Universiteit Utrecht

THE VALUE OF BEING THIN

An ethical analysis of the conflict caused by the unusual balance in values of AN patients.

MASTER THESIS IN APPLIED ETHICS

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ABSTRACT

In this thesis I will explore a conflict that medical practice is faced with, when dealing with patients who suffer from anorexia nervosa. These patients are primarily concerned with losing weight, in order to achieve their ultimate aim of being thin. This aim is in common perception and in medical practice considered as unreasonable. Therefore, medical practice is aimed at treating these patients to regain a healthy weight and prevent them from death as a result of their underweight. In medical practice, competent patients are allowed to make autonomous decisions with regards to their treatment. Although patients with anorexia nervosa hold a rather unusual balance in their values, they satisfy the required criteria for competence. Medical practice is legally required to take the decisions of these patients seriously. Since their decisions can threaten their health and their life, it is unclear how medical practice should deal with this issue. This study illustrates an ethical analysis of this conflict, and offers three lines of reasoning medical practice can accept to deal with this matter. My main aim is to illustrate which options there are for medical practice, in order to support the wellbeing of patients with anorexia nervosa. This analysis will provide an answer to the question whether or not medical practice should accept that people with anorexia nervosa value being thin as more important than their health or their life.

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INTRODUCTION

Anorexia nervosa is a mental disorder which is characterized by the extreme thinness of its sufferers. Patients with anorexia nervosa (hereafter referred to as AN) have a strong aversion towards fatness. Even though they are very thin, they perceive themselves as being too fat. A self-imposed and strict diet aimed at losing weight, results in the extreme underweight typical to AN.[1] Other associated behaviours are vomiting, over-exercising and the abuse of laxatives.[2] The consequences of AN can seriously endanger the health of the patients and can eventually lead to death.[3,4] The largest proportion of people who are affected by this disorder are young women in their teenage years or young adulthood. Because AN occurs significantly less among men and mainly strikes people in westernised countries, it is argued that there are certain sociological influences which effect the development of the disorder, such as a westernisation of the culture or an idealisation of thinness. Some other factors which are believed to influence its development are a low self-esteem, a family history of eating disorders, perfectionism and a dissatisfaction with one's body. The exact relation between the development of the disorder and these influences remains unclear.[5] In this thesis I will explore the unique characteristics of anorexia nervosa and the difficulties this can lead to for medical practice. A remarkable characteristic of this mental disorder is that patients tend to have a different balance in their values than people who do not suffer this illness.[6] Unlike most people, AN patients do not accept *health* as one of their primary values.[7] Instead, they value *being thin* as their main aim. The importance of being thin overrules all other values until the extent when it becomes more important than health or life itself.[8] This issue leads to concerns in medical practice about how to deal with the unusual balance in values of AN patients. Patients are legally permitted to make decisions with regards to their treatment when they have the capacities to be considered *competent,* such as being able to understand their condition and the consequences of different treatment options. Unlike most people who suffer from a mental disorder, AN patients seem to match these criteria for competence quite well. They seem to have a clear

[1] WHO. (1993) p.135
[2] Tan, J. et al. (2003a) p. 627
[3] Tan, J. et al. (2003a) p. 627
[4] Tan, J et al. (2010) p. 12
[5] Tan, J. Hope, T. Steward, A. (2003b) p. 533
[6] Tan, J. et al. (2006) p.273
[7] Holroyd, J. (in Radoilska, L) (2012) p. 156
[8] Tan, J. et al. (2006) p.274

understanding of their condition and make their choices based on rational considerations.[9] Health care has to take the decisions of AN patients seriously, because they are considered competent. However, their unusual balance in values leads to choices which can be difficult to accept for medical practice. For instance, AN patients are likely to choose to refuse treatment, even though this would endanger their lives. In this thesis I will investigate whether or not health care should accept that people who suffer from AN value *being thin* as more important than health or their lives. Firstly, I will address the issue of competence, in order to provide a more substantive understanding of the conflict. Secondly, I will illustrate the current debate with regards to the issues of competent patients with an unusual set of values. Thirdly, I will offer an approach for medical practice to deal with the unusual balance in values of AN patients, by illustrating three theories of wellbeing. Finally, I will provide a final answer to the question whether or not medical practice should accept that people with AN value being thin as more important than health or their lives. The main aim of this thesis is to explore the best way for medical practice to deal with this conflict. Therefore, I will aim at applying these theories, rather than evaluating the plausibility of theories themselves.

[9] Tan, J. et al. (2003) p. 627

1. COMPETENCE

The competence of AN patients leads to difficult issues for medical practice. The unusual set of values of AN patients leads to odd decisions with regards to their treatment. In this paragraph I will touch on the specific issues medical practice is concerned with, by illustrating criteria used to assess competence and relate these to people who suffer from AN.

1.1 Assessing Competence

Promoting the wellbeing of patients has traditionally been the primary aim for medical practice.[10] This idea has led to a shift over the last decades, from a directive patient-doctor relationship, towards a relationship of shared decision making. The aims and values of competent patients are now considered in the process, whereas traditionally they were only slightly taken into account.[11] The reason why the preferences of patients are considered, is because they know best what is best for themselves.[12] For instance, a physician might consider it is best for a patient who suffers from severe pain to take painkillers, even though they make him sleepy. The patient might attach more value to being alert than to get relieved from pain, therefore the patient would judge to withhold from the painkillers. The development towards shared decision making has changed the influence of both the physician and the patients. Traditionally, it was the role of the physician to decide for the patient. Today, he has to advise the patient and share his expertise and knowledge. The patient uses his aims and values to balance the consequences of the advise provided by the physician.[13] This transition in medical practice has given competent patients a substantial influence in the process of their treatment. The physician uses a competence assessment tool to determine whether a patient can be considered competent. These tools prescribe the criteria which a patient has to satisfy in order to be considered competent. A widely accepted instrument is the *MacArthur Competence Assessment Tool – Treatment* (MacCAT-T).[14] This tool measures people's capacity in four elements, these are; the ability to

[10] Buchanan, A.E. Brock, D.W. (1989) p.29
[11] Brock, D.W. Wartman, S.A. (1990) p.1595,1596
[12] Buchanan, A.E. Brock, D.W. (1989) p.29
[13] Buchanan, A.E. Brock, D.W. (1989) p.29
[14] Tan, J. et al. (2006) p.268

understand relevant information, the capacity to reason about the potential risks and benefits of the available options, appreciation of one's situation and the consequences of each choice, and finally the capacity to express a decision.[15] Another competence assessment tool, which is used in the UK, is the Mental Capacity Act (MCA). This act regulates the process of decision making for people who are found to be legally incompetent. The act describes certain factors used to determine a patients competence. A person lacks capacity, according to the MCA, when he or she is unable to understand relevant information, retain this information in his or her memory, weigh that information, and communicate the decision.[16] The assessment of the competence of patients is in the Netherlands regulated under the *´Wet op de geneeskundige behandelingsovereenkomst´* (WGBO). This law prescribes the rights of patients to get access the necessary things to make a good decision, which among other things includes that patients need to get sufficient information about their medical condition, an adequate amount of privacy and a substitute decision maker for those who are incompetent.[17] The criteria which the WGBO uses to determine the competence of patients are; whether they have the capacity to understand and balance the options for treatment, whether they understand the consequences of certain decisions and finally whether or not a person is capable of making a decision.[18]

The criteria to assess competence differ per assessment tool. However, they all emphasise the importance of the ability to understand and weigh information relevant to their condition and treatment. Patients who satisfy the criteria in the assessment tools, are legally permitted to influence the process of decision making with regards to their treatment. In the next paragraph I will illustrate on what basis AN patients are considered competent and what issues this causes for medical practice.

1.2 The Competence of AN Patients

The competence of patients is assessed by a physician with the use of competence assessment tools. Patients who are considered competent are legally allowed to join in the process of decision making and their preferences has to be taken seriously by the physician.

