

Category system

1. cases of EOL care for AN
1.1. outcome of EOL care for AN
1.1.1. enhanced psychological wellbeing of patients
1.1.2. improved social relationships
1.1.3. death
2. conceptual questions
2.1. AN as disorder vs. not
2.1.1. AN as disability
2.1.2. AN as disorder
2.1.2.1. AN as psychosis
2.1.3. AN as adaptive coping mechanism
2.1.4. AN as reaction to sociocultural pressure
2.1.4.1. strictly biomedical concept of AN renders patients a mere object of the “medicolegal alliance”
2.2. coerced re-feeding as treatment of AN vs. not
2.2.1. artificial nutrition is life-saving, doesn’t treat AN but gives time for AN treatment
2.2.2. artificial feeding is part of AN treatment although in itself insufficient
2.2.3. artificial feeding is part of AN treatment as it treats one of the manifestations of AN
2.2.4. moral status of life-sustaining measures vs. treatment
2.3. AN as end-stage disease
2.3.1. AN cannot be “end-stage” bc
2.3.1.1. lack of pathophysiologic process leading to death with or without treatment
2.3.1.1.1. prognostication is uncertain bc not based on pathophysiologic indicators
2.3.1.1.2. most medical complications are treatable
2.3.1.2. untreatability only stems from patient refusals
2.3.1.3. clinical remission is always possible
2.3.1.4. AN cannot be terminal (and “end-stage” is the last stage of a terminal disease)

2.3.1.5. no established staging system/no established definition of end-stage AN
2.3.2. “end-stage” AN can currently not be identified with acceptable certainty
2.3.3. definitions of end-stage AN
2.3.3.1. long duration without remission despite diverse treatments
2.3.3.2. deterioration
2.3.3.3. all treatment options have been tried without success
2.3.3.4. no good treatment options left, AN is intractable
2.3.3.5. “end-stage” AN is when further treatment is futile
2.3.3.6. no hope of recovery
2.3.4. potential benefits of labeling AN “end-stage”
2.3.4.1. acknowledges the reality of mental suffering
2.3.4.2. treatment refusal would be a rational decision
2.3.4.3. patients or their surrogate DMs could make qualitative futility judgements
2.3.4.4. end-of-life planning should be initiated
2.3.4.5. protects from unlimited coercive interventions
2.3.5. potential harms of labeling AN “end-stage”
2.3.5.1. might be based on professionals’ frustration --> result in premature und unjustified deaths
2.3.5.2. professionals could make futility judgments on medical grounds
2.3.6. procedural safeguards needed such as ethics consults, repeated DMC assessments
2.3.7. judgement of end-stage is not necessary for shifting goals of care, severe treatment refractoriness is sufficient
2.4. AN as terminal disease
2.4.1. AN can be terminal because...
2.4.1.1. a prgnosis of < 6 months to live can be established when patients do neither eat nor are fed
2.4.1.2. conditions can be both treatable and terminal
2.4.2. conceptualizations of terminal AN
2.4.2.1. uniform temporal course of psychopathology + irreversible organ damage
2.4.2.2. advanced stage with no known cure, inevitably leading to death
2.4.2.3. terminal AN defined by futility of further treatment/unresponsiveness + life-threatening severity

