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However, in 1978, 1.2 infants died in rural areas for every one infant from urban areas. This ratio rose to 1.7 in 2007 [4]. The same trend is observed when the richer western part of Turkey is compared with the poorer eastern part, being a clear indicator of the poor not receiving proper health care. The big problem is that the rich are getting richer every year and the gap between the rich and the poor is increasing.

Health care should not be completely privatized, especially in developing countries, and one single model of health care reform will not solve health care problems. Primary health care is essential in these countries and must be provided by the state. In addition to the poor, the combination of unregistered labor force and high unemployment rates form a large group of population that cannot afford private health care. This fact alone makes a payroll tax financed system unrealistic. Health care in these countries should be provided mainly by the state at least until these countries join the "developed" countries.

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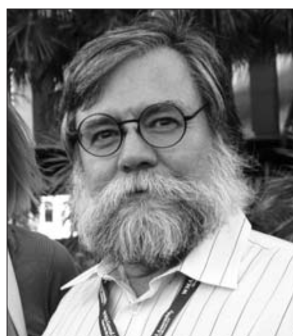
Physicians and Hunger Strikes in Prison: Confrontation, Manipulation, Medicalization and Medical Ethics (part 1)



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Introduction

The act of *fasting for a prolonged period of time as a form of protest* goes back more than a century. It has been used since the suffragette movements in the UK and the US in the early 20th century. Hunger strikes occurred sporadically in Ireland during the long protracted struggle between the Irish Nationalists and the British authorities. In the first half of the last century, Mahatma Gandhi, in Britain's Imperial India, went on and off hunger strikes many times, both when in and out of prison. It was Gandhi who perhaps actually gave hunger strikes their *lettre de noblesse* as a means of making the protest known to the general public. Hunger strikes attracted world-wide attention in the late 20th century in Belfast and Turkey. Ten much politicized deaths in Northern Ireland and several dozens deaths in Turkey put hunger strikes back in the news. In this century, the vast media attention given to hunger strikes by the inmates at Guantánamo Bay did not center on the phenomenon of the protest, but of the very controversial "solution" applied – force-feeding the hunger strikers. There have also been other, less highly publicized, hunger strikes in Europe, the Middle East and elsewhere, which have attracted particular media attention, and have raised different controversies.

The 21st century hunger strikes put the spotlight onto the high-level, often heated arguments between two antagonistic authorities. On the one hand, there are the Prison authorities, responsible for keeping prisoners confined, and also legally responsible for their welfare. Then there are the judicial authorities, judges and lawyers that apply and process the rule of law in the wide sense of the term, including appeals and demarches, for sentenced and remand prisoners. Both prison and "judicial" authorities are non-medical entities. To simplify the text, both shall hereafter come under the generic term of "custodial authorities", unless one of the two needs to be specified. On the other hand, there are the "medical authorities", the physician(s) in charge of caring for prisoners who go on hunger strike, and by extension the national medical association, and further up the World Medical Associa-

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tion (WMA). The recent confrontations on hunger strikes have been between these two groups of authorities, "custodial" and "medical". In some cases, it has almost been as if the actual hunger striker, as an individual person, has become an afterthought. The conflict has been mainly around the "custodial" authorities who have decreed and imposed force-feeding, and those who are the only ones who can perform it, the actual physician(s), who often object, with the implicit support of the WMA. The controversy has in fact not been so clear cut, as there have been physicians willing to perform force-feeding of hunger strikers, taking sides with the "custodial" authorities, and, as shall be seen, against their ethical principles.

The controversy around this force-feeding, which has essentially been a major issue in just one context – Guantánamo Bay – but has been the Damocles sword in many others, is a major issue, but it is just the tip of the iceberg. As shall be shown, the force-feeding controversy is indeed a serious bone of contention for the medical profession. However, the true role of the physician has been corrupted and co-opted. By "medicalizing" the situation with the contentious solution of force-feeding, the "custodial" authorities have shifted the onus onto the doctors to "solve the issue", i.e. to make the protest fasting cease. Physicians have been *ordered* to intervene, artificially feeding fully conscious and mentally competent prisoners *against their will*. This is what constitutes the force-feeding which shall be one of the focal points of this paper. The *real* role the doctors should be playing in the vast majority of cases will also be defined and illustrated. From and ethical, practical and clinical perspective, in many if not most cases, there are better options than force-feeding available in the competent management of a hunger strike. We will describe them in this paper.

The reason the "custodial" authorities have shifted the responsibility for making the hunger strike stop is obviously because prolonged fasting is undoubtedly not good for health. The physician's role, however, is not just about monitoring calorie intake (or the lack thereof), controlling blood pressure and weight-loss – and ultimately inserting a tube down a hunger striker's throat to deliver nutrients by force. As shall be demonstrated, the physician can and should play much more important role, which in most cases will facilitate to avoid getting close to the need for any feeding. This role, however, requires having a relationship of trust, as there should be in any doctor-patient relationship. Imposing any solution perverts this relationship, perhaps irretrievably, and prevents physicians from carrying out their task of intermediary, towards a compromise, and a solution acceptable to all. This is the practical basis for the ethical prohibition of force-feeding. Forced treatment against the competent informed consent of the patient destroys trusting and functioning doctor-patient relationship. The practical consequence of that destruction is the elimination of almost all non-coercive solutions to the hunger strike. Furthermore, the practice of force-feeding corrupts the already fragile foundation of trust between all correctional physicians and their patients, and may have the effect of undermining the efficacy of the profession in the prison at large.

