Silos of internal medicine and psychiatry: anorexia nervosa as a paradigm

Silos da clínica médica e psiquiátrica: a anorexia nervosa como paradigma

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DOI: 10.5935/2238-3182.20130061

ABSTRACT

This essay aims to rescue the concept of internal medicine and attempt to reflect, based on the history of Medicine and Psychiatry, on the technological changes of the contemporary world and their consequences in current medical practice. Anorexia nervosa is used as a paradigmatic example, and allows a contrastive discussion on the importance of the classical concept of internal medicine when approaching these manifestations. The method used was based on the reading of the history of Medicine and Psychiatry, allowing a critical observation of the directions taken by current medical practices.

Key words: History of Medicine; Psychiatry; Clinical Medicine; Anorexia Nervosa.

RESUMO

Este ensaio pretende resgatar o conceito de clínica, procurando fazer reflexão, a partir da história da Medicina e da Psiquiatria, das mudanças tecnológicas do mundo contemporâneo e suas consequências na prática médica atual. A anorexia nervosa é usada como exemplo paradigmático, permitindo contrapor à posição corrente e discutir a importância da concepção clássica da clínica na abordagem dessas manifestações. O método usado fundamentou-se em leituras da história da Medicina e da Psiquiatria, o que permite observar, de forma crítica, a orientação da prática médica atual.

Palavras-chave: História da Medicina; Psiquiatria; Medicina Clínica; Anorexia Nervosa.

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INTRODUCTION

The word *clinic* refers to general Medicine and has its etymological origin in the term *klinein*, which means bed. Thus, clinic is what happens at the patient's bedside or, put another way, what is not found in the books or learned from a single case.[1]

The current medical model, centered on diagnosis, drug therapy, and statistical protocols often leaves the clinical aspect aside.[2] However, actual medical practice makes evident the importance of expanding the attitudes and the scientific method when dealing with cases that do not fit in standard approaches despite attempts to thus reduce them by means of homogeneous positivist science discourses.

We identify within this context certain eating disorders including all the variants of anorexia, bulimia, and obesity. These are serious manifestations that call upon physicians and psychiatrists to work together in finding a course of treatment, a process frequently marked by impasses. With a complex and multifactorial etiology, the subjective determinants of a patient's illness are evident.

Submitted: 05/16/2012
Approved: 12/07/2012

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Although Medicine is well familiarized with the physiology of nutrition and dietetic ideals for the proper functioning of organisms, there is something that escapes protocol approaches. The current model of treatment of such manifestations focuses on the diet issue, which is easily measurable by science, to the detriment of patients' unique constitutive relationship with their bodies. This fact seems to contribute to the high rates of unsatisfactory treatment results evidenced by clinical studies.

This article, through a reflection on the history of medical and psychiatric clinical practice, contends that the classical conception of the clinic has been given an underprivileged place in current medical practice. Anorexia nervosa will then be approached as a paradigmatic example in order to discuss the importance of rehabilitating this conception.

The medical clinic

In "The Birth of the Clinic", Michael Foucault uses this title to report on the birth of modern scientific Medicine sustained, initially, by the anatomoclinical model.[3]

Despite being a millennial social practice, founded by Hippocrates, only at the end of the 18th century did Medicine begin to work with a more rigorous methodology and, as a result, build a more consistent body of theory. The social transformation brought about by the advent of the bourgeois society reaches the medical discourse, guiding it based on reason and experience. During this period, several discoveries and elaborations enabled the current medical instrumentation.

Philippe Pinel (1745-1826) was the first physician to formalize the fundamentals of internal medicine, structuring it as experience based on a method proposed by Condillac. For this philosopher, knowledge is a process in which perception of phenomena that constitute reality is described by means of language. Thus, Pinel structures clinical practice as an experience that favors observation and the attempt to translate what is seen into speech, and once that is done to group the perceived phenomena and classify them by names. Despite sharing with the empiricists a distrust of the possibility that reality is completely seized by knowledge and language, Pinel maintained the clinical method as a conscious and systematic way of pursuing a description that was as close to real as possible.[4]