2.4.2.3.1. terminality as (competent) futility judgements by patients
2.4.2.3.2. life expectancy of six months or less
2.4.2.4. clinical remission unlikely plus futility of further treatment
2.4.3. AN cannot be terminal because...
2.4.3.1. irreversible organ damage is only a possibility, not inevitable consequence of the disease
2.4.3.2. it is not lethal/usually fatal
2.4.3.2.1. starvation and most sequelae are reversible
2.4.3.3. AN is treatable/clinical remission is always possible
2.4.3.3.1. threat to life comes from treatment refusal, not from lack of treatment options
2.4.3.4. patients don't have DMC to refuse treatment
2.4.3.5. terminal AN cannot be defined/identified bc prognostication is uncertain
2.4.3.5.1. lack of pathophysiologic indicators
2.4.3.5.2. lack of uniform temporal course/established staging system
2.4.3.6. no consensus criteria/definition for terminal AN
2.4.4. potential benefits of a diagnosis of terminal AN
2.4.4.1. a diagnosis of terminal AN may be validating, promote autonomy, relieve suffering and enable a good death
2.4.4.2. a terminal AN diagnosis facilitates access to compassionate EOL care including support for the family
2.4.4.3. encourages honest patient-provider discussions about care
2.4.4.4. a diagnosis of terminal AN may foster motivation for recovery
2.4.5. potential harms of a diagnosis of terminal AN
2.4.5.1. can trigger maladaptive schemas/behavior
2.4.5.2. risks countering hope for recovery and increasing demand for and access to MAiD
2.4.5.3. will lead to additional/unjustified deaths
2.4.5.4. risks reducing access to care
2.4.6. terminal AN needs a consensus definition
2.4.7. a diagnosis of terminal AN should be revoked in case of change
2.4.8. terminality is not necessary for EOL care
2.4.8.1. rejecting the term "terminal" does not change the mortality rate

2.5. moral status of (in)compliance/treatment refusal
2.6. futility in AN treatment
2.6.1. conceptualizations of futility of coerced life-sustaining measures
2.6.1.1. impossibility
2.6.1.1.1. irremediably shortened life expectancy (physiological futility)
2.6.1.1.2. impossibility of clinical remission
2.6.1.2. quantitative futility
2.6.1.2.1. unacceptably low chance of survival
2.6.1.2.2. unacceptably low probability of clinical remission
2.6.1.2.2.1. economic futility due to “no insurance”
2.6.1.2.2.2. failure to respond to all known effective interventions
2.6.1.3. pseudo-futility
2.6.1.3.1. a sign of incompetence of the treatment team
2.6.1.3.2. futility judgements as rationalizations/reification of negative feelings towards the patient
2.6.1.4. qualitative futility
2.6.1.4.1. unacceptably poor benefit/burden ratio
2.6.1.4.2. patients are not worth the resources necessary for treating them
2.6.1.5. futility as a justification for physicians to unilaterally decide to forego a treatment
2.6.2. Coerced life-sustaining measures cannot be futile bc...
2.6.2.1. patients refuse, not request treatment
2.6.2.2. patients can be kept alive
2.6.2.3. clinical remission is never impossible
2.6.2.3.1. one cannot extrapolate from past treatment failures to future ones
2.6.2.4. prognosis for AN in general is good
2.6.2.5. lack of treatment success stems from treatment refusal, a symptom to be treated
2.6.2.6. AN cannot be “end-stage” or “terminal”
2.6.2.7. patients don’t have DMC to make qualitative futility judgements
2.6.2.8. instances of physiological futility reflect a medical illness (not the AN anymore)

2.6.2.9. there are no established/objective criteria for futility judgements
2.6.2.10. reliable prognosis is (currently) impossible
2.6.2.10.1. futility can theoretically apply to AN but cannot currently be determined in individual patients bc
2.6.2.11. of lack of access to high-quality care
2.6.3. futility is commonly used, no better term available
2.6.4. coerced life-sustaining measures can be futile
2.6.4.1. when “actively dying”/if high risk of death from forced feeding
2.6.4.2. bc the notion that one cannot die from a mental disorder is mistaken
2.6.4.3. when (consecutive) psychotherapy for AN has a very low success chance
2.6.4.3.1. untreatability/lack of remaining viable options
2.6.4.3.2. when previous consistent refusal of psychotherapy when competent
2.6.4.3.3. when consecutive psychotherapy is cost-prohibitive
2.6.4.4. bc some patients declare treatment futile and stop showing up for care
2.6.4.5. bc some patients have DMC to make qualitative futility judgments
2.6.4.6. bc futile treatment is futile both for the competent and the incompetent
2.6.4.7. <-> reverse futility
2.6.4.8. (only) prolonging a life of subjectively unacceptable quality
2.6.4.9. when patients declare futility and stop showing up
2.6.4.10. when patients fail to/cannot show the minimum cooperation necessary
2.6.5. potential benefits/arguments in favor of using the concept of futility
2.6.5.1. respects autonomy, allows self-determination
2.6.5.2. can prevent overtreatment
2.6.5.3. justifies shift to palliative care
2.6.5.3.1. allows patients to die with dignity
2.6.5.4. global rejection of futility in AN is stigmatization
2.6.6. potential harms of/arguments against using the concept of futility
2.6.6.1. disguises clinicians value judgements (f.ex. about resource allocation) as objective judgements
2.6.6.2. implies that caring for these patients would be a waste of time, effort and money

