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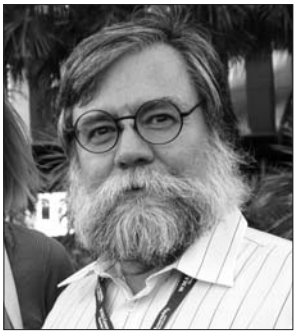
Physicians and Hunger Strikes in Prison: Confrontation, Manipulation, Medicalization and Medical Ethics (part 2) (part 1 vol. 59 N 1)



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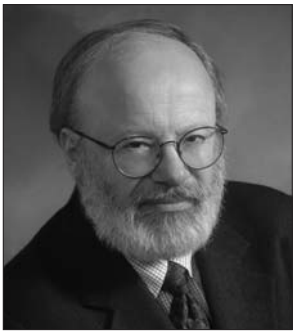

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Past Practices and Controversies

This second section examines specific hunger strikes from the recent past, to discuss the pitfalls and stumbling points encountered by both custodial and medical authorities. As will been seen, a conflictual situation develops mainly because the non-medical, custodial authorities decide to stop the protest by ordering the physician intervene. In some cases this may be out of genuine concern that the fasting prisoner(s) may come to harm. In our experience, however, it more often is simply to ensure taking all precautions so that no prisoner "kills him/herself." As a determined hunger striker is hardly likely to simply accept an "order" from the physician to resume eating, the doctor is then instructed to feed the fasting prisoner against his/her will, i.e. force-feed.

The examples chosen are from different countries, different contexts. What is important is the phenomenon that each example illustrates. This is neither intended to be an analysis in any way of the underlying political situation, nor to justify either side in positions taken regarding the reason for the hunger strikes. The aim is to show how these hunger strikes have been handled, or (mostly) mishandled, and to review briefly the decisions taken and why they were taken. Hence it is not important to identify the specific case and country, with the obvious exceptions of the well-publicized cases of Guantánamo Bay and Northern Ireland (N.I.). All examples are based on personal field experience or that of close colleagues.

Ethical Background: the Evolution of "WMA Malta"

The Northern Ireland hunger strikes in 1980 and 1981 took place in the context of "the Troubles" in Ulster, at a time when there were mass arrests of I.R.A. militants and accusations of brutality and worsened by the public order forces. Some years before, to avoid any medical involvement in interrogations and other such activities the British Medical Association had approached the WMA, so a clear position be taken regarding medical participation in such non-medical activities. (At one point, the British authorities had suggested that physicians sit in on interrogations to see there was "fair play"…). The WMA issued its declaration of Tokyo in 1975 against the participation of doctors in any form of torture. In this Declaration, one of the Articles (originally "5", now in the revised 2006 version, "6") mentioned hunger strikers, stipulating:

"Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner."

Few doctors know why this clause is included in what is essentially a declaration on non-physician participation in torture. The reason[1] relates to situations that may occur where torture is taking place. If a prisoner being tortured decides to protest against his plight by refusing to eat, the physician should not be obliged to administer nourishment against the prisoner's will, and thereby effectively revive him for more torture. This was the reason for the inclusion of this article in the Tokyo declaration. The wording "artificially fed", instead of "forcibly fed" was an imprecise choice of wording, as "artificially" clearly does not convey that it was feeding against the prisoner's will that was prescribed. It also implied not to resuscitate an unconscious prisoner, victim of torture, even without force being used, so as to send him back for more.

During the hunger strikes in N.I. in 1980 and 1981, force-feeding was not performed. The UK doctors never envisaged the possibility "that there be any circumstances where the *due process of law* would require a physician to force-feed anybody against

1 Reyes H., Luebeck; *op. cit.*

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their will."[1] A clear position for the upholding of patient autonomy was taken by the U.K. during the hunger strikes in Northern Ireland. Respecting autonomy came with a price. Ten deaths resulted before the prisoners broke off their strike, and the authorities quietly gave in to some of the prisoners' demands.

After these dramatic events in Ulster, it was awhile before there were any such determined protests leading to loss of life. Many hunger strikes took place during the next 15 years, in the Middle East, in Latin America and elsewhere, but never led to any showdowns as in Northern Ireland. Protest fasting in most of these contexts, without wanting to minimize neither the prisoners' sincerity nor their grievances, never went "down to the wire". In South Africa, however, in the 1980s, there were "more serious" hunger strikes. This led the South African doctors to seek further guidance from the WMA, about hunger strikes *per se*, and as a result, a new declaration, exclusively on hunger strikes in custody, was drafted and passed by the World Medical Assembly in Malta in 1991 (hereafter "Malta 1991"). This new document defined the different forms of fasting, the role of the doctor in monitoring the patient, and mentioned the effects of "terminal" hunger strikes.