Ethical framework: the "WMA 2006 Malta declaration"

The World Medical Association (WMA), is the "international organization created in 1947 to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians, at all times"[1]. At the time of writing this, it comprised about one hundred national medical associations, including the American Medical Association (AMA), one of its founding members. The WMA issued specific medical ethical principles relating to hunger strikes in its Declaration of Malta of 1991 ("Malta 1991"), updating them in 2006[2] ("Malta 2006"), together with an accompanying Background paper and Glossary[3]. The WMA guidelines recognize that hunger strike situations are complex and require the physician to make individualized clinical judgements. Discussions around the WMA guidelines for dealing ethically with hunger strikes have led to heated confrontations between custodial and judiciary authorities, on the one hand, and physicians on the other. In some cases local medical authorities, not familiar with the WMA guidance, of choosing not to follow it, have added to the confrontation. Heated arguments, sometimes in the full spotlight of the media and general public, have even distracted from the plight of the actual hunger striker(s). As shall be seen, these confrontations may in some cases have pushed fasting prisoners into adopting positions more radical than they initially intended to take. It is this phenomenon, and how to avoid it, that this paper ultimately intends to document and so to provide practical recommendations for constructive action.

How and why "Malta 2006" evolved from the original "Malta 1991" relates directly to the complexitiy of hunger strike management, and is discussed in the second section of this paper.

Definitions: what are hunger strikes – and what they aren't

There is a vast literature on hunger strikes, making it almost futile to ask, "what a hunger strike is." Nonetheless our experience around the globe has shown time and again that many fundamental misunderstandings and misconceptions about hunger strikes

1 www.wma.net *What we do*

2 http://www.wma.net/en/30publications/10policies/h31/index.html

3 *WMA Declaration of Malta – A Background Paper on the Ethical management of Hunger Strikes.*, In: World Medical Journal, Vol 52, N° 2, June 2006, hereafter WMJ. One of the authors of this paper was co-author of the background paper, together with the British Medical Association (AS).

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persist. It is first necessary to recall what is meant by a "hunger strike", what is *not* meant… what benchmarks need to be defined, and finally how such fasting is intended to "work."

Hunger strikes fundamentally are a form of protest against the custodial authority where the hunger striker is attempting to draw attention to a grievance by creating an urgent situation that may bring unwanted attention or shame upon the authority as a means of moral leverage.

Perhaps the earliest recorded hunger strike, in the sense of a political protest against the custodial authority, was that of the revolutionary Vera Figner in Czarist Russia in 1889. At the beginning of the 20th century, in the UK, countless suffragettes suffered ignoble force-feedings ordered by the British judiciary authorities, widely reported and vehemently criticized at the time. Eloquent posters showed how these brave women were submitted to force-feeding, a tube being inserted by a doctor into their stomachs while they were held down, struggling. It was however Mahatma Gandhi, protesting against the government of his Majesty "Emperor of India" who gave hunger strikes their *titre de noblesse*, in the first half of the 20th century.

There have been many hunger strikes in the past thirty or so years. However, not all prisoners "who-refuse-to-eat" should be considered hunger strikers. The generic term "hunger strike" is used to cover a variety of very different situations in which a prisoner refuses to take nourishment as a form of protest. Two main types of fasting protesting prisoners can be distinguished, differing essentially by their *modus operandi,* the "food refusers" on the one hand, and the (true) "hunger strikers" on the other. The vast majority of what prison directors, lawyers, judges, the media and even most physicians call "hunger strikers", are in fact *food refusers*. The difference, as shall be seen, is a major one, as in the case of the "refusers", those prisoners do not have the slightest intention of hurting themselves by fasting "to the brink" so to say. Therefore, there will be no question of forcing them to take food, force-feeding them, and hence little or no ethical dilemma involved at all.

Food refusers are what a senior medical colleague working in the prisons of Northern Ireland used to call "*the blokes who give hunger strikes a bad name!*"… These are prisoners who for any motive, great or small, justified or not, important or petty, *declare themselves* to be on "hunger strike"; make a big fuss over it; ensure that the prison director, the prison staff, the doctor, if possible their families, and above all the media, *know* they are "on strike". The key concerns here are that this type of the so-called "hunger strike" is always short-lived. Food refusal as defined is quite common amongst common-law prisoners, generating a "lot of noise", but most often not much else. Such prisoners trumpet whatever their complaints are, but in fact they have not the slightest intention of hurting themselves by their fasting. Medical staff who are used to this category of prisoners call them the "*professional* hunger strikers" – "who go on strike at the drop of a hat"… Others less kindly call their action "nuisance fasting", as it generates extra work for the medical staff, but essentially for no purpose.[1]

Who, then, is a "true" hunger striker? Are there different "categories" of hunger strikers? Are there "real" hunger strikers and "phoney" hunger strikers, as some authorities have asked[2]. Before the Turkish protests at the end of last century, hunger strikers were often classified as "serious", when like Bobby Sands, they were effectively ingesting **only** water, and thus posed a risk to their lives by their action. Any other form of fasting was deemed "not-so-serious". These other forms were by far the most common among prisoners who were fasting, but who also took nourishment "on the side" and were thus deemed to be "cheating" on their strike. This vast majority had their strikes catalogued as "not-so-serious". One of the authors of this paper fell into that trap at the time. While the Irish hunger strikers fasted totally and died after eight to ten weeks from acute malnutrition, the Turkish hunger strikers obviously *did* take some nourishment on the side, as they survived much longer than the Irishmen. The Turks did this to make their protest last as long as possible, to extend the moral pressure put on the authorities, and on public opinion. A great many of them died anyway, from prolonged and not acute malnutrition, after up to several months. Thus, simplistic distinctions cannot be made when dealing with this complex issue.