[15] Appelbaum, P.S. Grisso, T and Hill-Fotouhi, C. (1997) p.1415
[16] Finstein, E. (in Radoilska, L) (2012) p.172
[17] Rijksoverheid: Wet op de geneeskundige behandelingsovereenkomst (2015)
[18] Rijksoverheid: Wilsonbekwaamheid (2014)

For instance, a competent patient who needs lung surgery to prolong his life, has the freedom to choose whether or not he wants to accept this treatment. Although a physician might not agree with this decision, he has to accept the patient´s wishes. Jochen Volmann shows that many people who suffer from a mental disorder do not satisfy the required criteria for competence.[19] In a quantitative study on the competence of people with AN, Jacinta Tan et al. found that AN patients scored well on the MacCAT-T test. Although many of the participants showed difficulties with thought processing and concentration, most of them appeared to have a reasonably high score in understanding their condition and the additional risk. Also their reasoning abilities and their ability to express their choice was perceived as adequate.[20] One of the participants who was interviewed in this study, expressed that he/she was aware of everything that happened around him/her, even while being very ill. The mother of the participant replied that she believed that the reasoning ability of her child was not decreased due to the disorder, but functioned rather well. She argued that her child understood the facts and consequences of his condition very well. The mental capacity of her child was improved due to the time he/she spent thinking about the consequences of each decision relevant to the disorder.[21] In medical practice, it is also recognised that AN patients can be considered competent. Lot Sternheim, a postdoctoral researcher at Utrecht University on the topic of eating disorders, confirms the conclusion drawn by Tan et al. She explains that the physicians who work with AN patients check whether their patients can be considered competent. Although AN patients can sometimes be tired and clouded in their thoughts due to malnourishment, most of them seem to understand the facts and consequences of their conditions quite well.[22] Volmann argues that the fact that AN patients can be considered competent is a unique characteristic of AN, because all other patients with a mental disorder examined by the MacCAT-T scan showed a decrease in their mental capacities.[23] Having diminished mental capacities is not part of the diagnostic criteria of AN, as shown in the *´Classification of Mental and Behavioural Disorders´* of the World Health Organisation. The only characteristic which is related to the mental capacity of AN patients, is that they have a mistaken self-perception - they perceive

[19] Vollmann, J. (2006) p.290
[20] Tan, J. et al. (2006) p.270
[21] Tan, J. et al. (2006) p.271
[22] Sternheim, L. (2016) Telephone interview
[23] Vollmann, J. (2006) p.290

themselves as being too fat.[24] Apart from a false body image, it is not part of the characteristics of the disorder, that the patients show a decrease in their cognitive capacities.

Although Tan et al. show that AN patients have the required capacities to be considered competent, they express reason for hesitation. Their study shows that some of the participants had difficulties in concentration and thought processing. Firstly, due to their low weight, the patients show difficulties in thinking. The ability to focus on one thing for a long time, the ability to be aware of their condition, as well as the ability to process thoughts seem declined.[25] One of the participants in their research mentions that he/she could only concentrate on something when he/she really wanted to know what it is and also that it is difficult to concentrate on something for a long time.[26] Secondly, due to a mistaken body image, AN patients show an inconsistency in what they know and what they believe. Often participants are aware of the seriousness of their condition. Since their perception of their body does not match the factual information about the seriousness of their illness, it is hard for them to believe that information about their condition actually applies to themselves.[27] One of the participants mentioned that, when he/she was very ill, he/she did not believed that there was an actual risk of dying.[28] Even though some of the most severe AN patients can be judged as competent, AN has an influence the decision making capacity of the patients.[29] Many of the participants in Tan et al. their research express that their ability to make autonomous decisions is affected by the amount of freedom which physicians provide them with. Therefore, Tan et al. argue that physicians should facilitate the competence of AN patients, rather than hinder it.[30]

As shown in this paragraph, AN patients are considered competent. Because they are legally permitted to join in the process of decision making, physicians have to take their decisions seriously. Like I have already mentioned, AN patients have an unusual balance in their values. They value being thin to such an extent that they perceive it as more important

[24] WHO. (1993) p.135,136
[25] Tan, J. et al. (2006) p.270
[26] Tan, J. et al. (2006) p.270
[27] Tan, J. et al. (2006) p.270,271
[28] Tan, J. et al. (2006) p.272
[29] Tan, J. et al. (2006) p.276, 279
[30] Tan, J. et al. (2006) p.273

than their health or their life.[31] This divergent set of values leads to some odd decisions. For instance, people with AN generally choose to refuse treatment for their disorder, even when accepting treatment would benefit their health significantly and possibly safe their life.[32] The Dutch television show *'Tot op het bot'* shows the image of teenage girls who are significantly endangered by their low weight. Some of these girls value being thin so highly, that they starve themselves to the extent that their health and lives are severely put at risk. In spite of the fear expressed by their surroundings (family, friends, and medical practice) that their disease will result into their death, some of the girls kept refusing to eat anything which could lead to the increase of their weight.[33] Such dangerous decisions are considered irrational and wrong by most people. Therefore it seems tempting to overrule such unusual decisions. However, since AN patients are competent, physicians cannot simply disregard these unusual choices for being odd. The conflict between the odd balance in values and the competence of AN patients, leads to difficult issues for medical practice, because it is unclear how physicians should deal with this ambiguity. This study aims at finding what the best way is to deal with this unusual set of values. This issue has been already been addressed in the ethical debate. However, I will show that this does not provide a substantive answer to how medical practice should deal with the unusual values of AN patients. In the next paragraph I will illustrate the debate with regards to competence and values and show what I believe is missing. Later in this thesis, I will offer a different way to approach this conflict.

2. COMPETENCE AND VALUES

Physicians are legally required to take the unusual decisions of AN patients seriously, because they have the capacities required for competent. Although it is clear that the decisions of AN patients cannot simply be disregarded, it remains unclear how physicians should deal with their unusual values. The difficulties which are caused by competent

[31] Tan, J. et al. (2006) p.274
[32] Tan, J. et al. (2003) p.627
Tan, J. Hope, T. Stewart, A (2003a) p.697
[33] Tot op het bot. *"Episode 1-6"* (2013)

patients with a divergent set of values, has led to the claim of some authors that there is something wrong with the way in which competence is assessed.

Louis C. Charland refers back to the research proposed by Tan et al, and argues for a different understanding of the way in which competence should be assessed. He claims that the standard tools used to assess a person´s competence are not sufficient, because they fail to consider a person's underlying values. Charland claims that personal values are required for competence, because people need to have a set of values in order to weigh the risks and benefits of their options. Therefore, people cannot be considered competent when they do not have a clear set of values.[34] Allen E. Buchanan and Dan W. Brock argue for an equal understanding of competence. They argue that there are three capacities required for competence. The first two capacities - which are the capacity to understand and to communicate, and the capacity to reason and deliberate - are equal to those in common assessment tools (e.g. MacCAT-T scan or the MCA). The third capacity is to have a clear set of values and goals, which is required in order to evaluate the harms and benefits of a certain decision.[35] Buchanan and Brock understand competence as a *relational property*. This means that the competence of a person is not only depended upon his capacities, but also on some aspects of the decision itself.[36] For instance, a person might be competent to decide what to eat for dinner, but not competent to decide whether or not to undergo surgery. According to Buchanan and Brock, the competence of a patient depends on the amount of risk or benefit attached to a certain decision.[37] People need only a small amount of competence to decide on a low risk choice, and need a large amount of competence for a high risk choice. How risky (or beneficial) a certain decision is, depends on the amount of value people attach to the subject of the decision.[38] For instance, when a person highly values being independent, than the choice to undergo surgery which will improve the flexibility of his limbs is of much higher risk, than the choice to undergo surgery that will regain the growth of his hair. For a person who highly values looking good, the latter choice is of higher risk. The high risk choice required a higher degree of competence. In following Buchanan and Brock's line of reasoning, this means that the competence of a person

[34] Charland, C. J. (2007) p. 283,284
[35] Buchanan, A.E., Brock, D.W. (1989) p.23
[36] Buchanan, A.E., Brock, D.W. (1989) p.60
[37] Buchanan, A.E., Brock, D.W. (1989) p.51
[38] Buchanan, A.E., Brock, D.W. (1989) p.52

depends on his values. Since the amount of competence is determined by the amount of risk of a certain decision, and the amount of risk is determined by a person's values, the competence of a person depends on his/her values. According to Buchanan and Brock, the amount to which a choice affects the values of people determines whether or not someone should be considered competent to make particular decision.