While "Malta 1991" mentioned artificial feeding, still it did not explicitly forbid *force-feeding*. At the time, forcible treatment was not an issue, and hence was not considered as a problem. After the deadly mistake, occurring during a hunger strike in the Middle East in the early 1980s, which resulted in the death of two prisoners who were forcibly fed – liquid nutrients being erroneously introduced into the windpipe rather than the oesophagus – force-feeding, already rare, had practically disappeared. The hunger strikes in Turkey in the late 90s led to an unprecedented number of deaths. At least 60–70 prisoners, and also many family members fasting outside the prison, died. The deaths from fasting occurred after periods of time well beyond the "72 days", which implied they had not been "totally fasting", and so died from prolonged, not acute, malnutrition. This was a completely different situation from that of the 1981 Irish Hunger Strikes. The Turkish hunger strikes and the way they were ultimately "managed" by the authorities and by the prisoners are a complex issue, well beyond any detailed discussion here. The point to be stressed is that there was no question of any forcible feeding, the confrontation being of a very different complexity. It was the Turkish strikes that triggered the revision of "Malta 1991"[2] at the WMA. Initially, the new draft was intended to refer essentially to the confrontation in Turkey. However, as the revision was taking place and being debated within the WMA, the equally serious situation at Guantánamo Bay was taken into consideration. The use of systematic force-feeding at Guantánamo Bay led to a review of the ethical issues involved, and to reaffirming patient autonomy over just beneficence at any cost. This was the main reason for the WMA considerably strengthening the condemnation of force-feeding, distinguishing it this time clearly from voluntary artificial feeding[3]. The new "Malta 2006" was revised and passed by the World Medical Assembly in South Africa in 2006.

The Controversy Around Force-feeding

The situation at Guantánamo Bay (Gtmo) has been widely documented in the press since 2001, and there is now a large amount of information accessible to the public. Force-feeding at Gtmo is now well documented in many articles in prestigious journals, and on countless websites[4]. Force-feeding was implemented there by physicians, and may still be at the time of this publication. This constitutes a violation of the principles set down by "Malta 2006", and constitutes an example of medical complicity in what the WMA has defined as inhuman and degrading treatment. The WMA's firm position against force-feeding is explained in detail in the Background paper[5] accompanying the revised 2006 version of "Malta". Article 13 of "Malta 2006" states:

"Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. …"

Physicians now should unequivocally know that it is their ethical duty not to participate in, nor condone, any such coercive procedures. Guantánamo Bay is a typical example of "medicalization" being implemented as the "solution" to a problem the custodial authorities – in this case the military -- cannot accept. The term used, "asymmetric warfare"[6] brings to light a fundamental contradiction in the response to hunger strikes in the Guantánamo context. On the one hand, medical intervention by force-feeding is "justified" as necessary to provide humane *medical* treatment to prisoners, to save their lives. On the other hand, hunger strikes being described as a new type of "warfare" cannot have a "medical" solution. It is either suppression, by any and all means possible, of an act of warfare, or it is providing

1 Written statement to the author by a former senior medical officer who was involved at the time in the Irish hunger strikes.

2 Reyes, H. *Force-Feeding and Coercion: No Physician Complicity*. In: Virtual Mentor, American Medical Association Journal of Ethics, October 2007, Vol. 9, No 10, pp 703-708.

3 WMJ; *op. cit.*; Glossary

4 *http://www.nytimes.com/2006/02/22/international/middleeast/22gitmo.html?scp=1&sq=Force-Feeding%20at%20Guant%E1namo%20Is%20Now%20Acknowledged&st=cse*

5 WMJ; *op. cit.*

6 Annas G.J., *op. cit.*

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humane treatment – one cannot have it both ways!

Two arguments for feeding hunger strikers even against their will have been given by the military authorities responsible for Gtmo. The first argument is that force-feeding has had to be implemented to "save lives". This statement is fallacious, as the feeding was being administered very early on, after a maximum of 10-15 days of total fasting. As has been shown, at this stage there is no risk of dying from fasting. When pressed with this reasoning, the custodial authorities have switched their argument to being "not to save lives, but to save their health". This is again a fallacious argument, vaguely disguising the real intent, which is to break the protest, indeed to suppress the "asymetrical warfare".