A "hunger striker", as we use the term here, is thus a prisoner who uses fasting as a way of protesting, and is willing to place his health – and perhaps his life – "on the line", so as to be heard by an authority that does not allow any other meaningful way for him to make his grievances known. The masculine form is used here to ease the reading of this text, as the great majority of hunger strikers in the world are indeed males, with all due apologies and respect to the suffragettes, and even more so to the Irish and Turkish women hunger strikers who died. The determination of a hunger striker to carry through with his actions is subject to many factors and pressure from many sides. It is therefore unfair to judge the "seriousness" of a hunger strike on any one criterion alone. Each context, and each individual, must be judged on its, or his, own merits.

It is paramount to realize that the hunger striker, in the vast majority of cases, does *not* fast with the intention of dying! Thus, to compare hunger strikes to "suicidal behaviour" is a major error, made by many,

1 Owing to the fact that most of these actions are short and self limited, optimal management often involves little to no response by either custodial or medical authorities for the first 72 hours assuming the patient is healthy at baseline. The clinical rationale for this approach will be explained later in this paper.

2 The author's own personal experience of twenty-eight years working as a doctor with the ICRC…

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including judges and senior physicians who should know it better. Going on a hunger strike is not an attempt to commit suicide. A hunger striker wants to make his case known, to protest, and to change his situation or perhaps change the world. He wants to ***live*** better in that world, not to ***die*** in it. Bobby Sands was as determined as any hunger striker could be, yet if he had obtained from Margaret Thatcher a concession to his demands the day before he died, he would have taken nourishment. The Greenpeace activists who used to sail their boats into the atoll where French nuclear tests were being carried out in the Pacific Ocean, in the early and mid-1990s, were not seeking to get themselves blown up. They were most certainly *not* suicidal. They *were*, however, willing to risk their lives as a last resort, in order to publicize their protest against nuclear weaponry. Indeed, soldiers often enter the battle with full knowledge that their mission carries with it the high risk of death. But they are not suicidal. Death is a risk of the form of protest called "hunger strike." It is not the goal, and therefore, a death by hunger strike is not suicide.

As will be developed further on, this comparing determined hunger strikes to "suicide" is a common misunderstanding through lack of knowledge in many cases, but also through "bad faith". In the case of the hunger strikes at Guantánamo Bay, Department of Defence (DoD) directive 2310.08e *specifically* classifies any hunger strike as an "attempted suicide" or an attempt to "self-harm." This is an improper and inaccurate classification that has persisted in the face of efforts by a number of outside health professionals to correct the Department's policy.

In most cases when the term "hunger striker" is used, there is a political connotation to the protest fasting. The common denominator between Emily Pankhurst, suffragette; Bobby Sands, IRA leader and member of Parliament; Holger Meins, member of the German "Baader-Meinhof" group in Germany in the 1970s; and the already mentioned Turkish hunger strikers, is that all of them evoked political motives for ceasing to take nourishment, and steadfastly "stuck to their guns". Less well-known prisoners have to consider the probability of their protest being heard, and how far they really want to go to get attention.

To conclude, a prisoner who goes on a hunger striker, determined to pursue the fasting for a certain length of time, does so because s/he feels, rightly or wrongly, that such an action is a "last resort" to be heard. The demands will vary considerably according to the time and context, but the protest fasting most often seen as the "only way" to be taken seriously. As shall be seen, it is up to the physician to determine "*how seriously a hunger striker wants to be taken seriously*"…

Clinical Framework: Diet and Time

The benchmarks that need to be clearly defined concern diet and time frame. It may seem a bit ludicrous to define any "diet", since it would seem that hunger strikes imply a lack of any intake of nutrition. However, as shall be seen, a majority of the so-called "hunger strikes" involve less-than-total fasting. Therefore some definitions are called for. The time frame will define when a hunger strike should attract attention, and how long a span of time one can actually last.

Diet

There are different kinds of fasting and different concepts of "eating", but for our purposes only three are important.[1]

- The **dry hunger** striker takes no food or water of any kind. This is often put forward, by the hunger striker wanting attention, or by the authority to justify intervention, as a "very dangerous" form of hunger strike, as a body cannot survive very long without any water. No "dry hunger striker" will survive more than a few days at most, depending on climate and temperature. Hunger strikes need time if they want to exert any effect, thus this kind of strike is by definition counterproductive. It may be either a "gimmick" to attract publicity, or the manifestation of a possible psychological problem. There is no known record of a hunger striker dying on a "dry" strike.
- **Total** fasting means no solid food, and **only** ingestion of **water.** This differs from the US definition, which uses the term "total fasting" for what has been defined above as "dry hunger strike". This is unfortunate because the concept of "Voluntary **Total Fasting**" is in fact what a hunger strike is all about. Two litres of drinking water a day is the suggested quantity, with or without salt, preferably mineral water... In a "rigorous", i.e. *strict* hunger strike, à la Bobby Sands, there would be no other addition to the water, no sugar, no vitamins and certainly no nutritive concoction. **Non-total** fasting simply means a "less rigorous" hunger strike, and includes practically any other type of fasting, e.g. with vitamin and mineral intake; sometimes liquid nutrients taken in addition to plain water; or other supplements. The term is not strictly defined, as it also includes a supposedly strict, "total", hunger strike – with *unofficial* ("on the sly"…) intake of food. The physician must know what type of a hunger strike the prisoner is on as this will change the approach he may have in dialogues with the prisoner(s).