I agree with Buchanan and Brock that a more or less stable set of values is needed order to make a decision. Without values, it is difficult to decide what option for treatment you prefer. However, I disagree that personal values should be considered in order to assess the competence of a patient. Taking personal values into account leads to certain issues with regards to people who have an unusual set of values. Considering personal values in assessing people´s competence, implies that accepting certain values indicate a ´higher level´ of competence than accepting other values would. For instance, there are two people with equal rational capacities. If their values were considered in assessing their competence, this would mean that the person who attaches more value to watching documentaries, would be considered more competent, than a person with the same capacities who values watching reality series. Marc Wicclair emphasizes this argument by claiming that the competence of a person cannot depend on the content of his choices. He argues that competence implies that a person is able to balance different options for treatment. Claiming that a person is competent when he chooses option A, but incompetent when he chooses B, is simply wrong. Wicclair describes a situation of two people who have to decide whether to accept or forgo some treatment. Refusing the treatment would lead to substantial harm, accepting it would result in prolonging their lives. The person who accepts this treatment, would be considered competent, the person who refuses it as incompetent. Wicclair shows with this example, that arguing that the level of competence of a person depends upon his values is mistaken. Deciding on either one of these options (to accept or refuse treatment), requires the ability to weigh and understand the consequences of both.[39] Therefore, only the rational abilities of people should be considered as necessary capacities for competence and people their values should not be considered in determining whether or not someone is competent. Govert den Hartogh emphasises this argument. He argues that many theorists claim that the standard conception of competence - as expressed in the MacCAT-T scan or other instruments - is flawed, because they fail to consider a person´s values. According to these theorists it is

[39] Wicclair, M.R. (1991) p. 103,104

unclear how physicians should deal with people who hold a different set of values, because their values are not taken into account. For instance, it is argued that these tools are incapable to deal with the peculiarity of anorexia nervosa, because they fail to consider with the fact that AN patients weigh a disproportionate value to being thin.[40] Den Hartogh disagrees with this claim. He believes that competence should be understood as the ability to reason about what you believe is important. Values are merely an input for this process. Thus, although competent patients need their values to come to a decision, having values is not part of competence itself. Therefore, the absence of a coherent set of values cannot indicate a lack of competence.[41]

I agree with Den Hartogh and Wicclair that personal values should not be considered in assessing a person's competence. Competence implies the ability to understand and balance all options for treatment, a person's values are merely an input to get to a decision. Claiming that a person is competent, only when he accepts value A and not B, disregards the capacity of patients to balance and weigh options for treatment.

The conflict of competent patients who have an unusual set of values is addressed by arguing whether or not personal values should be considered in the assessment of competence. As shown, this is not a good solution to deal with competent patients with unusual values. The fact that AN patients are competent, requires physicians to take their decisions seriously. In the next paragraph I will propose a different way for medical practice to deal with the competence of people with AN and their unusual set of values.

3. WELLBEING

The unusual set of values of AN patients leads to difficulties for medical practice. Due to their balance in values, they make decisions which are generally regarded as odd and dangerous. Because AN patients are competent, physicians are legally compelled to take these choices seriously. However, accepting that they refuse treatment in order to lose weight, will cause serious damage to their health and will probably lead to their death.

[40] Den Hartogh, G. (2015) p.79
[41] Den Hartogh, G. (2015) p.79,80

Considering people's values in assessing their competence - as is suggested to be a solution to this conflict - disregards people´s rational capacity to balance different options for treatment.

The ultimate aim of medical practice has traditionally been to promote the wellbeing of their patients. Competent patients therefore are allowed to choose the option for treatment they regard as best for themselves.[42] With AN, this leads to difficulties for medical practice, because their decisions are not generally regarded to promote their wellbeing. Isis Elzakkers et al. refer to this issue by examining whether or not overriding the preference of AN patients to refuse treatment will be beneficial for them. In order to find an answer, they have reviewed and summarized all the obtainable and relevant literature on the subject. Their research illustrates that compulsory treatment will promote the wellbeing of AN patients in the short run. Their wellbeing is promoted, because treatment will save their lives, and also because most patients will eventually recognize the importance of treatment.[43] The long-term effects of enforced medical care are unknown, because they have not been studied sufficiently.[44] Since it is unsure whether the wellbeing of AN patients is promoted if their preferences are disregarded and they are forced into treatment (especially on the long term), research has not provided a sufficient answer on what balance in values promotes the wellbeing of AN patients best. In order to answer the question whether or not medical practice should accept that AN patients value being thin as more important than their life, I will offer an ethical approach to illustrate what balance in values will promote the wellbeing of AN patients best.

Derek Parfit addresses the notion of wellbeing. He mentions that there are three theories which provide an answer to the question: what is best for a person? These theories are an hedonist theory, a desire-based theory and an objective-list theory. An hedonist account prescribes that what is best for people, is what would make his life the happiest. A desire-based theory of wellbeing prescribes that what is best for a person is to fulfil his desires. Finally, according to an objective-list account there are things that are good and bad for a person, apart from what a person perceives as best for himself.[45] In the next paragraphs, I will illustrate each theory more substantively and relate it to the practice of AN. The main

[42] Buchanan, A.E. Brock, D.W. (1989) p.29
[43] Elzakkers, I. et al. (2014) p.849
[44] Elzakkers, I. et al. (2014) p.847
[45] Parfit, D. (2012) p.294

aim of this thesis is to study whether or not medical practice should accept that AN patients value being thin as more important than their health or their lives. For that reason, I will not offer a critical analysis of the theories themselves, but address these theories to illustrate what could follow if medical practice would accept this line of reasoning.

4. HEDONIST THEORY OF WELLBEING

In this paragraph I will illustrate to what extent the wellbeing of AN patients is promoted, if medical practice would accept the balance of values as prescribed by the hedonistic approach. Firstly, I will offer a more substantive overview of the hedonistic theory. Secondly, I will relate this theory to the balance of values of AN patients, in order to see to what extent their wellbeing is promoted if medical practice would accept this line of reasoning.

4.1 Hedonism

The hedonistic theory of wellbeing prescribes that what is best for people, is what makes them the happiest.[46] In the hedonist theory, wellbeing is defined as the experience of happiness, which is understood as the positive balance between experiences of pleasure and the avoidance of pain.[47] Jeremy Bentham and John Stuart Mill are the two most influential hedonists. Bentham argues that an action is morally right when it maximizes the overall happiness of all people who are affected by it. Bentham understands pleasure and pain mainly in terms of physical experience.[48] In balancing happiness he considers everyone involved, thus also those who are not directly affected by the action.[49] There are certain objections against Bentham´s utilitarian theory, which are primarily related to his simplistic understanding of happiness. For instance, because he fails to appreciate higher human capacities as a distinctive source of happiness.[50] John Stuart Mill offers a more extensive