Xavier Bichat (1771-1802) founded the anatomical-clinical method. With pathological anatomy supporting the clinic, he saw as its foundation the objective to describe diseases that allowed a correlation of symptoms with the findings in the body. Thus, the method starts to move away from an analysis based solely on words or on susceptible perceptions transcribed into language. At that moment, according to Foucault, illness becomes detached from metaphysics and ceases to be part of the invisible, and starts to have death as its reference. The prestige conferred on dissection of cadavers and objective observation enabled the first scientific discourse on the individual.[4]

Since then this has become the hegemonic model in Medicine, with outstanding contributions from true founders of important areas of knowledge, such as those from Rudolf Virchow (1821-1902) in cellular pathology, Robert Koch (1843-1910) and Louis Pasteur (1822-1895) in microbiology, Claude Bernard (1813-1878) in Physiology, Gregor Mendel (1822-1884) in genetics, and Ehelich (1854-1915) in pharmacology.

Thus, the study of diseases, previously merely descriptive and mainly based on observation of symptoms, progressed successively to anatomical-clinical, pathophysiological and etiopathogenic criteria, moving away from the sickbed and its surroundings to the laboratory. In addition to searching for a correlation between clinical data and the lesions of organs with altered functions and probable causes of illnesses, physicians started to become interested in explaining the intermediate mechanisms of diseases (pathogenesis) through functional and biochemical alterations, which allowed them to modify and give scientific basis not only to diagnosis, but especially to therapy. Since then, it is understood that symptoms can dispense with structural lesions, which constitutes a milestone for biological Medicine.[5]

The knowledge amassed in the 19th century was followed by the 20th century technological era, a time when scientific Medicine has progressed more than in its entire history. These transformations are not accounted for only by changes in the production of medical knowledge, but also by a series of changes in the organization of society and the medical profession. Medicine, which was a focus of State intervention, went on to receive investments arising from economic interests, thus ceasing to be a liberal profession.[5]

The considerable volume of knowledge produced and the massive introduction of technologies led to the emergence of a high number of disciplines. Medical practice, in its turn, was fragmented into several specialties. In this sense, physicians who acted in vari-

ous areas saw their authority and prestige decline in benefit of specialists, who began to act as if they were real engineers of the body decomposed as a machine.[6]

That is, despite technical advances, physicians were distancing themselves from their patients. New diagnostic techniques have contributed for physicians to act more and more like technicians and patients to be seen as objects of investigation and intervention. Consequently, the doctor-patient relationship became increasingly subordinate to technical protocols and evaluation devices, excluding subjectivity or trying to standardize it.

Scientific Medicine had a strong impulse to consolidate itself as the dominant practice in 1910, with the implementation of the Flexner Report in medical education in the United States. Since then, the biomedical model, centered in the disease and in the hospital, has become the basis of medical education and practice, and the social, psychological, and economic dimensions of health are submitted and reduced to the biological model. The positivistic approach was adopted and the only recognized knowledge becomes that produced by the scientific method. After World War II the biotechnology model of teaching, practice, and construction of medical knowledge was consolidated globally. In this context we see the emergence of evidence-based medicine, which promotes the idea of checking interventions made in statistically significant studies. For this end, objectifying the clinical picture and the idea of healing becomes a necessity, eliminating the influence of any bias that might escape control, including the subjective factors related to the illness and the doctor-patient relationship. From there it became possible to create homogeneous and predictable treatment protocols.

It is worth remembering that although evidence-based medicine dominates current medical practice, there are other currents, such as person-centered medicine, which have functioned as important counterpoints for this here reflection.[7] We know that illness is a human phenomenon not restricted to biological events but one that involves reactions related to each individual's subjectivity and environment. When considering the healing that is expected of Medicine, this idea becomes especially true. Michael Balint (1896-1970) already emphasized the importance of the doctor-patient relationship in treatment when he remarked that the doctor, when prescribing, prescribes for himself.[6] This relationship suffered from the consequences of technological and scientific development and lost its importance in medical training.

Therefore, the initial idea of internal medicine that favors patients and their relationship with doctors seems to have been gradually forgotten. It is no coincidence that the great exponents of internal medicine often remind their students that "the clinic is sovereign". At the beginning of his book *Semiologia Médica* Professor Mário Lopes makes a fundamental distinction between disease and illness.[8] He defines disease as a biological event characterized by anatomical, physiological or biochemical changes. As for illness, it is considered as personal, cultural, and interpersonal reactions to diseases or discomforts, i.e. it is a human rather than biological phenomenon. For these reasons the professor advocates for the use of the term illness, emphasizing that whenever a disease affects an individual, its manifestations are always unique; these are the ones that must actually be diagnosed and treated by doctors.