The determination and hence "seriousness" of a hunger strike depends on its duration and not alone on its being total or not. A non-total hunger strike may be just as determined as a total one – and lead to deaths as well, only at a much later stage, as was the case in Turkey in the nineties.

1 See WMA Internet Course for Prison Doctors. *Hunger Strike*, Chapter 5; accessible at http://www.wma.net/en/70education/10onlinecourses/20prison/index.html

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The fact that a non-total hunger strike allows more time for negotiations is a positive – not an inconsistent – position. Physicians need to keep this in mind, as prison authorities tend to malign non-total fasting as "cheating". Some even may deny a declared hunger striker any access to food as if they were "calling his bluff". Although this may "break" some hunger strikes, it may radicalize others and may uselessly lead to loss of life. Denying access to nutrition is of course unacceptable as a medical intervention.

These distinctions are emphasized here as a question of credibility for medical staff, as terms of reference. Anyone, claiming that hunger strikers have been on total fasting for six or nine months, *de facto* proves that the fasting was not total. This in itself is ***not*** a problem, and the physician should abstain from the arguments some prison authorities, or the media, would like to get him into – whether the fasting is "genuine" or not… A physician needs to clearly state that any form of fasting can indeed be prejudicial for health, and that the doctor's role is to see what the best solution is in each case. He should not fall into the trap of "confirming" a hunger striker is indeed "eating on the sly" as this will destroy his credibility for negotiating both with the hunger strikers and those around him. Any partial fasting for a lengthy period of time will provide much more time to perhaps finding a face-saving solution for all involved – and thus be instrumental in avoiding fatal outcomes.

Timeframe

"When does a hunger strike begin"? Skipping several meals may well be a form of food refusal – and therefore a form of protest – but such short-lived, often episodic, fasting certainly does not qualify for the term hunger strike. There are no set criteria for the minimum duration for protest fasting, so reference can be made to physiology. A healthy, normally nourished adult, without any medical contra-indication to prolonged fasting, should have no problem whatsoever **fasting totally** (i.e. taking only water) for around 72 hours. This is when the onset of ketosis, the presence of metabolites known as "ketone bodies", usually occurs, for physiological reasons[1].

Ketosis is discernible clinically on the breath by what has been described a "pear-like smell". Ketosis subdues the voracious sensation of hunger, "hunger pangs", experienced during the first 2–3 days of total fasting. It could thus be argued that, as a simple "rule of thumb", **total fasting** (i.e. taking water only) for **longer than 72 hours** qualifies on metabolic grounds for the term hunger strike. The appearance of ketone bodies in the breath will depend on many factors, including body mass and fat, but this rule of thumb has been found to work in the majority of cases. Strictly fasting for 72 hours does absolutely no harm to anyone in good health, but does need *some* determination, and thus allows separating so to say "the wheat from the chaff".

The purpose of this "test" is to eliminate any confusion with **short-lived fasting**, which should not even qualify as "food refusal" – most cases petering out by themselves before 72 hours. It will not be relevant – and may even be counter-productive – to insist on distinguishing between somewhat more determined food refusers (but food refusers nonetheless) and hunger strikers immediately after the 72 hours. Such food refusers will not want to lose face by appearing to be less determined than real hunger strikers.

At the other end of the spectrum, there can be another rule of thumb. The fatal outcomes of terminal total fasting were medically documented during the 1981 hunger strikes in Northern Ireland. **Death** occurred during these total hunger strikes anytime between 55 and 75 days. During the 1981 Irish hunger strikes one of the "Ten Men" died at 46 days, according to one account because he could no longer ingest water[2] only one exception at 46. Similar experiences have confirmed this time bracket – the three-week span being due to differences in initial physical constitution, and individual adaptation. It is not possible to precisely predict when, within this time span, death may or is "most likely" to occur.

Death caused by ingesting only water does not occur before six weeks, and usually later if the person was in good health at the start of the fasting, and *after* a specific phase of the total hunger strike, called the "ocular motility" phase[3]. The clinical manifestations during this phase last about a week, roughly between 35 and 42 days according to the very few contexts where it has been medically observed, and are troubles of ocular motility due to progressive paralysis of the oculo-motor muscles:

- uncontrollable nystagmus
- diplopia
- extremely unpleasant sensations of vertigo
- uncontrollable vomiting
- extremely difficult to swallow water
- converging strabismus

The onset of this phase has been described as the most unpleasant stage by those who have survived prolonged fasting, and is the one most dreaded by prisoners who envisage beginning a hunger strike.

What is essential for the clinician to know here is that the beginning of the final stages of fasting occur *after* the "ocular" phase", hence roughly from six–seven weeks onwards. It is during the weeks following the ocular phase that the hunger striker may progressively become no longer capable of clear discernment. Survival any time after ten weeks of total fasting is practically impossible.

1 WMJ; *op. cit. p.*32

2 Walker R.K. (2006) *The Hunger Strikes*. Belfast: Lagan Books; p. 126

3 See WMA Internet Course for Prison Doctors, Chapter 5, www.wma.net

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In short, the "72–72" rule holds: seventy two hours should be the minimum for any fasting to be taken seriously; and 72 days are the maximum a hunger striker taking *only* water can hope to last. This knowledge is indispensable for the physician so he can realistically modulate his interventions as needed. Total fasting is the form of hunger strike that can pose a vital threat as early as six weeks into the hunger strike; and death occurs between the 8th and 10th week.