There have been rare cases of hunger strikers dying very early on in their protest fasting. One of the ten 1981 N.I. hunger strikers, Martin Hurson, died after 46 days, from a complication that apparently did not allow him to ingest water. A recent 2012 case of a California prisoner on hunger strike, dying after one week"[1] is still being medically investigated, but the death was most certainly not due to the fasting alone.

The second argument issued by the military authorities for intervention has been that the vast majority of internees at Gtmo "accept" in fact being thus fed, meaning they do not struggle and fight against insertion of the naso-gastric tube, "because they do not want to die". If this were to be the case, i.e. voluntary acceptance of the feeding, it would *not* constitute ***force***-feeding, but artificial feeding. The latter, as has been stated, is not a transgression of ethics as by definition it implies voluntary acceptance of medical intervention from the hunger striker.

1 *http://rt.com/usa/news/california-hunger-strike-gomez-187/*

This argumentation nonetheless warrants further scrutiny. One of the higher authorities in the military command has stated that at Gtmo they have been "strapping some of the detainees (*sic*) into *restraint chairs* to force-feed them and isolate them from one another after finding that some were deliberately vomiting or siphoning out the liquid they had been fed"[2]. This is also the reason naso-gastric tubes have not been left in place, as they can indeed be used to empty the nutrients introduced into the stomach by a hunger striker not wanting to receive food. The point is obvious: the fact that restraint is "necessary" proves that the administration of nutrients is *not* accepted voluntarily, and hence constitutes force-feeding.

This being said, one must look beyond this first stage, as force-feeding has been the systematic policy at Gtmo[3] for many years now, and not merely an exceptional intervention. The military authority quoted earlier admitted that "…commanders (had) decided to try to make life less comfortable for the hunger strikers, and that the measures were seen as successful. … Pretty soon it wasn't convenient, and they [the hunger strikers] decided it wasn't worth it," … "A lot of the detainees said: 'I don't want to put up with this. [resisting force and the restraint chair] This is too much of a hassle."

It is thus deliberately misleading to ascertain that the feeding implemented at Gtmo is not coercive because a hunger striker gives up protesting and struggling. Knowing that he cannot prevail against the physicians charged with feeding him, a hunger striker may even renounce resisting at all. Seeing fellow hunger strikers being forced to submit to the naso-gastric feeding and the restraint chair may be enough to discourage any resistance.

2 *http://www.nytimes.com/2006/02/22/international/middleeast/22gitmo.html?scp=1&sq=Force-Feeding%20at%20Guant%E1namo%20Is%20Now%20Acknowledged&st=cse op. cit.*

3 Annas G.J; *op. cit.* and others

In this respect, "Malta 2006" specifically states, in the same Article 13:
"Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting."

The whole discussion around the policy of force-feeding hunger striking internees at Gtmo thus centers on this flouting of the clear prohibition for physicians to participate in inhuman and degrading treatment.

Much has been debated regarding the issue of whether force-feeding qualifies as a form of torture. The WMA does not use the term *torture*, but declare force-feeding as "inhuman and degrading treatment", making it a violation of Common Article 3 of the Geneva Conventions of 1949, which condemn "cruel, humiliating and degrading treatments". *Repeated* force-feedings can only make the situation more degrading and inhuman. However, legally speaking, as there is no clear *intent* "to inflict pain", the juridical definition or torture according to the UN 1984 Convention against Torture would arguably not be met. The distinction here between "inhuman and degrading treatment" and "torture" is not the point – *force*-feeding is a violation of medical ethics under any circumstances.

Indeed, in many non-military settings, the force-feeding is not only legally permissible, it is actually ordered by the courts. Court orders do not invalidate the professional obligation of the physician to act within the bounds of medical ethics. While such conflicts are notoriously challenging for individual physicians, violations of professional ethics greatly undermine the integrity and autonomy of the medical profession and may have profound consequences on the future efficacy of the profession. As a practical matter, they have the immediate impact of damaging the ability of professional colleagues and future physicians to establish

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trust with fellow prisoner patients; and as we have said, without trust, medicine cannot be practiced.