The psychiatric clinic

Psychiatry, though considered a medical specialty, has clinical peculiarities that deserve to be highlighted. Given the specificity of its object, its foundation was never the anatomical-clinical method, although that possibility was always in the horizon.[4]

When faced with madness, Pinel kept his belief in the clinical method, believing that in psychic illness there was a functional disorder in the central nervous system that might or might not be due to structural damage. This is the most radical functionalist position in the history of Psychiatry to make mark in the discipline. Thus, Psychiatry was born out of the clinical method and the functionalist postulate, favoring phenomenological observation and description. It was inaugurated with Pinel's "Treatise on Insanity" (1801).[4]

Jean-Étienne Dominique Esquirol (1772-1840), the most orthodox of Pinel's disciples, introduced the psychopathological concept of dualist madness, i.e., the etiology could be caused by a functional disorder or brain injury. He thusly reinvigorated the organicist and naturalistic concept of psychic illness, reacting against his master's radically anti-organicist doctrine.[9]

Pinel and Esquirol wre the great names in this initial period of clinical psychiatric. The French and German schools then began to study and describe mental disorders more profoundly, establishing the fundamentals of psychiatric nosology.

Wilhelm Griesinger (1817-1868), founder of the classic school of German Psychiatry, encouraged by the discovery of Bayle's general paralysis, postulates his radical anatomist hypothesis that all mental disorders were diseases of the brain. He divided mental disorders into those that had already confirmed anatomical-pathological substrates and those in which these substrates were still to be detected. While the works by Pinel and Esquirol had a characteristically literary style, Griesinger's work displayed the characteristics of a practical handbook, such as prevails today.[10] Emil Kraepelin (1855-1926) followed this work describing the symptoms in detail and organizing the clinical findings by medical model.

From the late 19th century on, psychiatry becomes marked by heated arguments between organicists and idealists. The organicist theory was backed by others besides Griesinger, such as, for example, Von Krafft-Ebing (1840-1902), Wernicke (1848-1905), and Korsakov (1854-1900). The idealist concept, which stated that mental disorders were caused by psychological mechanisms, had representatives such as Freud (1856-1939), Jung (1884-1958), Melanie Klein (1882-1960) and Otto Rank (1884-1939). Many scientists, for instance Esquirol (1772-1840), Herbart (1776-1841), Jean-Pierre Falret (1794-1870), Morel (1809-1873), Eugen Bleuler (1856-1939) and Gilles de La Tourette (1857-1904), adopted a less extreme position as they understood that biological and psychological mechanisms acted jointly to determine the health-illness phenomenon.

The effervescence of this descriptive movement in Psychiatry defined classes with broader limits, which allowed for some circulation of subjective aspects involved in the diseases of the soul. Even Griesinger, with his radical organicist theory, used Herbart's psychological concepts as a reference, anticipating the theses that would be taken up by Sigmund Freud a century later, as for instance the theory of the ego. [9] In fact, many of the classes set in classical Psychiatry were appropriated by Freud for the purpose of creating clinical psychoanalysis. This neurologist made an epistemological break in the understanding of psychic illness, proposing a shift from observing to hearing and carrying on with psychopathological research in this field. [9]

Paul Bercherie, in his inventory of the legacy of the history of psychiatric knowledge, chooses the term clinic for classical Psychiatry, underscoring that it refers to the basic postulate that mental disorders must be understood as a particular variety of somatic disorders that can be described and broken down into simpler elements and, from there, grouped and classified. However, he suggests that the nature of this orientation carries in itself the germ of its failure; after all, once madness is understood as an illness, the search for a typical case becomes a rarity or simply a fallacious construct of the observer. In this sense, he resumes the debate proposed by empiricists that language could never exhaust reality.[9]

Bercherie concludes that, when faced with the impossibility of a total classification system that truly encompassed the reality of the practice and the etiological definition of the disorder in question, the clinic in its classic sense will be extinguished in about half a century after Pinel created it. [9]