Physicians should not be overly obsessed by these benchmarks. On the one hand, they should be alert to the global clinical situation, as it has been mentioned. On the other hand, and they should remember that the vast majority of hunger strikers do not come anywhere close to the "ocular phase". The main point is that there is time before things *theoretically* can become alarming, and the physician will need to use this time constructively for the benefit of all.

Understanding how hunger strikes "work"

Hunger strikes in prisons can become effective forms of protest only in countries where there is some respect for basic human rights values[1] or at the very least *a desire to appear* to have such respect. If such values do not exist, or are flouted, hunger strikes will either be repressed, or all and any knowledge about them be stifled. If a hunger strike is to have any effect, by "shaming" the authorities into action, it is necessary for it to become public knowledge. If it does not, "protest fasting" is unlikely to have any impact at all and custodial authorities may well choose to ignore it – rendering any such fasting moot.

Confrontations between the custodial/judicial authorities and the medical staff thus imply a hunger strike that is in the public eye. Such a clash does not always occur. The hunger strikes in Northern Ireland in the 1980s and in Turkey in the 1990s created vociferous confrontations – but not with the physicians. Force-feeding was not an issue either in Northern Ireland, as the authorities and physicians decided to acknowledge patient Autonomy. If a prisoner refused to take food, it was his or her right, and as long as that person was capable of discernment in taking the decision, it was to be respected. In Turkey, the situation was very much more complex, but force-feeding was not an option either. Hunger strikes in other contexts have been a mixture of different models, the vast majority of them "benign", with short-lived confrontations.

A hunger strike is a way to protest against the detaining authority. A prisoner may feel, rightly or sometimes wrongly, that all means of making his or her grievances known have been thwarted. By refusing to eat, such a prisoner tries to retain, or regain, some "control" over what is left to him or her – the body and its nourishment. A hunger striker thus uses *control over bodily integrity* as a "last resort" for protesting. Any custodial authority, with the support and all the weight of the judicial (or in the case of Guantánamo Bay, "military") authority, will attempt to control all aspects of prisoners' lives. In a (real) hunger strike, the authorities consider this protest fasting tantamount to a "hostage situation", where hostage taker and hostage is one and the same person. They consider it as a form of "blackmail". This is what they find intolerable and cannot accept. It has to be stated here clearly that a competent prisoner, that is to say, capable of discernment, and not submitted to any pressure or coercion, direct or indirect, has the right to autonomy. This includes accepting or refusing any treatment, once informed of the pros and cons. This also includes fasting as a way of protest, as this can be considered as a last resort the prisoner has to make a message known or to make a demand. As has been mentioned, the maximum authority on medical ethics has decided that patient autonomy trumps beneficence in such a case, and that a physician should respect not to force a hunger striker to eat. Some voices have tried to circumvent the right to autonomy by stating that prisoners are *never* in a position to take any decisions freely. This is not tolerable. As is generally accepted[2], "prisoners are sent to prison *as* punishment, not *for* punishment", and this includes prisoners still having the right to make decisions about their welfare.

As prolonged fasting can arguably become a medical problem, the "custodial" authorities often medicalize the issue by order force-feeding. Their argument is that the reason physicians should intervene is to "save lives". They thus "throw the hot potato", so to say, into the medical camp, and ordering the physician to solve their problem and thus quell the protest. The counter argument to this is relatively simple, as the weight of the ethics is in favour of the physicians. The physician's role is not to "resolve the problem" with an unethical invasive procedure against the patients informed refusal. The power to "resolve the problem" lies with the authorities; only they have the power to engage in negotiations regarding the grievances of the hunger striker. The physician's role is to counsel the patient about the health effects of the various options and even make recommendations for what would be best for the health of the patient. In addition, the physician must communicate the general health status of the patient to the authorities as needed. While not the mediator for the grievances *per se*, the physician, as a professional, has the ability to calm the situation by injection of reason and rationality as an intermediary regarding the *health status* of the patient as well as the various permissible clinical options. However, there needs

1 Reyes, H. *Medical and Ethical Aspects of Hunger Strikes in Custody and the Issue of Torture (*1998) In: Maltreatment and Torture, Oehmichen M. (ed.) Lübeck: Schmidt-Römhild; J. P. Restellini (1989) *Les gr→ves de la faim en milieu pénitentaire* .Staempfli (ed) In:Revue Pénale Suisse (Bern), Geneva, Vol. 106

2 Reyes H. (1996) *Doctors at Risk*. In: Healthy prisons: A vision for the future. Report at the 1st International Conference on Healthy Prisons. Liverpool

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to be a full and careful assessment in every case, as shall be seen.

Second, and more important still, the vast majority of hunger strikers, as has been stated, do *not* want to "die". Hence, there should be no need to use force to feed them. During the first weeks of the hunger strike there is time. The physician needs to obtain their trust, by talking to them and having them accept the physician in an additional role of confident, mediator, neutral intermediary or something similar as the case may be. The physician should never appear as the one who is there to implement the will of the custodial authority.

Some, very few hunger strikers, may have sufficient motivation to pursue their fasting, and will not allow the physician to intervene. They constitute a very small minority. The physician responsible for the patient, and not an "outsider" who only arrives once a critical stage has been reached, should then act according to the guidance provided by "Malta 2006". This shall be discussed in detail further on with reference to examples from the field.

The majority of controversial cases are precisely in between these extremes – and the controversy is most often due to custodial authorities clashing with the physicians.