2.6.6.2.1. blames patients and families
2.6.6.2.2. reinforces stigma
2.6.6.3. can trigger maladaptive schemas
2.6.6.3.1. can induce hopelessness and suicide
2.6.6.3.1.1. treatment-resistance can induce hopelessness/giving-up
2.6.6.3.2. can make patients not access care
2.6.6.4. can cause loss of access to care and result in unjustifiable deaths
2.6.6.4.1. can lead to demoralization of healthcare professionals
2.6.6.4.2. allows clinicians to abdicate responsibility
2.6.6.4.3. duty to care for patients regardless of chances of success
2.6.7. specific, always pertains to a particular treatment for a particular patient at a particular time
2.6.7.1. futility judgments only on case-by-case individual basis possible
2.6.8. normative --> physicians not allowed to decide about futility without the patient/society
2.6.8.1. futility judgements should be made by the patient
2.7. DMC of AN patients for life-and-death-decisions
2.7.1. AN patients often incompetent
2.7.2. assumption of incompetence
2.7.2.1. assumption of incompetence based on diagnosis of AN
2.7.2.2. assumption of incompetence based on BMI/starvation
2.7.2.3. assumption of incompetence based on treatment refusal
2.7.2.4. assumption of incompetence in youth
2.7.2.5. AN patients are incompetent bc there is no tool to assess their DMC
2.7.3. AN patients can have DMC for life-and-death decisions
2.7.3.1. no incapacity judgments based on diagnosis alone
2.7.3.1.1. AN as cause for incompetence is a circular argument
2.7.3.1.2. that would be discrimination/interfere with the right to self-determination
2.7.3.2. no incapacity judgments based on content/treatment refusal alone
2.7.3.2.1. treatment refusals can stem from rejection of a disempowering "AN patient" role

2.7.3.2.2. no incapacity judgements based on decision to refuse alone, even if harmful
2.7.3.2.3. bc that would unduly restrict freedom of choice
2.7.3.3. Who can be competent?
2.7.4. same/different procedure for DMC judgements than for other patients
2.7.4.1. DMC, not lack thereof, has to be proven
2.7.4.1.1. <-> presumption of DMC needs to stay
2.7.4.2. higher threshold for DMC for very harmful decisions
2.7.4.3. more thorough DMC assessments in AN patients refusing life-sustaining feeding
2.7.4.4. take assessment of family and health professionals into account
2.7.5. alternative criteria for (in)capacity judgements
2.7.5.1. more stringent criteria for DMC
2.7.5.1.1. alternative cognitive/rational criteria for (in)capacity judgements
2.7.5.1.1.1. incompetence bc decision is made for irrational reasons (such as irrational fears)/or goals
2.7.5.1.1.1.1. capacity defined as acting in ones best interests
2.7.5.1.1.1.2. <-> treatment refusal can be a rational decision
2.7.5.1.1.1.2.1. refusal can be an affirmation of a life the patient can conceive of living
2.7.5.1.1.1.2.2. decisions make sense in the context of their neurobiological and personality traits
2.7.5.1.1.1.2.3. bc burdens can outweigh benefits
2.7.5.1.1.1.3. <-> rationality of reasons cannot be objectively determined
2.7.5.1.1.1.4. <-> right to make irrational decisions
2.7.5.1.1.1.5. <-> right to be wrong
2.7.5.1.1.1.6. <-> would obviate freedom
2.7.5.1.2. incompetence bc of pathological values
2.7.5.1.2.1. <-> objective, clear, coherent, reasoned differentiation of pathological and authentic values cannot be given
2.7.5.1.2.2. incompetent bc decision is inauthentic/patients lack healthy identity
2.7.5.1.3. volitional instead of cognitive incapacity
2.7.5.1.4. emotional/psychological DMC