In Guantánamo Bay, restraint chairs accompanied by threats and muscular interventions,were used, and any recalcitrant to the feeding thus made to comply. This situation of coercion, the force-feeding, was maintained for weeks, months and more on fasting detainees. The WMA Declaration of Malta qualifies "force-feeding" unequivocally as "a form of cruel, inhuman treatment" – but this refers to a "one-shot" force-feeding. The WMA never envisaged a situation whereby repeated force-feedings would be applied to the same individuals over such long periods of time. There is no historical precedent for hunger strikes lasting over five years and "managed" with inhumane and unethical practices in this coercive way[1]. There may be one exception to this, Irom Chanu Sharmila of India who has been on a hunger strike for more than a decade. It could arguably be necessary to now submit to the WMA the question of how long-term and repeated force-feedings should be qualified.

Lessons from Guantánamo

At Gtmo force-feeding was accordingly made mandatory. It was the Secretary of Defence who specifically decided that the decision was a **military one**, to be made by the non-medical camp commander, but that would be implemented by physicians[2] [3].

"The use of physicians to aggressively break a prison hunger strike raises complex medical ethical and legal issues that have been the subject of international debate for decades."[4] It is a perverse medicalization of the issue, imposing a medical act on an unwilling patient, thus taking the physician away from the role of medical intermediary. The issue became so politicized that the most senior physician in the Pentagon at the time contradicted his base commander on the issue of the hunger strikers being suicidal[5] and suggesting that the case of hunger strikers at Guantánamo was like the Terri Schiavo case[6]. "There is a moral question. Do you allow a person to commit suicide? Or do you take steps to protect their health and preserve their life?[7]" The order was then given specifically requiring military physicians to perform an act in direct violation of medical ethics.

Another recent case in Switzerland illustrates this point. The heated arguments between the judiciary, adamant to "break" a well-known hunger striker by having the doctors force-feed him, and the physicians, refusing to comply citing the support of their Medical Association, even though the decision to force-feed was (surprisingly) sustained by the Swiss Federal Tribunal (the equivalent in the US to the Supreme Court) led to a stand-off. In the end, the physicians stood their ground and firmly refused to give in to any judicial authority that flouted medical ethics, be it the highest Tribunal in the land.[8] They were right in doing so, and the judiciary was wrong to try to get physicians to violate medical ethics, including the clear directives on hunger strikes of the World Medical Association[9].

It is this abuse of the medical role of prison authorities and even the judiciary that has led to serious confrontations. Unfortunately, the spotlight has been turned more and more onto the extreme violation of medical ethics in the case of hunger strikes – force-feeding – neglecting almost totally the real role of physicians. This real role of doctors has been discussed earlier and it will be further addressed later on.

The US military authorities do not dispute that force-feeding violates medical ethics, but insist that physicians follow orders because force-feeding is necessary for national security reasons. National security, not the prevention of "self-harm", is the real issue. Physicians at Gtmo, mainly Navy reservists, have complied with orders, although it is possible that any physician not willing to do so may have been directed elsewhere. In Switzerland, eighty prominent physicians signed a petition resisting such "orders" from the highest court in the land, the Federal Tribunal[10], and the order was revoked.

The Conflict that Needn't Be

Guantánamo Bay has been merely the most visible example of "medicalization" of the controversy around hunger strikes, in the media spotlight because of the characteristics of the place and its inmates. Such "medicalization" occurs, however, to a lesser degree, in prisons everywhere. The custodial authorities' first and utmost priority is maintaining security and "peace and quiet". A prisoner who protests by fasting, by definition will do it "noisily", to attract as much attention as s/he can, and

1 Polgreen, L. *In India, 11-Year Hunger Strike over Military Violence is Waged in Shadows*. In: New York Times, September 11, 2011, 5. Annas G.J. personal communication.

2 Annas, G.J. *Military Medical Ethics – Physician first, last, always*. In: N Engl J Med 2008; 359; 1087-90

3 Rubenstein, L.S., Annas, G,J, *Medical Ethics at Guantánamo Bay Detention Centre and in the US Military: a time for Reform* In: *Lancet 2009*, 374; 353-55

4 Annas G.J. *op. cit.* Footnote 10

5 Wei M., Brendel J.W., *op. cit*.

6 Media Roundtable with Department of Defense Assistant Secretary for Health Affairs William Winkenwerder, News Transcript, June 7, 2006 available at: *http://www.defenselink.mil/transcripts/transcript.aspx?transcriptID=33*

7 Annas G.J., *op. cit.*

8 Editorial by Dr. Jacques *de Haller*, President of the Swiss Medical Association (FMH); *Bulletin des Médecins Suisses*, September 2010, N° 39.