Role of the Physician spelled out

The physician has a role to play when a prisoner decides to fast for longer than 72 hours. Whether the prisoner is a "food refuser" as defined above, or a real hunger striker, the physician has to determine whether any initial medical factors need assessment or intervention. An insulin-dependent diabetic, or a prisoner with a history of gastric ulcer should not be fasting, whether seriously or "food refusing." If the physician has the trust of the prisoner, in most cases the prisoner will understand, and relent from fasting.

The physician has a more crucial role to play when caring for a prisoner who decides to go on a serious hunger strike. In this case, the physician has certain ethical principles to respect, as set down in the guidelines established by the World Medical Association[1]. Even more important however – the physician has a different role to play, if s/he has the trust of the hunger striker, as stated previously. The physician is in an ideal position, and has the time, to try to find a compromise solution, calm everyone down and ultimately defuse the conflictual situation. In the very few hunger strikes involving die-hard or desperate hunger strikers – respecting the ethics of the situation will be paramount. In the majority of cases, the situation gets out of hand by the blundering and often bad faith of custodial or judicial authorities – and sometimes of those physicians who do not follow the ethical guidance. An ethical physician is able to act constructively – but only if she or he knows how to avoid the many pitfalls involved, and defends the ethical high ground against the non-medical authorities who may try to force unethical conduct. Finally, the physician needs also to know that prisoners, the hunger strikers, can *also* attempt to manipulate him. Here the physician needs to stand firm, and defend "physician autonomy" as well as "patient autonomy"[2].

Thus, the physician's role is twofold. First, there is the clinical and "technical" evaluation of the situation, initially after 72 hours, and on an on-going basis. Second, there is the ethical framework within the doctor-patient relationship, the essential element here being that of trust between the hunger striker and the physician. It is this second aspect that has been skewed in recent well-publicized hunger strikes, for reasons that shall be illustrated with examples.

The doctor-patient relationship

Any hunger strike fasting should be a voluntary action undertaken by a prisoner as an individual without coercion from anyone. This is not always easy to determine in a prison setting. Pressures on hunger strikers come from many directions[3]. The prison authorities; the prison officers; family members; often the media; other prisoners; and even sometimes medical staff, all have some sort of influence, and can exert pressure on the hunger striker(s). The physician responsible for caring for the fasting prisoner should appreciate this fact, and be prepared to deal each entity as the case requires. The *voluntary* nature of the hunger strike is thus an imperative factor to determine. Whatever decision a hunger striker makes has to be his or her own. The prisoner's bodily integrity is involved, and the physician has to be certain that no outside coercion is exerted on the prisoner. It is not uncommon for prisoners to be "volunteered" to go on a hunger strike, by their peers or by an unofficial prisoner hierarchy. In extreme cases, such hierarchy may even "force" a prisoner to keep fasting way beyond whatever moment he or she would have stopped. The physician has a duty to detect such a case, so as to help him or her break loose from such coercion.

Thus during on-going discussions between doctor and patient, it will be necessary to find out how serious the prisoner is about not taking any nourishment for how long a period of time. The physician and the medical team need this information to act efficiently in the best interests of all[4].

Physicians should not let their overall view of the situation be obscured by the *obsession* of the hunger striker dying in the early stages of a hunger strike. Even considering the shortest time frame, there is at least a month, thirty full days, before the afore-mentioned "ocular" phase which flags the passage to the

1 Malta, *op. cit.*

2 Allen S. dixit.

3 WMA Internet course for prison doctors; *op. cit.*; Chapter 5.

4 Gravier B., Wolff H. *et al. Une gr→ve de la faim est un acte de protestation – Quelle est la place des soignants?*, *In:* Bulletin des Médecins Suisses 2010 N° 39 , pp 1521-25.

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more dangerous second stage of a prolonged total hunger strike. During these 30 or more days there is plenty of time for the physician to play a constructive role. All too often, and because of the hubbub around "V.I.P." (very important prisoner) hunger strikes, it is the authorities who become nervous and make decisions or issue feeding orders that are unwarranted and premature. The physician thus has a duty to inform the custodial, and if need be the judicial, that there is no medical emergency looming.

The doctor-patient relationship in any context implies that the patient, in this case the prisoner hunger striker, trusts the physician. This is not a moot point. Relations between prisoners and medical staff are always fraught with uncertainties, and a degree of mistrust. If the physician is seen as part of the coercive system any prison of necessity is, then any relationship of trust will be in jeopardy. In prisons, inmates cannot choose their physician; nor can the doctors choose their patients. Conscientious prison doctors know this and do their best to demonstrate they are there to care for prisoners, and not to enforce discipline. In many countries, unfortunately, this principle has yet to be accepted, and is seen still as foreign to local culture.

It should further be anticipated here that any bond of empathy between the doctor as healer and his patient is obviously skewed, if not eliminated altogether, if physicians have participated in abusing prisoners or in military cases (e.g. Guantánamo) participated in interrogations. Whether the methods used for interrogation "qualify" as ill-treatment or torture is beyond the scope of this paper – what matters is their being perceived as such by the prisoners. In such cases, developing a relationship of trust may just not be realistic. In such cases, prisoner access to outside physicians may be the only solution. This type of case will be considered in the final recommendations.

The main point to make here, in discussing the doctor-patient relationship is upstream from such intervention. It is to draw the prison doctors' attention to the fact that they are the ones who can make a difference, and can in most cases avoid getting into the force-feeding controversy. The vast majority of prisoners neither want to die nor "hurt themselves", as it has been stated. The custodial authorities resent the protest, and want it ended. Furthermore, they do no want any prisoner to die "on their watch" because they are on hunger strike. The physician obviously wants also to avoid any fatal outcome of the hunger strike. One wonders, then, how it is that heated confrontations do ensue, though everyone agrees to the essential fact that deaths must be avoided.