2.7.5.2. less stringent criteria for DMC
2.7.6. defending the functional/procedural test of DMC
2.7.6.1. consideration of values unnecessary
2.7.6.2. capacity requires only capacity for DM, not actual understanding, appreciation, and reasoning
2.7.6.3. right to live one's life according to one's preferences and values
2.7.6.4. everything else is discrimination
2.7.6.5. patients can be found incompetent with the functional test
2.7.6.5.1. appreciation: not believing information/ not applying it to oneself
2.7.6.5.2. understanding: AN symptoms as delusions/mistaken beliefs
2.7.6.5.2.1. <-> these are not mistaken beliefs but unorthodox values which deserve respect
2.7.6.5.3. reasoning: inability to weigh information
2.7.6.5.4. reasoning: incompetence bc of discrepancy between goals and decisions
2.7.6.5.5. appreciation: incompetence bc of no insights into illness
2.7.7. alternative decisions for which the patient's DMC needs to be assessed
2.7.7.1. incapacity to refuse to eat does not imply incapacity to refuse medical treatment for AN
2.7.7.2. competent decision about own QOL and prospects of further treatment
2.7.7.3. some patients can differentiate suicidal thoughts from therapy-weariness
2.8. call for ethico-legal exceptionalism
2.8.1. fundamental criticism of ethical principles
2.9. terminology for foregoing coercive life-sustaining measures/EOL care
2.9.1. abandonment, negligence, failure, giving up
2.9.2. collusion with the AN
2.9.3. suicide assistance
2.9.4. euthanasia
2.9.5. murder (starving the patient to death)
2.9.6. legitimate treatment refusal
2.9.7. treatment based on patient's preferences, values and prognosis
2.9.8. part of the trajectory of living with AN

2.9.9. treatment focusing QOL
2.10. terminology for patient refusals of life-sustaining measures/requests for EOL care
2.10.1. patient refusal of treatment/request for EOL care as self-harm
2.10.1.1. patient refusal of treatment/request for EOL care as suicidality/request for euthanasia
2.10.1.1.1. not suicide bc no intent to die (merely acceptance of death as unintended consequence)
2.10.2. patient refusal of treatment/request for EOL care as AN symptom
2.10.2.1. patient refusal of treatment/request for EOL care as symptom of psychosis
2.10.3. patient refusal of treatment/request for EOL care as a rational decision
2.11. moral status of suicide (assistance) and euthanasia
3. ethical reasoning about EOL care for AN
3.1. beneficence-based arguments for coercive life-saving/against EOL care
3.1.1. AN is never terminal
3.1.1.1. good prognosis of forced feeding regarding survival
3.1.1.2. somatic sequelae are reversible
3.1.1.3. withdrawal of life-sustaining measures only appropriate when inherently fatal
3.1.2. moral duty to preserve life
3.1.2.1. live is (always) worth living -> best interest/beneficence = being kept alive
3.1.2.2. sanctity of life/life as an absolute value
3.1.2.2.1. <-> life is not an absolute value
3.1.2.3. right to life
3.1.2.4. preventing premature/avoidable deaths especially in young persons
3.1.3. clinical remission is always possible
3.1.3.1. forced feeding enables/gives hope for clinical remission in the future
3.1.3.1.1. future research may improve outcomes
3.1.3.2. duty to maintain hope and keep providing treatment
3.1.3.3. sometimes several forced refeedings are necessary before progress can occur
3.1.3.4. most patients profit from treatment and have an acceptable QOL