9 "Malta 2006", *op. cit*.

10 de Haller J., *op. cit.*

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get as much support as possible from all sides. A hunger striker is seen therefore as a trouble-maker, a "hostage taker" as has been mentioned. The tendency to "have the doctor" solve the problem is not limited to Gtmo.

Hunger strikes elsewhere have had similar, though mostly attenuated, complications. A case in point was a collective hunger strike in a Latin American country, where an ICRC physician played a key role in finding a solution. By speaking to the prisoners both collectively and individually, it became clear that none of them wanted to die, but all wanted their protest to continue and make as much "noise" as possible. The doctor could thus persuade the hunger strikers to accept intravenous lines and the administration of vitamins and nutrients. The prisoners continued proclaiming they were still "on hunger strike". The physician played his role of intermediary discreetly, refusing to comment publicly on whether the hunger strike was "really genuine". Had he made any public statements, this would have been seen by the hunger strikers as a betrayal of trust, possibly leading to a breakdown in the process of reconciliation. It was finally a representative of the Church who brought about a peaceful resolution.

Other recent examples in the Middle East have proven again that if the physician plays his or her role of discreet, trusted medical intermediary, there will be no need for any force to be considered. The hunger striker not wanting to die may be persuaded to accept medical help in exchange for some face-saving "concession" for example. Or he may accept transferral to hospital so as to be able to "blame the prison doctor" for having to refrain from pursuing the protest fast. The prison doctor must be ready to shoulder this blame, having the interest of the patient as a priority. Furthermore, it will allow for smoothing the conflictual situation between the custodial authorities and the protestors.

Thus, there need be no conflict once all parties agree that a solution has to be found so as not to endanger anyone's life.

Allowing the Prisoner One Last Chance

The debate on respecting autonomy, and not imposing treatment on hunger strikers is most often a moot point. The hunger strikers at Guantánamo Bay were force-fed early, and it will never be known how many of them could have been coaxed out of their collective strike had the doctors been able to have an independent role of medical intermediary. Some well meaning voices have intransigently supported respect at all times of, for example, any written instructions, calling the (exceptional) hunger striker who goes "all the way", to be respected.

This is certainly the policy that was applied to the Northern Ireland hunger strikers. However, a recent personal example will illustrate exactly the contrary, and still be in accordance with the guidance in "Malta 2006".

In a hunger strike in Transcaucasia, the prison doctor took it upon himself to resuscitate a vociferous political hunger striker who had reached the confusional phase late in total fasting. This was, in fact, contrary to the hunger striker's ***written*** instructions. On the face of it, this case would seem to be a violation of medical ethics by the prison doctor.

Some time later, this same prisoner protested about the prison doctor's actions to one of the authors of this paper. When questioned as to why he had gone against the hunger striker's *written* decision not to be resuscitated, the local doctor explained that he came from the same region as the hunger striker. "In his heart", he said, he knew the patient would not want to die, so he intervened once the prisoner was no longer alert and aware of what was happening. This prison doctor did well in doing so. As the hunger striker confessed to the author, he was actually delighted to find himself alive and well – but he did not want either the authorities or the prison doctor to know this! This example may be uncommon, but it is not atypical of the ambivalence there is in many cases.

Prisoners begin a hunger strike often not really knowing what they get into. As shall be discussed further on, some will "paint themselves into a corner" at some point, and may not know how to back off. It is here the doctor can play an important role. Force-feeding will not be an issue, since this type of hunger striker does not want to harm himself. In the privacy of the medical consultation, away from any outside peer pressure, the physician often easily convinces the hesitating protester to accept artificial feeding. As to the ethical guidelines, it is important to understand that "Malta 2006" *specifically* allows such leeway to the treating physician who knows the patient, and should thus have the final word in deciding what is best[1]. Article 10 reads:
"If no discussion with the individual is possible and no advance instructions exist, physicians have to act in what they judge to be the person's best interests. This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties."

The prison doctor who thus ignored the Transcaucasian hunger strikers' *written* instructions thus took the risk of erring by going against the expressed will of the prisoner – but in fact he ended up taking the right decision. The physician retained the proper authority to exercise judgment, in

1 WMJ; *op cit.* 10. Artificial feeding, force-feeding and resuscitation; p. 40

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good faith, in assessing the patients' will in a difficult clinical situation.

"Malta 2006" allows for error. If the Transcaucasian prisoner had torn away his intravenous lines and naso-gastric tube upon revival, then the prison doctor would have been justified in not interfering a second time. This will be discussed in the final point before reaching a conclusion.