[46] Parfit, D. (2012) p.294
[47] Robeyns, I. (2014) p.64
[48] Robeyns, I. (2014) p.64
[49] Peterson, M. (in Robeyns, Nys and Van Hees). (2014) p.80,81
[50] Robeyns, I. (2014) p.64,65

theory of wellbeing. In contrast with Bentham, he argues that there is an hierarchy in different kinds of pleasure. Pleasure which is experienced through higher abilities (such as listening to classical music), leads to 'better' happiness, than pleasure which is attained through lower abilities (such as physical joy).[51] In order to know what experiences lead to a better kind of happiness, Mill offers a test to differentiate between the quality of different experiences. Consider that there are two kinds of pleasures. The kind of pleasure which is preferred by most (or by all) people who are familiar with both, is the most desirable kind of pleasure and will therefore lead to a better kind of happiness. For instance, if all people who have experienced listening to the music of Johann Sebastian Bach as well as listening to the songs of Justin Bieber, prefer listening to Bach. Than listening to Bach leads to a better kind of happiness. Mill continues by arguing that if one of these two kinds of pleasure is preferred over the other, even though experiencing it would lead to more discomfort (for instance if listening to Bach requires more concentration then listening to Justin Bieber), then this kind of pleasure is one with a superiority in quality. Especially when a high quantity of the other, would not outweigh a small experience of the quality of the most desired pleasure. If listening to Bach for just one hour, would outweigh listening to Justin Bieber for days, than listening to Bach is an experience of superior quality. According to Mill, this would inevitably lead to the preference of pleasures attained through higher abilities - such as the intellect.[52] Therefore, it is impossible that listening to Justin Bieber would be considered to lead to better happiness, because listening to Bach is experienced through higher abilities, such as the appreciation of the complexity of his music. Although Mill's theory prescribes that an activity which maximizes overall happiness, is what is morally right, he emphasizes that happiness cannot be promoted at the cost of others. Therefore, he introduces the *harm principle*, which implies that happiness should not be maximized at the cost of causing harm to other people.[53] Promoting the overall happiness of a group of a hundred people, by inflicting pain upon one of them, is morally wrong according to the harm principle. Consider for instance ancient Rome, where slaves were forced to fight as gladiators to entertain others. This is not considered problematic on Bentham's view, since gladiator fights increase the overall happiness. On Mill's account, such activities are morally wrong, because the harm

[51] Robeyns, I. (2014) p.64,65
[52] Mill, J.S. (1863) p.12
[53] Peterson, M. (in Robeyns, Nys and Van Hees). (2014) p.85

principle prescribes that happiness cannot be promoted by inflicting pain upon others. Although there is some disagreement between Mill´s and Bentham´s theory of what is the best way to promote happiness, both agree that an act is morally right when it maximizes the overall happiness.

Understanding wellbeing in terms of happiness, seems fairly reasonable. However, there is some criticism regarding the classical understanding as proposed by Bentham and Mill. For instance with regards to the fact that the utilitarian understanding considers everyone involved, in determining whether an act is morally right or wrong. If I do voluntary work which I consider unpleasant (but not necessarily painful either), I ought to do it according to the utilitarian understanding of hedonism, because it promotes the overall happiness. Therefore, this theory fails to consider the wellbeing of the individual as its main concern. Henry Sidgwick describes a different understanding of hedonism, which he refers to as *egoistic hedonism.* This perception explains that people should aim at the promotion of their own happiness. This theory is justified by the idea that promoting your own happiness is very reasonable and more in line with common sense than the classical understanding of the theory. If people can choose between several option, it is reasonable if they choose the option which provides them with the greatest amount of pleasure and the least amount of pain.[54] For instance, when a person can choose to receive a higher salary for the same amount of work, it is reasonable for him to accept this increase, as it makes him more happy. If a person would experience more pleasure by getting less money for the same amount of work (for instance, because he knows that the money will be invested in fair trade products instead), it is reasonable for him to refuse the money. According to Sidgwick, the egoistic hedonism does not require a solid method to determine what option of choice offers the greatest amount of happiness, because every man can decide for himself what makes him the happiest.[55] The best way to understand what promotes happiness and reduces pain, is by what Sidgwick refers to as the *empirical-reflective* understanding of egoistic hedonism. This idea prescribes that people know how much pleasure or pain an experience will give them, by actually experiencing it.[56] In order to know whether drinking wine will give you an experience of pleasure or pain, you have to drink wine first. Thus, according to Sidgwick,

[54] Sidgwick, H (1907) p.55,56
[55] Sidgwick, H (1907) p.56
[56] Sidgwick, H (1907) p.56

what promotes people´s wellbeing best on the egoistic account of hedonism, is by doing or experiencing things which promote their own happiness. In the next paragraph I will illustrate in what way medical practice should deal with AN patients according to the hedonist understanding of wellbeing. I will do so by illustrating which answer the hedonist theory offers to the question which balance of values promotes the wellbeing of AN patients best, in order to show whether or not medical practice should accept that AN patients value being thin as more important than their health or their life.

4.2 What is best for AN patients?

In this paragraph I will address which balance of values promotes the wellbeing of AN patients best from a hedonist account. This value theory implies that medical practice should deal with AN patients in a way that promotes their pleasure and reduces or avoids their pain. What would promote the happiness of AN patients is not so easy to determine. On the one hand, their wellbeing would be promoted if they could continue their behaviour of avoiding food and losing weight. As shown by Tan et al., some participants prescribed that having anorexia nervosa made them more in control, more popular and *happier.*[57] On the other hand, their wellbeing would be promoted if medical practice would treat them for their disease. The participants in the research of Tan et al. mentioned that they felt miserable and experienced difficulties associated with their disorder, such as difficulties in thinking.[58] Thus, what would make AN patients the happiest remains unclear. The utilitarian approach as proposed by both Bentham and Mill prescribes that the happiness of everyone involved should be considered to measure to what extent the happiness is increased. If medical practice would accept that AN patients are free to follow their value of being thin, this would cause severe damage to their health and probably lead to their death. The damage to the health and the death of AN patients would increase the amount of pain of all people involved. Therefore, allowing patients to act in line with their primary value of being thin will not promote the overall happiness. Also, Mill´s harm principle prescribes that happiness cannot be increased by causing pain to others. Since allowing AN patients to starve themselves would make them feel miserable and cause pain to their loved ones, the classical

[57] Tan,J. et al. (2006) p.275
[58] Tan,J. et al. (2006) p.270,275

hedonist theory prescribes that medical practice should not allow AN patients to value being thin as more important than their health or their lives.

This seems like a clear answer to the question. However, by taking the happiness of everybody affected into account, the hedonist theory does not primarily consider the wellbeing of AN patients themselves. Sidgwick´s understanding of egoistic hedonism is primarily concerned with the wellbeing of the individual. This means that AN patients should be free to decide what is in their best interest. According to Sidgwick, people know what is best for them by experience. As shown, AN patients associate both experiences of pleasure and pain with their condition. AN makes them more happy, but also more miserable at the same time. Therefore, the egoistic hedonism as introduced by Sidgwick does not offer a clear answer to what will promote the wellbeing of AN patients best.

It seems rather difficult to address the wellbeing of AN patients from a hedonistic point of view. Since AN patients experience both pleasure and pain as a result of their disorder, it remains unclear which balance in values would promote their wellbeing best. Research by Charlotte Keating, and the study of Caroline Davis and D. Blake Woodside, show an interesting characteristic of anorexia nervosa. Their findings offer some explanation to why the hedonistic theory does not provide a suitable answer to the promotion of wellbeing of AN patients. Keating claims that people with anorexia nervosa have characteristics of *anhedonia*, which is the incapability (or reduced ability) to experience pleasure.[59] She explains the latter, by illustrating that there are abnormalities in the brain of AN patients, which indicate a distortion of the capability to experience reward and punishment.[60] An example mentioned in the article, illustrates that AN patients show little difference in their brain in response to a highly rewarding stimulus compared to a more neutral rewarding stimulus. Because AN patients show little response to experiences of reward, it gives reason to assume that AN patients are less susceptive to hedonistic stimuli.[61] However, Keating mentions some doubts with regards to this experiment. The stimuli used in this experiment were water and sucrose. Therefore it is possible that AN patients are not necessarily less susceptive to hedonistic stimuli in general, but show decreased interest in rewarding experiences which could lead to an increase of their body weight.[62] The research performed