The answer is a complex one, and has many facets that are not acknowledged by one or the other of the participants. The custodial authorities cannot accept that a prisoner holds him/herself – and therefore the whole system – hostage, by threatening to fast to death. In addition, judges and prison governors most usually have no knowledge about the medical evolution of total fasting, and fear "losing" a prisoner on their watch. Finally, the custodial authorities have no ethical obligation to respect the principle of patient autonomy, not to mention physician autonomy and usually do not understand this medical position.

Physicians, hold the key to solving the impasse in most cases. Before entering into considerations about exceptional cases of "diehard" hunger strikers, one should consider the much more frequent case that has been mentioned. A physician, if s/he can have a meaningful discussion in private with the fasting prisoner, should be able to determine what exactly the hunger striker is prepared – and is not prepared – to do. Once it becomes clear that the prisoner does not intend to go "all the way", the issue becomes that of serving as useful intermediary between the hunger striker(s) and the custodial authorities.

This is not necessarily an easy matter. A physician may be able to convince a hunger striker to accept an intravenous drip, for example, with or without nutrients, but at least with minerals and vitamins. Or even a naso-gastric tube in some cases. The point is, if the hunger striker has declared (not necessarily publicly) that s/he does not want to die, the whole issue of "force-anything" becomes moot. An agreement, even only tacit and unspoken, between the hunger striker and the doctor takes the latter off the hook, and allows for any and all measures to be taken. The physician then has the "diplomatic" task of weighing the sensitivities of both sides, and trying to avoid any side losing face as much as possible. This may entail, for example, inserting an intravenous line, while "allowing" the hunger striker to declare vociferously that the "hunger strike continues…" The physician may have to calm down a cantankerous prison governor, assuring him that all is for the better, and that the measures taken will eventually deflate the conflict and end the fasting.

The key element here is time. Hunger strikes only "work" if there is enough time for negotiation and for communication. (This is the main reason why a "dry" hunger strike is an aberration, leaving no time at all for any appeasement to be found.)

What the physician then has to do is maintain this relationship of trust – both with the hunger striker and with the nervous custodial authorities who are itching to "do something" to make the protest stop.

Hunger strikes *à la Bobby Sands*, i.e. going all the way with strict total fasting are an extremely rare occurrence. The reason the whole argumentation about hunger striking and force-feeding has inflated to what it has is mainly because of the custodial authorities increasing tendency to enforce force-feeding, leaving the physicians no leeway at all to act as intermediaries. In the case of military physicians, they may be less than knowledgeable about the ethical guidelines that were being flouted, or they agree on principle to follow superior orders whatever they entailed.

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If indeed a hunger striker is adamant about not giving in at any cost, then the physician must theoretically weigh the principle of patient autonomy (informed consent and the right to refuse treatment) against that of beneficence before deciding what to do. In fact, this discussion has already taken place within the World Medical Association, and the guidance given for doctors in "Malta 2006" is quite clear.

When such a conflict exists, it is the *autonomy* of the informed, competent patient that is the governing principle. Beneficence, in the words of the WMA, "includes respecting individuals' wishes as well as promoting their welfare…" Avoiding harm "means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not involve prolonging life at all costs, irrespective of other values."[1] Thus, a competent individual who is informed and able to understand the implications of his/her choice cannot be treated against h/h will. They can refuse contemporaneously or in advance of losing mental capacity[2].

Examples shall be given in the second part of this paper that fully illustrate the correct ethical conduct of a hunger strike, in the event that it does go to its final resolution. What is perhaps infinitely more important is that the physician most often has the power to *avoid* the conflictual situation getting anywhere near death by starving. This will be developed in the "Way Forward" section below.

The clinical role of the physician when caring for hunger strikers

The medical evaluation of the prisoner on hunger strike requires an accurate assessment of both his/her physical and mental health, and first of all a precise and candid history. Any ailments or diseases should be diagnosed and if necessary documented. The prisoner should be given accurate clinical information about the foreseeable effects of fasting in his or her particular case. The fasting prisoner needs to be aware that heretofore-unknown underlying health problems may come to the foreground *because* of the total fasting, and should indicate whether they accept treatment or pain relief for these. Some diseases, such as gastritis, any kind of ulcer, duodenal or gastric, diabetes, other metabolic diseases, to mention but the most obvious ones, should be contra-indications to going on hunger strike. As previously stated, if the physician can explain this to the prisoner convincingly and so s/he does not get the (false) impression that it is all merely a ploy to get the hunger strike to stop, in most cases the hunger strike will quickly desist.

This first evaluation should also determine the mental state and competency. If refusal of food is a manifestation of some mental disorder, such as severe depression, psychosis, or anorexia, then the situation is ***not*** that of a hunger strike. The authors of this paper have argued that most mental disorders disqualify a prisoner from the "status" of hunger striker, and make him a full-fledged patient requiring medical attention. A prisoner, refusing to eat because of a mental affliction, may be reasonably declared incompetent to refuse treatment. A psychiatrist may even prescribe medically prescribed feeding, if and when such feeding is necessary to sustain such a patient's life. To the extent that individual competency assessment has been properly conducted, this may be medically indicated. The physician should direct care at treating the underlying mental disorder or illness. For this reason, when in any doubt, a full psychiatric assessment of the fasting person is an essential feature of the evaluation.