> *The joint outcome of the impasses of the clinical practice, of the doctrinal urgency and of the prospects of therapeutic pragmatism was that the clinic slowly disappeared – first its spirit, then its contents. Open a classic Psychiatry manual: it can be seen more as a bundle of tangible documents, described and analyzed, than a treatise of pathological Psychology similar to our modern works, with no examples, no reports or clinical cases, no illustrations, without an examination plan or a true semiological inventory. It has been a few decades since Psychiatry became ashamed of pure clinic, simple observation, of gazing; [...]*[9:317]

It is remarkable that observation-based clinic was extinguished in 1920 as there have been no discoveries of new nosological entities since then, although attempts are still made. From then on Psychiatry has moved toward defining its concepts more clearly, thereby making the orientation boards more systematized, rigid and, consequently, impoverished.

Current Psychiatry is the result of attempts to approximate psychiatric knowledge and the technological model of medicine, in which diagnosis becomes more objective and stable, enabling controlled clinical trials that ensure standardized treatments based on scientific evidence. The cornerstone of this transformation was the creation of the "Diagnostic and Statistical Manual of Mental Disorders III" (DSM III) in 1980, which aimed at establishing a manual from a descriptive and atheoretical perspective. Once psychiatric knowledge focused on neither the etiology nor the process of mental illness, it created a classification based on easily observable phenomena in the clinical practice that could be described without any specific theoretical reference. This manual would assist not only the interests of psychiatrists who needed to set more ac-

curate boundaries between the normal and the pathological and, consequently, of Psychiatry's own field of action, but also the interests of the pharmaceutical industry, which needed to distinguish individuals who should take medication from those for whom this type of intervention would not be justified. [11]

What we now know as Biological Psychiatry is consolidating itself at the moment. In it the patient is reduced to a series of signs and symptoms that fall into homogeneous categories with treatments based on empirical data verified through studies acknowledged in the scientific world. Since then, Psychiatry became one of the areas of medicine whose vocabulary is most widely disseminated in society, with the illusory promise that the apparatus of the neurosciences would be enough to encompass human subjectivity.[11]

In 1994, the American Psychiatric Association (APA), sustaining the break with debates on the etiology of psychic illness, dear to classic psychiatrists, publishes the DSM IV. Although this manual shows conceptual continuity with the DSM III, it claims to go beyond simplifying communication between researchers and clinicians in the field and intends to serve as educational support to the teaching of Psychopathology. [11]

Before long, the DSM IV became the fundamental clinical manual of current Psychiatry. This manual proposes that patient assessment should be carried out from several variables arranged in five axes. The first consists of the main psychiatric disorder; the second, of personality disorders and mental retardation; the third, of general medical conditions; the fourth, of environmental and psychosocial problems; the fifth, of patient functioning over a certain period. [12]

Currently, medical residency programs in Psychiatry focus on the diagnoses and algorithms of the DSM IV, as well as on prescription drugs, which leads to a reduction of emphasis on collecting the patients' history and the possible psychotherapeutic interventions. It is true that this manual tries to recover some of what was lost from the variables on axis IV, which proposes a survey of psychosocial and environmental factors contributing to the development and exacerbation of the disorder in question. However, most of the time this evaluation is forgotten and, when made, it is superficial.

It is indisputable that greater knowledge of brain functions and the advances in psychopharmacology provide a space where it is possible to create more effective treatments for patients suffering from psychiatric disorders. However, it is essential that the clinical practice retains its classical sense, i.e. that it considers each case unique with its own singularities and teachings. For this, clinicians should be open to become acquainted with other kinds of knowledge about subjectivity without shunning listening, observation and interventions for the theoretical-scientific apparatus, which conceives the subject as merely a result of biological determinants. This consideration is especially true when faced with clinical pictures for which the psychopharmacological treatments do not yield satisfactory effects, as in anorexia nervosa, which is discussed below.