3.1.3.4.1. <-> reduction of AN-behavior over the course of coercive treatment might stem from patients surrendering to medical power
3.1.4. forced feeding is beneficial as it gives patients something to oppose
3.1.5. forced feeding expresses “tough love” and concern for the patient
3.1.6. repeated aggressive measures are not automatically inappropriate
3.2. calls for hard paternalism (coercion of patients with DMC)
3.2.1. <-> hard paternalism perpetuates stigmatization
3.3. beneficence-based arguments for EOL care
3.3.1. EOL care be only intermittently
3.3.1.1. not coercing can lead to more functional behavior
3.3.2. concept of EOL care enables advance care planning
3.3.3. EOL care improves quality of dying/relieves suffering
3.3.4. EOL care preserves dignity, honor the life lived
3.3.5. EOL care exemplifies the virtue of compassion
3.3.5.1. EOL care embodies humility at the limitations of medicine/mental health care
3.4. non-maleficence-based arguments against EOL care
3.4.1. EOL care can induce hopelessness
3.4.2. availability of EOL care undermines patients motivation for curative treatment/induce a death wish
3.5. nonmaleficence-based arguments for EOL care/against coercive life-saving
3.5.1. burdens of CSLM
3.5.1.1. forced feeding is invasive and burdensome
3.5.1.1.1. <-> forced feeding is not objectively unbearable
3.5.1.2. forced feeding goes against patient’s dignity
3.5.1.3. forced feeding can increase psychopathology/dysfunctional behavior
3.5.1.4. forced feeding entails risk for somatic complications
3.5.1.5. forced feeding can damage the therapeutic alliance
3.5.2. coercion can be ineffective
3.5.2.1. coercion does not guarantee survival, may even shorten life

3.5.3. burdens of forced feeding can outweigh the benefits
3.5.4. sustaining life with coercion is only justifiable with acceptable chance for recovery
3.5.4.1. some patients have a very poor long-term prognosis regarding mental health
3.5.4.1.1. it cannot be predicted who will recover after CLSM
3.5.4.2. poor prognosis regarding QOL
3.5.4.3. some AN patients cannot continue fighting
3.5.5. end suffering as best interest of the patient/imperative to not prolong suffering
3.5.5.1. rejection of EOL care condemns patients to endless cycles of somatic decompensation and coercion
3.5.6. coercion as based on professionals aggression, anxiety and frustration
3.5.7. patients should not be forced to try any treatment option
3.6. autonomy-based arguments for coercive life-saving
3.6.1. forced feeding (could) restore autonomy
3.6.1.1. being kept alive gives patients the opportunity to change their mind
3.6.1.2. forced feeding can change the values on which treatment refusal is based
3.6.1.3. forced feeding can restore autonomy to give an advance directive for EOL care/competent refusal
3.6.2. AN patients generally don't have a death wish/acceptance of risk of death
3.6.2.1. some patients are retrospectively thankful for coercion
3.6.2.1.1. <-> reports of retrospective gratitude are anecdotal and suffer from selection bias
3.6.3. AN patients' refusal of life-sustaining treatment is never grounded in a wish for a better quality life
3.6.4. autonomy as relational virtue instead of individualistic/must be exercised responsibly
3.6.4.1. cultural differences in autonomy as a relational virtue
3.6.4.2. responsibility for decisions lies with patients
3.6.5. as patients don't have DMC, their refusal need not be respected
3.7. autonomy-based arguments for EOL care
3.7.1. competent refusals should be respected
3.7.1.1. right to decide about life-sustaining measures, right to die and right to choice in dying
3.7.1.1.1. reflects stated wishes
3.7.1.2. treatment efficacy is not sufficient reason for overriding patient refusals