An examination of the hunger striker's psychiatric and medical history may reveal factors affecting decision-making abilities and cognitive processes[3]. It has already been mentioned above that a hunger striker, almost by definition, does *not* want to die, s/he is *not* trying to commit suicide by fasting to death. There is often confusion in the minds of prison authorities and judges, who are steadfastly determined against any prisoner "killing himself" or "escaping justice by committing suicide".

The psychiatrists M. Wei and J.W. Brendel have stated, "*Most commonly, hunger strikers do not have mental disorders…*". The distinction is paramount between behaviours intended to kill oneself and behaviors undertaken to protest as a last resort. A politically motivated hunger striker may pursue a total fast with a very positive goal in mind, for himself, or his community – so as to "live better", even risking death if his plea not be heard[4]. The Turkish prisoners who went on repeated and prolonged hunger strikes in the late nineties did not want to die – even if though they were vociferous in declaring they were on "death fasts". The suicide excuse does not apply to prisoners at Guantánamo, even though some could arguably have multiple reasons to feel desperate and hopeless. As Major General Jay W. Hood, the camp's commander, told a group of visiting physicians in the fall of 2005, "the prisoners at Guantánamo are protesting their confinement; they are not suicidal"[5].

The already mentioned more difficult role for the physician is the all-important task of acting as medical intermediary if consistent with the patient's wishes. This does not mean negotiating the terms of the hunger

1 Malta, *op. cit.*, Article 19

2 *Medical Ethics Today*, 2nd ed. (2004) British Medical Association, London; pp. 602-607, 623-625

3 Wei M., Brendel J.W..*Psychiatry and Hunger Strikes*. In: Harvard Human Rights Journal, Vol. 23, 2010.

4 WMJ Case example 1; *op. cit.*; Wei M. Brendel J.W., *op. cit.*, Footnote 16

5 Okie, S *Glimpses of Guantánamo – Medical Ethics and the War on Terror.* In: N Engl J Med 2005; 353:2529-34.

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strike, nor interceding on behalf of either party. It may imply determining what possible alternatives to harm-causing, prolonged total fasting can be acceptable. In this way the physician acts in the hunger striker's best interests, while respecting freely taken decisions. This will, again, require a relationship of trust.

The custodial authority sometimes sees the physician as being the "final umpire – the one charged with informing the hunger striker that fasting "to the end" can result in irreversible harm and death. This limited role of the doctor misses the main point. Too much is focused on what should be done *late* in the fasting, and not enough on what should be done during the less pressured time *earlier on* in the fasting – where better solutions exist. In fact, in the collective experience, the best opportunities to de-escalate and resolve a hunger strike occur long before there is any real risk of serious harm or death. The more technical and monitoring roles for medical staff in the supervision of hunger strikes, concerning laboratory exams, weight monitoring, electrolyte intake are fairly straight-forward have been largely documented elsewhere[1] and shall not be repeated here.

To be continued...

1 *Assistance in Hunger Strikes: a Manual for Physicians and Other Health Personnel Dealing with Hunger Strikers*. (1995) Johannes Wier Foundation for Health and Human Rights; Amersfoort, Netherlands, ISBN 90-733550-122

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Ian Trevor Field

Ian Field, a past Secretary General of the World Medical Association died on 23 December 2012 after a long illness.

Ian was born in Rawalpindi, then in British India (now in Pakistan) in 1933. His father was a Regular Army Officer, not medically qualified, serving there during the dying days of the British Raj. Ian childhood and early education were in India. During the second World War he remained in India, while his father was reported killed in action but was in fact captured by the Japanese and held in Changi for 3 years. During this time Ian was admitted to a military school in Poona alongside the younger sons of maharajas. He had been given the aristocratic Hindu caste of a warrior to fit with the princely hierarchy.

When his father was eventually freed the family returned to the UK and settled in Bournemouth where Ian completed his school education. After school he undertook national service in the Royal Engineers, starting an interest which remained all his life.

Having decided to study medicine Ian applied to medical school. His choice of Guys Hospital, University of London was cemented when they presented him with tea in a china cup when he attended his interview in military uniform.

Guys was the ideal choice; not least as he met there Christine who was to become his wife for 52 years.

After qualifying and the usual round of house posts Ian entered General Practice, becoming a GP principal. He joined the BMA staff as an assistant secretary in 1964, rising to Undersecretary before leaving in 1974/5 to work in International Health first with the Department of Health (then DHSS) and later with the Overseas Development Agency (ODA) where he rose to Chief Medical Adviser. Ian rejoined the BMA in 1985 as Deputy Secretary for National Medical Services, the trade union "arm" of the BMA, and because BMA Secretary in 1989.

Amongst many other significant achievements while working at DHss and the ODA Ian was responsible for relationships with the WHO and with the Council of Europe. At that time the latter in particular was emerging as an important voice that would influence health policy within the UK, and Ians deep understanding of the processes and politics as well as of the policies was invaluable.

In the ODA Ian was advising ministers on how the UK could use its influence, and money, to improve the health lot of the poor in developing countries. This included work on some of the great killers of those, and indeed of these, times. He chaired the WHO Global Advisory Committee on Malaria; he was the only member who had personally had malaria and he remembered the toll it took from his childhood in India.

Along with those roles came exotic travel. I was exciting o visit China officially, to be taken to Bokhara and Samarqand by the Russians and to be wined and dined with the Japanese. But alongside the fun of meeting new people and exploring new places he