DISCUSSION

Anorexia nervosa: a challenge to the current medical model

Anorexia has been the subject of interest and controversy in the medical field for over 300 years. It is a chronic disease that usually affects young subjects, causing significant physical and psychic damage. Among all psychiatric disorders, anorexia nervosa presents the highest rates of mortality. Studies show that these patients' quality of life tends to be worse than that of schizophrenics, the severity paradigm in Psychiatry. [14]

Anorexia nervosa (AN), as defined by the DSM IV, is characterized by a refusal to maintain minimum body weight, intense fear of weight gain, distortion of body image, and changes in the menstrual cycle.[12] This definition, contrary to what is observed in more classical references, gives no indication as to the best way to refer to the various degrees of severity found. Henri Ey, for example, in his "Handbook of Psychiatry", distinguishes cases of anorexia that come close to hysteria from those close to schizophrenia. The former are more frequent and fall into the so-called psychosomatic character, given the occurrence of features like denial of the psychic conflicts and tendency to feel them as a bodily disease. These cases usually have a more favorable prognosis. At the opposite end are the cases characterized by difficulty of understanding and treatment, displaying a "terrifying appetite for death". Ey asserts that death does not occur mainly due to the catastrophic malnutrition, but to the exhaustion resulting from several therapeutic attempts. Among these extremes, there are other difficult cases associated with personality disorders that, despite not being

as serious as the former, typically include relapses and psychiatric complications. The current classification, by not stressing the various possibilities in presentation, severity, and prognosis of cases, acquires more statistical value than clinical guidance. After all, the assessment of treatment applied to patients sorted homogeneously in cases of anorexia nervosa becomes uncertain and difficult to interpret.

Despite investments in research, the proposed treatments still deliver unsatisfactory results. Rates of full, partial, and unfavorable recovery from AN after therapeutic interventions are of 20, 30 and 20%, respectively. Although these rates seem encouraging, a large number of patients maintain physical, mental, and social dysfunctions and the rate of cases turned chronic is around 20%. Crude mortality rates range from 5 to 20% and increase with longer follow-up periods. [16,17]

Current evidence regards the psychopharmacological approaches as inefficient and the psychotherapeutic interventions as the basis for treatment.[18,19] At this point, a certain degree of uneasiness is noted in current Psychiatry, which focuses on diagnosis, drug-based treatment, and standardized psychotherapies.

Considering that psychotherapeutic treatments must be permeated by an appropriate doctor-patient relationship, caution is needed regarding statistical tests that do not comprise this element that, despite being the basis of treatment, is difficult to measure.[18,20] Furthermore, the presentation of AN is heterogeneous, difficult to distribute into therapeutic categories, and its progression depends on many factors (family, comorbidities, and the doctor's and the medical team's relationship with the patient, the therapeutic team's experience, working methods etc.). Thus, qualitative work based on the construction of clinical cases may allow for a more judicious assessment.

In a review of 23 studies interviewing patients with eating disorders to determine which treatments they believed to be the most suitable, empathy, support and understanding were mentioned as essential elements for recovery. Psychotherapic approaches were considered the most useful, and medical interventions focused exclusively on weight were evaluated as ineffective. This finding shows the importance of addressing broader issues that go beyond food and weight. [21]

The clinical treatment must be adapted according to the clinical and nutritional changes of each patient. The major difficulty found in practice is the patients' resistance to acknowledge the severity of their habits and their deliberate and adamant refusal to relinquish them. Although the literature does not show differences between the results of more complacent or stricter treatments in circumventing that refusal, the approaches vary from more coercive to more flexible. [22]

The refusal to be treated and to eat, one of the most important clinical aspects of anorexia, requires that doctors try several coercive approaches, which are often met with tenacious opposition by patients. A more careful analysis of the literature, as well as of the clinical experience in the care of patients with anorexia indicates that a parsimonious attitude is best suited to compulsory treatments.

Among the coercive treatments, the apex is compulsory hospitalization and force-feeding through nasogastric or nasoenteric tube, a controversial treatment according to the Brazilian Code of Medical Ethics. It is worth remembering that, although the re-establishment of weight and eating pattern minimally appropriate for the patient's life is one of the objectives of the treatment, it should not be the only one in view of the severity of the psychological complications associated with these cases. In addition, compulsory treatment, conducted against the patient's will, should be evaluated only after recourse to all other approaches, including referrals to other services and professionals. [18,20]

The issue of compulsory hospitalization for severe cases is object of great controversy in the literature. Some support this type of intervention given the possibility that the patient's nutritional state may lead to cognitive and behavioral changes, affecting the patients' capacity for autonomous decisions. Others point to the permanence of this capability, highlighting the need to respect autonomy in order not to reinforce the passive role of patients associated with eating disorder symptoms. [23-25]