[59] Keating, C. (2010) p.73
[60] Keating, C. (2010) p.75
[61] Keating, C. (2010) p.77
[62] Keating, C. (2010) p.76

by Caroline Davis and D. Blake Woodside also illustrate that AN patients show signs of anhedonia.[63] They compared AN patients with patients who suffered from bulimia nervosa and a comparison group (which was composed out of people who no longer met the weight criteria for AN, but have had a former diagnosis). This study shows that people who suffered from AN had a much higher score on anhedonia, than the rest of the group. This means that they are significantly less susceptive to experiences of pleasure or reward.[64] Like Keating, David and Woodside also tested the hedonistic experiences of AN patients, with the use of food as a stimuli. Therefore, the same doubts apply to their study. Since both studies mainly focussed on the hedonistic response to food, it is unclear to what extent AN patients have a reduced capacity to experiences of reward and pleasure in general. The fact that anhedonia is associated with the characteristics of the disorder, does not show that AN patients are incapable of experiencing pleasure and pain. However, it might indicate, to some extent, why addressing the wellbeing of AN patients from a hedonistic theory does not lead to a clear answer. More research has to be conducted in order to understand whether or not AN patients are anhedonic in general and not only with regards to stimuli associated with weight gain. However, such research is beyond the scope of this thesis. Whether or not medical practice should accept that AN patients value being thin as more important than their health or their lives, according to the hedonist theory, remains inconclusive, because it is unclear what balance in values would promote the wellbeing of AN patients best. In the next paragraph I will illustrate whether the desire-based theory of wellbeing provides a more plausible answer to the question what balance of values promotes the wellbeing of AN patients best.

5. DESIRE-BASED THEORY OF WELLBEING

In this paragraph I will illustrate to what extent the wellbeing of AN patients is promoted, if medical practice would deal with them as is prescribed by the desire-based theory. I will illustrate this matter in the same structure as the last paragraph. Firstly, I will offer an

[63] Davis, C. Woodside, D,B. (2002) p.190
[64] Davis, C. Woodside, D,B. (2002) p.192

overview of the desire-based account. Secondly, I will relate this theory to the practice of AN. I will illustrate to what extent their wellbeing is promoted if medical practice would deal with the balance in values of AN patients from this line of reasoning, in order to show whether or not medical practice should accept that AN patients value being thin as more important than their health or their life.

5.1 Desires

A desire-based theory of wellbeing prescribes that what is best for a person, is what fulfils his desires. The most simple version of the desire-fulfilment account is the *unrestricted theory.* This theory prescribes that a person's wellbeing is best promoted by fulfilling *all* of his desires throughout his life. This theory is considered highly implausible by Parfit.[65] For instance, fulfilling all of your desires also implies that your wellbeing is promoted when your desires are fulfilled without your awareness.[66] Suppose, I see a very ill woman on television who might only have a few weeks left to live. While watching the program, I wish for her to get better soon. Even though I am not aware of it, she miraculously recovers from the disease. According to the unrestricted version, this means that - since my desire is fulfilled - my wellbeing is promoted with her recovery. However, since I am unaware of her revival, nothing actually changed with regards to my wellbeing. Since this understanding of the desire-fulfilment theory is highly questionable, Parfit offers a different notion of the desire account, which is the *success theory.* This theory only concerns the desires people have about their own lives, which means that only the things that actually apply to people's own life can contribute to their wellbeing.[67] For instance, I want to be a successful teacher. My desire would be fulfilled if all my students were to pass their exams. If all my students succeed - even though I am not aware of it - it contributes to my wellbeing, because my desire to be a successful teacher is fulfilled. The success theory differs from the unrestricted version, because it only includes desires relevant to my aims in life. Suppose one of my students will take a course with a different teacher and passes his exams, it would not contribute to my wellbeing, because it is irrelevant to my desire of being a successful teacher

[65] Parfit, D. (2012) p.295
[66] Parfit, D. (2012) p.294,295
[67] Parfit, D. (2012) p.294,295

(even though I might like for the student to succeed). Thomas L. Carson offers a criticism with regards to the desire theory, which applies both to the success theory and the unrestricted version. He argues that people's desires can be misinformed, which means that the object of their desire is not what they truly want. For instance, I would like to buy a certain pair of jeans because I fancy the colour and they fit perfectly. However, what I don't know, is that this pair of jeans is of poor quality and will be ruined in a few weeks time. Thus, although buying the pants at that very moment will fulfil my desire, it will not actually contribute to my wellbeing, because I do not want to have a useless pair of jeans. If I had known at that very moment that this pair of pants would not last longer than a few weeks, I would never have purchased them. For this reason, Carson argues that the desire theory wrongfully implies that our desires indicate what is good for us.[68] Harry G. Frankfurt offer a theory which illustrates, why people can be mistaken in their desires. In his theory, he distinguishes different levels of desires. According to Frankfurt, people have both first and second order desires. A desire of the first order is merely an aim to do something or to act in a certain way. Frankfurt illustrates the structure of first order desires with the formula; A wants to X, in which X indicates an action. For instance, 'I want to eat a biscuit´. Frankfurt argues that A´s first order desire to X does not necessarily indicate a strength of the desire. A first-order desire does have to result into an action.[69] For instance, my first-order desire to want a biscuit does not have to be as strong that it will result into me actually getting a biscuit. A second order desire can also be recognised in the sense that A wants to X, but in this case it is not merely A's aim to want to X, but it is his *effective desire*. The second-order desire is not just an intention to do something, but this desire will certainly turn into action.[70] For instance, the second order desire in which I want to eat a biscuit, will definitely lead to the action of eating. A second order desire is not simply an intention, but it is a *will.*[71] Frankfurt offers an even more profound understanding of second order desires, which is for instance formulated in the way that A wants to want to X, or A want the desire to X.[72] These formulations of second order desires, indicate that people can want something that they actually have no desire for. For instance, that I want the desire to exercise (instead of eating

[68] Carson, T.L. (2000) p.72,73
[69] Frankfurt, H.G. (1971) p.8
[70] Frankfurt, H.G. (1971) p.8
[71] Frankfurt, H.G. (1971) p.8
[72] Frankfurt, H.G. (1971) p.9,10

a biscuit), because I want to be healthy. What Frankfurt illustrates with the distinction between first and second order desires, that there are differences between what people desire and what they actually want. The fact that people's desires are levelled, shows that people can have a desire for something, when it is not truly what they want. I could have a desire to eat a biscuit, when I actually want to have the desire to exercise. The unrestricted version and the success theory, wrongfully prescribes that a person's desire should be fulfilled, when it is not necessarily what he actually wants. When I have a desire to eat a biscuit, when I actually want the desire to exercise, then the fulfilment of my desire to eat a biscuit, will not contribute to my wellbeing. Robeyns mentions a different way in which the desire-based theory of wellbeing can be understood; as the fulfilment of our *informed desires*. Having the desires fulfilled of which all the consequences and all the relevant aspects are considered, is what promotes people's wellbeing best.[73] The desire account is further addressed by James Griffin. He refers to the distinction between an actual desire account (which is the unrestricted version) and an informed desire account. Griffin agrees that the actual desire account leads to many difficulties and misunderstandings of what a person's desires are, and what he needs to fulfil his desires. However, Griffin addresses some problems with regards to an informed desire theory as well. When someone is fully educated about the desirability of an object, but has no intrinsic interest in it, then this object would not satisfy his desire and therefore not contribute to his wellbeing. For instance, one might be informed that drinking very cheap wine would lead to a bigger headache in the morning and it is therefore better to drink expensive wine. The desires of a person who has no intrinsic desire to drink expensive wine and does not mind having an headache, will not be fulfilled by drinking expensive wine. Griffin perceives the actual- and the informed desire account as two extremes of a spectrum, and therefore he argues that desires need to be both informed as well as actual.[74] Thus, for the fulfilment of a desire to contribute to a person's wellbeing, it must be the desire of an object of which a person is fully informed of and in which he as an actual desire for. In the next paragraph I will illustrate what balance of values promotes the wellbeing of AN patients best according to the desire-based theory of wellbeing, in order to illustrate whether or not medical practice should accept that AN patients value being thin as more important than their health or their life.