3.7.1.3. patients have a right to die and right to choice in dying
3.7.2. coercion erodes patients autonomy
3.7.3. concept of EOL care promotes honest discussions about treatment options and prognosis
3.7.4. rejecting the possibility of competent treatment refusals in AN makes patients dependent on whether their physicians believe dying is in their best interests
3.7.5. as women are more associated with their bodies, they are seen as less rational and thus deemed incompetent more often
3.8. justice-based arguments for coercive life-saving
3.8.1. right to be treated regardless of compliance and costs
3.8.2. Treatment failures stem from lack of resources and/or expertise
3.8.3. EOL care is an excuse for clinicians to get rid of cumbersome patients
3.8.3.1. foregoing life-sustaining measures means blaming the patient for not recovering
3.8.4. EOL care for some AN patients suggest treatment of AN is always harmful/futile, endangering access to care
3.8.5. providing EOL care for AN would be intolerably distressing for healthcare professionals
3.9. justice-based arguments for EOL care
3.9.1. denying EOL care to protect the majority of AN patients is unfair to the minority who would profit
3.9.2. the purpose of medicine is not to serve the interests of the survivors
3.9.3. injustice regarding when DMC is assessed
3.9.3.1. in critically ill/dying patient, DMC can always be questioned
3.9.3.2. DMC is only assessed when patients refuse treatment/not questioned in cachexic tumor patients
3.9.4. EOL care should be needs-, not diagnosis-based
3.9.4.1. some AN patients meet WHO eligibility criteria for palliative care
3.9.4.2. same access like persons with somatic illnesses
3.9.5. refusal of EOL care for AN is stigmatization
3.9.5.1. psychological suffering can be as real and painful
3.9.6. EOL should not be available only to patients who could afford extensive AN treatment
4. legal aspects
4.1. UK jurisdiction
4.2. Israeli jurisdiction

4.3.	French jurisdiction
4.4.	substituted judgement in AN
4.5.	best interest as biomedical question vs. holistic
4.6.	rights-based arguments
4.6.1.	UNCRPD interpreted as ruling out incapacity judgements and coercion
4.6.2.	UNCRPD interpreted as ruling out coercion of competent persons
4.6.3.	ECHR: right to respect for private and family life
4.6.4.	ECHR: prohibition of inhuman and degrading treatment
4.6.5.	ECHR: right to life
4.7.	advance directives
5.	attitudes towards EOL care for AN
6.	practical aspects of EOL care for AN
6.1.	make voluntary treatment aiming at clinical remission/harm reduction available at all times
6.2.	deliberating about EOL care
6.2.1.	allow for enough time for thorough decision-making process
6.2.2.	do a detailed workup of the case
6.2.2.1.	including factors contributing to chronicity and treatment-refractoriness
6.2.2.2.	get second opinion on treatment options and prognosis from independent expert
6.2.3.	give best possible estimate of prognosis with and without treatment
6.2.4.	conduct two independent formal DMC assessments
6.2.4.1.	provide assistance for the patient to meet DMC criteria
6.2.4.2.	assess DMC in a period of relative stability, not (only) in crisis
6.2.5.	involve all stakeholders
6.2.5.1.	ensure the patient has a voice
6.2.5.1.1.	even when incompetent
6.2.5.2.	involve significant others
6.2.5.3.	involve the mental health care treatment team, especially long-term providers
6.2.5.4.	involve palliative care consultant

