2013.2765
5. Larkin E. P. (1991). Food refusal in prison. *Medicine, science, and the law*, 31(1), 41–44. https://doi.org/10.1177/002580249103100108
6. Nagahama, Y., Ito, T., Fujishiro, H., Akutagawa, H., Okabe, M., Ohtaki, H., Tsukada, S., & Fukui, T. (2022). Outcome of therapeutic interventions against food refusal in patients with dementia. *Psychogeriatrics : the official journal of the Japanese Psychogeriatric Society*, 22(1), 156–158. https://doi.org/10.1111/psyg.12769
7. Sullivan MD, Youngner SJ. Depression, competence, and the right to refuse lifesaving medical treatment. *Am J Psychiatry*. 1994 Jul;151(7):971-8. doi: 10.1176/ajp.151.7.971. PMID: 8010382.
8. Swindell, J. S., Coverdale, J. H., Crisp-Han, H., & McCullough, L. B. (2010). Focus on patient management: responsibly managing psychiatric inpatient refusal of medical or surgical diagnostic work-up. *Psychiatric services* (Washington, D.C.), 61(9), 868–870. https://doi.org/10.1176/ps.2010.61.9.868