[73] Robeyns, I (2014) p.67-69
[74] Griffin, J. (1986) p.10,11

5.2 What is best for AN patients?

Addressing the question which balance in values promotes the wellbeing of AN patients best from a desire-based account, implies to evaluate how to fulfil the desires of AN patients. The *unrestricted desire* of AN patients is obviously to lose weight and to be thin. Fulfilling these desires would simply imply to let them continue with their diet and allow them to lose weight until the point that they are satisfied. Addressing this issue from a success theory would lead to the same conclusion. The desire of AN patients with regards to their own life is to be thin. Fulfilling their desires would imply that medical practice allows AN patients to continue to lose weight. However, allowing them to lose weight to the extent to which they are satisfied, might propose a risk to their health and endanger their life. Parfit addresses to what extent success can contribute to people their wellbeing after they have died. He argues that the fulfilment of people´s desires with regards to their own life, also contributes to their wellbeing after death.[75] For instance, my students take their exams, and I die before I can see the results. If the results of my students turn out to be successful, it contributes to my wellbeing because my desires are fulfilled; if my students fail their exams, this would mean that my desires are not fulfilled and it will not contribute to my wellbeing. Thus, even if people die, fulfilling their desires with regards to their own life, will contribute to their wellbeing. What the success theory implies for AN patients, when their underweight leads to their death, is quite ambiguous. If they would die from their low weight, their desire to be thin is fulfilled, because they have died while being skinny. However, since their body will not remain intact after they die (their body would decay or be cremated) their death will not contribute to their wellbeing, because their desire to be thin remains unfulfilled. Thus, it is not reasonable to argue that the wellbeing of AN patients can be promoted after they have died.

Addressing the wellbeing of AN patients as suggested by Griffin, implies that both their actual and well-informed desires should be fulfilled. Their actual desire is to lose weight and to be thin. If they were fully informed about the consequences of their decisions, they knew that losing weight until the point where they are dead will not actually fulfil their desire of being thin. Their body will not remain thin (or at least not intact) after they have died. Therefore, they cannot possibly want to lose weight until they die, because it is not in line with their informed desire. Fulfilling their desire be then when it will lead to their dead, will

[75] Parfit, D. (2012) p.295

not contribute to their wellbeing. Their wellbeing would be promoted, if their actual and informed desires were fulfilled. This implies that they would want to lose weight (actual desire), but not to the extent to which it severely endangers their life (informed desire). To sum up, the desire-based theory prescribes that medical practice can best promote the wellbeing of AN patients by fulfilling their desires which are both informed as well as actual. This implies that medical practice should allow AN patients to be thin and lose weight to the extent that their underweight does not threaten their life.

As shown, the desire based theory offers a rather clear answer which balance in values promote the wellbeing of AN patients best. Griffin´s understanding of the desire-based theory, leads to an answer which respects both the value of being thin, as well as the value of life. AN patients are allowed to be thin, but not to the extent that it will lead to death. There is only one hesitation with regards to the desire-based theory as proposed by these leading theorists. This account, does not provide an answer on how to deal with the health problems which follow from the weight loss of AN patients. The desire account, as proposed by these leading theorists, does not offer a way to deal with the negative consequences of the fulfilment of desires; which are the health problems that follow from weight loss. Unlike death, having health problems is not in conflict with the desire to be thin. People can be very thin, and be unhealthy at the same time. Therefore, it does not seem problematic according to the desire-based that AN patients value being thin as more important than their health.

The answer to the question whether or not medical practice should accept that AN patients value being thin as more important than their health or their lives, according to the desire-based theory, is that medical practice should allow AN patients to value being thin. Since their desire to be thin is not in conflict with the value of health, medical practice should allow patients to value being thin as more important than their health. Being death is in conflict with the desire to be thin, therefore medical practice should not accept that AN patients value being thin as more important than their life. Thus, the desire-based account explains that medical practice should accept that AN patients value being thin as more important than their health, but not as more important than their lives. In the next paragraph I will address to what extent the wellbeing of AN patients is promoted, if medical practice would deal with the unusual values of AN patients from an objective-list theory of wellbeing.

6. OBJECTIVE LIST THEORY OF WELLBEING

In the former paragraphs I have illustrated to what extent the wellbeing of AN patients is promoted if medical practice would deal with them from a desire-based and a hedonist theory. These theories both provide a different view on the issue, one more plausible than the other. In this paragraph I will illustrate to what extent the wellbeing of AN patients is promoted if medical practice would reason from an objective-list theory of wellbeing. Firstly, by providing an overview of an objective list account and secondly, by illustrating to what extent the balance in values as prescribed by the objective-list account would be beneficial for AN patients.

6.1 Objective lists

The final theory of wellbeing as defined by Parfit is the objective-list theory. This theory prescribes that what is good for people does not depend on personal desires or values, what is good is defined on the basis of rationality. Objective positive values prescribe what characteristics people their lives should entail to be considered a good life. Examples of such values are health, education, friendship and love. What is bad for a person´s wellbeing are negative values, such as loneliness, disease and hunger.[76] A person who would be in good health, can enjoy education, is surrounded with love and friendship and who does not suffer from loneliness, disease and hunger, is considered to have a good life.

Objective-list theories are very useful for determining what is good for people, because they decide objectively what elements a person's life should entail in order to be accounted as good. Policy makers do not have to consider individual ideas of a good life, in order to guarantee that their policy ensures that people have a good life. They simply have to ensure that the objective positive criteria are attainable for everyone. Also, the objectivist approach is very useful to gain insight in the conflict between AN patients and health care. The main aim of health care is to regain people´s health, which means that the institution is designed based on the objective understanding that health should be promoted in order to promote people their wellbeing; health care works with an objective understanding of the value of health. Anyone who is labelled as unhealthy, is considered to be in need of help. However, AN patients do not accept health as their primary value. Since medical practice aims at

[76] Parfit, D. (2012) p.296

improving the health of AN patients, but AN patients rather aim for being thin, there is a conflict with regards to what is perceived to promote their wellbeing best. The values AN patients endorse do not follow from an objective value theory, but perhaps from their disorder or personal interest. However, since AN patients do not accept health as their primary value, it leads to a conflict with health care. Since AN patients do not endorse this value, their lives lack wellbeing according to the view of medical practice.

Although the objective-list theory offers a very useful way to answer what would promote people's wellbeing best, there are certain criticisms with regards to the objective-list theory. For instance, there is much debate about what should be on the list. An objective-list theory proclaims that there are certain elements, which are assumed to be objectively good for people. However, it is hard to find an objective idea or concept of ´the good´, which applies to all human beings. For instance, what is considered valuable in westernized countries is not necessarily valued in East Asia.[77] Martha Nussbaum is a very influential objective list theorist. Her theory offers a solid answer to this criticism. She has played an important role in the development of the *capability approach*, which prescribes that people's wellbeing is defined by the freedom they have to exercise certain capabilities. Nussbaum proposes a list of ten capabilities which should be available in order to consider a life worth living. Nussbaum's theory is closely related to the capability approach of Amartya Sen. His account prescribes that people's wellbeing is promoted if they are able to express their functionings. These human functioning's are the things a person can do or can be, such as being nourished or being in good health, having self-respect or having social capacities. Capabilities are the possibilities a person has to fulfil his functionings, such as having enough money to buy healthy food and to have proper access to health care. Thus, according to the capability approach, the wellbeing of people is promoted if they have the required capabilities to express their functioning's.[78] Like Amartya Sen, Nussbaum understands wellbeing as the availability of capabilities to express human functionings. Nussbaum provides a more substantive theory of what makes a human life worthy of living. She argues that many essentialist theories fail to accept that there are differences between people across cultures, time and place.[79] In order to ensure that her theory considers people in all their diversity,