6.2.5.5. involve ethics consultants
6.2.6. submit the matter to the court for external review
6.2.7. expect and care for emotional and moral distress
6.2.7.1. feelings of professionals/family need to be addressed before deciding about EOL care
6.2.7.2. Confusion: can one die from a mental disorder?
6.2.8. reflect on own biases, interests, beliefs, and values
6.2.9. consider caregiver burden and healthcare resources
6.3. eligibility criteria for EOL care for AN
6.3.1. Should there be quantified criteria, or only procedural criteria for case-by-case evaluation?
6.3.2. What weight is given to patient preference, provider assessment, and societal values?
6.3.3. established diagnosis of AN
6.3.4. patient's DMC confirmed upon careful assessment
6.3.4.1. patient has insight into AN
6.3.4.2. patient declares further treatment futile based on realistic assessment of QOL and prospects of treatment
6.3.4.3. patient understands and appreciates that death is the most likely outcome of her refusal
6.3.4.4. refusal is consistent with general values and preferences
6.3.4.5. patient has considered effect on family
6.3.5. unlikelihood of benefit from coerced re-feeding
6.3.5.1. benefit in terms of somatic health and quantity of life
6.3.5.1.1. medium- to long-term fatal outcome likely even with treatment
6.3.5.1.2. EOL care appropriate when "actively dying"/life-sustaining treatment physiologically futile
6.3.5.1.2.1. not necessary: medical instability
6.3.5.1.2.1.1. death must not imminent (as criterion for accepting refusal of future life-sustaining treatment)
6.3.5.2. benefit in terms of mental health and quality of life
6.3.5.2.1. treatment-resistant psychiatric comorbidities
6.3.5.2.2. deteriorating AN
6.3.5.2.3. several previous intensive and high-quality treatment attempts
6.3.5.2.3.1. including coerced treatment

6.3.5.2.4. previous treatment attempts harmful or ineffective/chronicity of AN
6.3.5.2.5. higher age
6.3.5.2.6. long duration of AN
6.3.5.2.6.1. late illness phase
6.3.5.2.7. no motivation for change/treatment noncompliance in the past
6.3.5.2.7.1. unable to accept the terms of a harm reduction approach
6.3.5.3. medical comorbidities/sequelae of AN, especially irreversible
6.3.5.4. high severity of AN
6.3.6. unacceptable quality of life/irremediable suffering
6.3.7. waiting period elapsed
6.3.7.1. try reasonable treatment options
6.3.7.2. (try) to treat to competence for advance directive
6.3.7.3. time for detailed assessment of criteria
6.3.7.3.1. patient wish consistent over time/carefully considered
6.3.7.4. family had time to elaborate regarding the patient's death
6.4. providing EOL care
6.4.1. get to know the patient before admission
6.4.1.1. get informed consent from the patient and/or her surrogate decision-maker
6.4.1.2. propose that the patient or her surrogate decision-maker sign a DNR order
6.4.1.3. help the patient redact an advance directive
6.4.2. expect and care for emotional and moral distress in all parties
6.4.3. assemble a multidisciplinary team
6.4.3.1. keep the mental healthcare team involved
6.4.3.1.1. educate PC providers
6.4.3.1.2. strive for continuity of care
6.4.3.1.3. preserve opportunity for curative treatment
6.4.3.2. conduct frequent multidisciplinary case discussions
6.4.3.3. involve palliative care providers

6.4.4. possible settings: home, hospital, nursing unit, hospice care unit
6.4.5. stop weigh-ins, calorie and exercise monitoring
6.4.6. encourage and support eating for pleasure
6.4.7. (de)prescribe psychotropic medication according to the patients assessment of benefit
6.4.8. medication and care for somatic symptoms such as pain
6.4.9. offer supportive therapy such as art therapy, massage therapy
7. needs of stakeholders
7.1. finding the right timing for discussing EOL care
7.2. defining, assessing and dealing with psychological and spiritual suffering (as opposed to physical suffering)
7.3. coping with prognostic uncertainty
7.4. having a clear concept of EOL care for AN
7.5. being supported by professionals from other specialties
7.6. differentiating treatment refusals grounded in the AN from competent, well-considered ones
7.7. coping with conflict between professional identity as a healer and valuing patients' quality of dying