Be that as it may, there is no evidence that resorting to legal coercion improves long-term survival. Patients who underwent compulsory hospitalization showed lower survival rates after six years of follow-up than those who submitted to treatment voluntarily. This requires careful interpretation since patients hospitalized compulsorily tend to be the more severe cases. The results did not show the benefits of long-term compulsory hospitalizaton[26], and a more recent study has shown no differences between the two situations.[27]

It is therefore impossible to reach a definitive conclusion about the use of coercive methods in approaching patients with more severe forms of anorexia. Hospitalization certainly can and should be

used in attempts to stabilize the most severe cases, which present a risk of death. Physicians should be fully committed to use their powers of persuasion to offer this alternative when they deem necessary, but it is suggested that they regard it as a negotiation.

As an alternative to the more coercive approaches, which focus on weight gain and normalizing appetite, there is the idea of a "weight contract" to be made with the patient at the beginning of treatment. This type of contract, first proposed by Hilde Bruch in the 40s, consists of a mutual agreement in which patients agree not to lose more weight and doctors in turn agree never to require them to eat or to increase the stipulated weight.[28] This approach is in line with Lasègue's idea; he was one of the first physicians to describe anorexia and to warn that the greater the insistence, the greater the patient's refusal. Furthermore, this approach distances itself from an understanding of patients with eating disorders as mere inadequacies of food intake and body awareness that need to be rectified, creating a space for important subjective elaborations that are present in the genesis of these cases.

The doctor's place in the treatment of anorexia nervosa

It can be said that, despite controversies in the treatment of AN, and regardless of the approach chosen, it should be based on the doctor-patient relationship and the singularities of each case that come to light in that relationship. Such foundations match those of the clinic, as discussed earlier in this text.

When it comes to the doctor-patient relationship, it is important to elucidate what this relationship refers to. After all, doctors can establish relationships with patients in several ways. They can believe they know exactly what the patient must do to improve, and impose, in more authoritarian or friendly manners, the treatment deemed more suitable, exempting the patient from the responsibility of choice. They can also continue demanding that the patients improve, thus putting them in a position of impotence. Considering the treatment for anorexia, this type of conduct can cause doctors to be frustrated and result in inadequate and iatrogenic attitudes toward patients. Thompson-Brenner et al. have recently shown the nefarious effects of prevalent negative reactions of clinicians toward eating disorders. This type of attitude reflects the concern, hopelessness, frustration, impotence and lack of training among health workers, contributing to failure and low adherence to treatment.[29]

Conversely, doctors may act as if they understand when, in truth, they know that they do not understand because they believe it is the patients who understand. Therein lies the enchantment of the clinic: what is not written in the books but is learned from each case.

In this sense, it is worth remembering that doctors, by isolating each case, have the possibility of somehow reckoning the possible clinical complications that are frequent in these patients throughout treatment, among which nutritional recovery syndrome and suicide.

CONCLUSION

Current medical literature reveals several controversies regarding treatment of anorexia. Perhaps one of the controversial issues is the understanding that treatment is aimed at anorexia itself and not at patients with anorexic symptoms, which reflects the repercussions of developments in the field of medicine and Psychiatry mentioned in the introduction. One of the consensual points is that, whatever the treatment chosen, it must be based on an adequate doctor-patient relationship.

Here a transcription Vialettes et al's reflection becomes appropriate.[23]

> *[...] the appropriate attitude when faced with this disconcerting, provocative, sometimes revolting and often discouraging disease could be modest tenacity. Modesty due to our ignorance of the mechanisms of the illness, our incertitude regarding the real efficacy of our treatment action, a success rate that is disappointing and above all our incapacity to predict its outcome in a given patient. It is also to be considered also that the patient is of a logic different than that deduced by our medical knowledge. The respect for what appears to us irrational demands tolerance for the individual though without leniency for the illness and for its desire for death [...].23:310*

Patients with anorexic symptoms, by putting any attempt of scientific standardization to the test, call on everyone to remember the essence of the clinical practice. After all, it is based on the clinic that it is possible to apprehend the singularities of each person in order to individualize their illnesses and create effective strategies for conducting their treatment.

Thus, all are invited to return to the clinic and the doctor's ever-original relationship with patients.

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