[77] Robeyns, I. (2014) p.73
[78] Sen, A. (1993) p.30,31
[79] Nussbaum, M. (1992) p.208

Nussbaum based her theory on an empirical evaluation of human beings in history. This evaluation led to a concept of the *universal shape of human life,* which is an idea about what functionings all human have across time and place. This theory is based on two facts: first, we recognise a human being across different cultures in different times and places. Second, there is general consensus about what features are necessary to consider a life *human,* and of which the absence would mean that a life is not human.[80] This evaluation leads to ten different elements which are part of every shape of human life, such as mortality, the human body, capacity for pleasure and pain, cognitive capacity, enfant development, practical reason, relatedness to other human beings and to other species and nature, humour and play and separateness. Every human being has these functionings, independent of culture, time, place, contact and the characteristics of the person. Nussbaum argues that anyone who lacks any of these elements can hardly be called a human. For instance, we can hardly call anyone without the need for food and water, or the need for shelter a human being. These elements of human life form the basis for a list of capabilities required for human functioning. This list prescribes ten capabilities a human being should be able to employ in order to have a life worth living. If anybody would be lacking the access to these capabilities, he/she would have an undignified life according to Nussbaum.[81] These capabilities are;

1. *Life*
2. *Bodily health*
3. *Bodily integrity*
4. *Senses, imagination and thought*
5. *Emotions*
6. *Practical reason*
7. *Affiliation*
8. *Other species*
9. *Play*
10. *Control over ones environment*

Nussbaum argues that these capabilities should be a focus of concern for public policy, which means that public policy should enable people the freedom to enact on these ten

[80] Nussbaum, M. (1992) p.214,215
[81] Nussbaum, M. (1992) p.216-221

capabilities.[82] Mika LaVaque-Manty has applied the capability approach to the context of eating disorders. He claims that eating disorders - such as AN -should be a matter of political concern. He argues that, when people avoid food even though there is plenty available, is an indication of injustice. This claim seems invalid, because people who have proper access to food, but refuse to use it, simply seem to choose not to make use of their capability. However, LaVaque-Manty claims that quite the opposite is true. He argues that, when a failure to exercise a capability occurs significantly more among a specific group, this indicates that the capability is not actually obtainable for them.[83] He illustrates that the unequal access to food, in cases where there is objectively enough food for everyone, is often the result of a prescribed social norms. For instance, suppose a situation in which all men get more food than the women. This distinction in the amount of food people of different sexes receive, is prescribed by the social norm that e.g. men are at the top of the family hierarchy. Such norms are generally perceived as arbitrary and unjust. LaVaque-Manty offers an example to illustrate the injustice which applies to people who suffer from an eating disorder. The self-imposed weight loss of women with AN in westernized countries is caused by a social norm which prescribes that women should be thin in order to be beautiful. The fact that this norm applies significantly less to men, indicates an inequality among sexes. The internalisation of this social norm by women (and acting in accordance with it), leads to a restricted ability to exercise their capabilities. The social norm that women should be thin, can result in the fact that they cannot make proper use of the capability of food.[84] Thus, when a social norm (such as *women should be thin in order to be beautiful)* which applies more to one group in society, withholds people from being able to exercise their capabilities, this is matter of injustice. Therefore, such a norm should be a matter of political concern and public policy should strive to change such a norm. In the next paragraph I will illustrate what follows if medical practice would deal with AN patients as prescribed by the objective-list theory. I will aim at finding to what extend the values as prescribed by this theory would promote their wellbeing, in order to find an answer to question whether or not medical practice should accept that people value being thin as more important than their health or their life.

[82] Nussbaum, M. (1992) p.216-222
[83] LaVaque-Manty, M. (2001) p.159
[84] LaVaque-Manty, M. (2001) p.160,161

6.2 What is best for AN patients?

In this paragraph, I will illustrate to what extent the wellbeing of AN patients would be promoted, if medical practice would accept the values and norms as prescribed by the objective-list theory of wellbeing. What promotes the wellbeing of AN patients best, would require to see whether the elements of a good life are satisfied in their life. The capability approach of Nussbaum provides ten elements which should be obtainable for everybody, to consider his life worthy of living. It seems as if this is not the case with AN patients. Due to their low weight, it is difficult for them to have a good health or to maintain bodily integrity (which Nussbaum understands as being able to have pleasurable experiences and to avoid unnecessary pain). Nussbaum expresses a clear responsibility to public policy to ensure that every human can enact on all capabilities.[85] This means, for instance, that health care should ensure that AN patients will regain their health and their bodily integrity. For instance, by providing the proper resources such as psychological help and medical care. Nussbaum argues that making options available for people enhances the freedom of choice for AN patients, rather than removing it. For example, anyone who has the available resources to eat plenty of food can always choose to fast.[86] Mika LaVaque-Manty disagrees, he argues that available resources which are required to exercise capabilities, do not necessarily imply that people are actually able to use their capabilities. For instance, the internalisation of the social norm that women should be thin to be considered good-looking, denies the access of female AN patients to the capability of food and bodily health. LaVaque-Manty argues that the restricted freedom to exercise capabilities due to social norms, indicates a matter of injustice. Therefore, social norms should be a matter of political concern. In line with the capability approach, public policy should ensure that AN patients can exercise their capabilities, especially with regards to having proper access to food and having good health. Therefore, public policy should aim at changing these social norms for the better, so that AN patients are not restricted from exercising their capabilities.

The answer to the question what is the best way to deal with the unusual set of values of AN patients from an objectivist account, is that public policy should ensure that AN patients can exercise all their capabilities, especially with regards to having bodily health and bodily integrity. Policy should ensure that the required resources are available to allow AN patients

[85] Nussbaum, M. (1992) p.222
[86] Nussbaum, M. (1992) p.225

to use their capabilities. When their access to these capabilities is denied due to social norms, the government (or medical practice) should ensure that these social norms are discouraged or changed, so that they do not longer withhold AN patients from exercising their capabilities.

The objective-list account prescribes quite clearly in what way the wellbeing of AN patients is promoted. However, by focussing on public policy the objective-list theory does not consider the needs of individual patients. Nussbaum and LaVaque-Manty assume that people want or need to exercise all their capabilities. Although it seems reasonable for a large group of people that their life would be more valuable if they could exercise all their capabilities. The objective-list theory does not consider the individuals who e.g. simply feel better when they are thin, regardless of social norms or the accessibility of resources. As shown by Tan et al., some AN patients mentioned that AN made them feel happy, more popular and more in control.[87] I do not wish to claim here, that AN makes people very happy, and therefore the capabilities approach should allow AN patients to continue to lose weight. Rather, I wish to claim that the objective-list account does not consider the preferences of individuals sufficiently. The answer to the question, whether or not medical practice should accept that AN patients value being thin, as more important than their health or their lives, according to the objective-list theory, is that medical practice should not accept their unusual balance in values. The fact that AN patients value being thin as their primary value, withholds them from exercising their capabilities. Public policy should ensure that the required resources are available, so that they are not restricted to use their capabilities, or they should ensure that the social norms that restrict them are changed.

[87] Tan, J. et al. (2006) p.275

CONCLUSION

In this thesis I have illustrated the conflict which medical practice is faced with when dealing with patients who suffer from anorexia nervosa. Although these patients suffer from a mental disorder, they are considered competent and are therefore allowed to make autonomous decisions with regards to their treatment. However, AN patients seem to hold a rather unusual set of values. AN patients attach an excessive amount of value to *being thin,* to the extent that it overrules all other values, such as *health* or *their life.* This unusual balance in values leads to remarkable decisions - such as refusing treatment when they are in poor health or when their life is threatened. The fact that these odd decisions cannot be disregarded, leads to difficulties for medical practice. Physicians cannot simply overrule the choices of AN patients, whereas accepting their decisions would be rather dangerous. In this thesis I have aimed at finding an answer to the question whether medical practice should accept that AN patients value being thin as more important than their health or their life. I have studied this question from three value theories of wellbeing, which all provide a different answer to the question: *what is best for people*. I have done so in order to illustrate what promotes their wellbeing best.

As shown, the answers provided by the theories are not equally satisfying. The hedonist theory does not offer a clear answer, because AN patients attach both positive and negative values to their disorder. Therefore, it is unclear which balance in values will promote their wellbeing in the best manner. This conflict can be resolved by considering everyone affected by the decision. However, by considering the pleasure and pain of everyone involved, the hedonist account does not consider the wellbeing of the patients sufficiently. Since the hedonist account does not provide a satisfying answer to the question which balance in values promotes the wellbeing of AN patients best, it is unclear whether or not medical practice should accept that AN patients value being thin as more important than their health or their lives. The desire-based theory offers a more plausible answer. The wellbeing of AN patients is promoted by fulfilling their desire to be thin. Being unhealthy does not stand in the way of fulfilling this desire. However, it is not possible to fulfil the desire of being thin, while being death. Therefore, medical practice should accept that AN patients value being thin as more important that their health, but not that they value being thin as more important than their life. The objective-list theory offers a clear answer as well. To promote the wellbeing of AN patients, the objective-list account prescribes that public policy should

ensure that AN patients are able to exercise their capabilities. This implies that public policy has to provide the required resources, such as medical treatment and psychological help and change social norms which restrict AN patients from exercising their capabilities. A negative connotation, with regards to the objective-list theory, is that it does not consider the preferences of the individual. As a final answer, the objective-list theory prescribes that medical practice should not accept that AN patients value being thin as more important than their health or their lives, because their unusual balance in values restricts their ability to exercise their capabilities.

As shown, both the desire-based theory and the objective-list theory offer a clear answer to the question whether or not medical practice should accept that AN patients value being thin as more important than their health or their life. A conclusive answer to this question depends on which line of reasoning medical practice accepts. The aim in this paper was to illustrate the implications these theories offer for medical practice, if they were to embrace one of these lines of reasoning. The aim was not to providing a conclusive advice of which theory medical practice should adopt. As shown, the hedonist theory does not offer any clear guidelines. Therefore, it is safe to claim that medical practice should not approach the unusual set of values of AN patients from this line of reasoning. Both the objective-list and the desire-based theory offer clear guidelines for medical practice. The objective-list theory approaches this question on the level of public policy, the desire-based theory offers a more personal approach. Which theory provides the best answer to the question whether or not medical practice should accept that AN patients value being thin as more important than their health or their life, depends on whether this question is best addressed from a more personal level or addressed from the level of public policy. Which of these approaches is the best requires further research and is beyond the scope of this thesis.

LITERATURE

Appelbaum, P., P. Grisso, and C. Hill-Fotouhi. "The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions." *Psychiatric Services* 48 (1997): 1415-1419.

Buchanan, Allen E., and Dan W. Brock. Deciding for others: the ethics of surrogate decision making. Cambridge University Press (1989).

Brock, Dan W., and Steven A. Wartman. "When competent patients make irrational choices." *New England journal of medicine* 322, no. 22 (1990): 1595-1599

Carson, T.L. (2000): Value and the Good Life, Notre Dame, IN: University of Notre Dame Press

Charland, Louis C. "Anorexia and the MacCAT-T test for mental competence: validity, value, and emotion." *Philosophy, Psychiatry, & Psychology* 13, no. 4 (2007): 283-287.

Davis, Caroline, and D. Blake Woodside. "Sensitivity to the rewarding effects of food and exercise in the eating disorders." *Comprehensive psychiatry* 43, no. 3 (2002): 189-194.

Elzakkers, Isis FFM, Unna N. Danner, Hans W. Hoek, Ulrike Schmidt, and Annemarie A. Elburg. "Compulsory treatment in anorexia nervosa: a review."*International Journal of Eating Disorders* 47, no. 8 (2014): 845-852.

Finstein, E (in Radoilska, L). "The mental capacity act and conceptions of the good." *Autonomy and mental disorder* (2012): 170-191

Frankfurt, Harry G. "Freedom of the Will and the Concept of a Person." In *What Is a Person?*, pp. 127-144. Humana Press, 1988.

Griffin, J. "Well-being: Its meaning, measurement, and moral importance." (1986).

Den Hartogh, Govert. "Do we need a threshold conception of competence?." *Medicine, Health Care and Philosophy* (2015): 1-13.

Holroyd, J (in Radoilska, L) "The mental capacity act and conceptions of the good." *Autonomy and mental disorder* (2012): 145-169

Keating, Charlotte. "Theoretical perspective on anorexia nervosa: the conflict of reward." *Neuroscience & Biobehavioral Reviews* 34, no. 1 (2010): 73-79.

Lavaque-Manty, Mika. "Food, functioning and justice: From famines to eating disorders." *Journal of Political Philosophy* 9, no. 2 (2001): 150-167.

Mill, John Stuart. "Utilitarianism." (1863).

Parfit, Derek. "What makes someone's life go best." *Ethical Theory: An Anthology* 13 (2012): 294-298.

Rijksoverheid. "Wet op de geneeskundige behandelingsovereenkomst." Last modified in 2015. Accessed June 2016 from https://www.dwangindezorg.nl/rechten/wetten/wgbo

Rijksoverheid. "Wilsonbekwaamheid." Last modified in 2014. Accessed June 2016 from https://www.dwangindezorg.nl/rechten/invloed/wilsonbekwaamheid-en-vertegenwoordiging/wilsonbekwaamheid

Robeyns, Ingrid. Nys, Thomas. van Hees, Martin., *Basisboek Ethiek* (Amsterdam: Boom, 2014)

Sen, Amartya. "Capability and well-being." (1993): 30-53.

Sidgwick, Henry. *The methods of ethics*. Hackett Publishing, 1907.

Sternheim, Lot. Interviewed by Nada Dijkema. Telephone interview, Utrecht, 14-06-2016

Tan, Jacinta. Hope, Tony. Steward, Anne and Fitzpatrick, Raymond. "Control and compulsory treatment in anorexia nervosa The views of patients and parents." *International Journal of Law and Psychiatry.* 26 (2003): 627-645

Tan, Jacinta. Hope, Tony. Stewart, Anne. "Competence to refuse treatment in anorexia nervosa." *International Journal of Law and Psychiatry*26, no. 6 (2003a): 697-707.

Tan, Jacinta. Hope, Tony. Steward, Anne. "Anorexia nervosa and personal identity: The accounts of patients and their parents." *International Journal of Law and Psychiatry.* 26 (2003b): 533-548

Tan, Jacinta OA. Stewart, Anne. Fitzpatrick, Raymond, and Hope, Tony. "Competence to make treatment decisions in anorexia nervosa: thinking processes and values." *Philosophy, psychiatry, & psychology: PPP* 13, no. 4 (2006): 267-282

Tan, Jacinta OA. Stewart, Anne. Fitzpatrick, Raymond, and Hope, Tony. "Attitudes of patients with anorexia nervosa to compulsory treatment and coercion." *International journal of law and psychiatry* 33, no. 1 (2010): 13-19.

Tot op het bot. *"Episode 1-6". Tot op het bot* video. 2013. Attained from http://www.npo.nl/tot-op-het-bot/POMS_S_BNN_425184

Vollmann, Jochen. "" But I don't feel it": Values and emotions in the assessment of competence in patients with anorexia nervosa." Philosophy, Psychiatry, & Psychology 13, no. 4 (2007): 289-291.

Wicclair, Mark R. "Patient decision-making capacity and risk." Bioethics 5, no. 2 (1991): 91-104.

World Health Organisation (1993). *The ICD-10 classification of mental and behavioral disorders: Diagnostic criteria for research. F50.0: Anorexia nervosa*