Volunteer or Volunteered ?

The common denominator to all problematic hunger strikes is the clash between medical and non-medical authorities. However, this should not distract the physician from other possible conflicts which will directly influence the ethical management of the hunger strikers.

A prisoner who decides to protest by fasting must do so voluntarily. As it has been mentioned, some voices object to *anything* being truly voluntary in a custodial setting, referring to the overall control exerted by the custodial authorities. Different pressure on the hunger striker has also been exerted, which in some contexts can be potent enough to force the hunger striker to pursue the protest that the individual would have broken off. It is here that the physician has a duty to identify such a case.

By making sure every hunger striker is seen and interviewed in the privacy of the medical consultation, the physician has a good chance of establishing sufficient trust to be able to know what the situation is. All too often, when many prisoners are all on strike together, they are kept in an open ward together. In such conditions it is easy for a "leader", identifiable or not, to exert pressure on the others to pursue a hunger strike all may not be in agreement with. To avoid this type of peer coercion, the physician must insist on seeing each hunger striker individually. If the hunger strikers initially refuse (possibly again because of peer pressure), the excuse of doing a "medical examination in private" usually gets them to consent.

Concerns about how to examine "hundreds of prisoners" individually should not be a major issue, as "mass hunger strikes" usually fade out after a few weeks, reducing the number down to the real and problematic cases. As will be developed in the recommendations and in contexts where this is feasible, hunger strikers should be kept in separate rooms – but not in isolation. To absolutely separate them and leave them incommunicado will be in most cases seen as a repressive measure, required by the physician to boot, and will not encourage the prisoners to trust the doctor.

Experience from many contexts has shown that many hunger strikers will, in the privacy of the consultation, even plead with the physician to help in getting away from peer coercion, or from a threatening leadership. If the physician can convey the message that s/he is there not to stop the strike, but to help the individual hunger striker, more than half the battle is won. It is then a question of finding a solution. This may entail transfer to the medical ward, for "further exams", or for "treatment of a medical condition". A form of "reverse medicalization" can be evoked here, the physician taking upon him/herself to give the individual a way out. This may be so as to merely "not lose face", important in many contexts. Or it may be to extract from reprisals a hunger striker who has "volunteered" to protest way beyond the length of time he may have envisaged initially. The result – medical care being provided – is the same as for the food refuser, but in the refuser's case it is clear from the start that the fasting is limited and to be under full medical control. It cannot be stressed sufficiently here the need for the physician to be able to convey to the hunger strikers that s/he is "on their side", meaning to provide care and empathy and whatever assistance is needed, and *not* as an agent of the custodial authorities.

Manipulators and Manipulated

The imposition on medical staff by judges, tribunals or other custodial authorities of orders to perform the task of force-feeding "recalcitrant" hunger strikers, knowing full well or ignoring that this is contrary to the doctors' ethical principles, is a form of manipulation. Physicians should never let themselves be manipulated this way, whatever the authority evokes, be it judicial or military. Even in situations of "dual loyalties", whereby physicians owe loyalty to, for example, the Prison Service, or the Armed Forces, the bottom line must always be respect for their ethical principles[1]. Physicians are first and foremost responsible to their patients[2] [3], and they have the full support of the World Medical Association behind them in this.

There is a different form of manipulation that physicians also should avoid. Individual or groups of hunger strikers may also seek to "use" the doctor. Recent cases of what one may call "problematic hunger strikes", i.e. going beyond a mere couple of weeks, in politically charged contexts, have given rise to such behaviour. A hunger striker may tell the physician in confidence that for sure he *neither* does want to die *nor* endanger his health. While accepting assistance in the form of an intravenous line or possibly even nutritional intake in the discretion of the medical consultation, the hunger striker tries to manipulate the doctor, for example, insisting he makes a public statement to the press, or blatantly lies to his superiors in the prison. This is unacceptable when it is obviously a form of manipulation of the physician, trying to get him to collaborate with the protest. The physician has to remain on neutral ground, and thus retain credibility

1 Reyes, H. *Medical ethics subject to national law: Should doctors always comply*? In: Medische Neutraliteit; Jaargang 51, 8 November 1996 MC NR 45; pp. 1456/1459

2 Annas G.J. *op. cit.*

3 Allen S., Reyes H.; *op. cit.*

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on all sides. While there is not need to be specific, towards the press for example, on "what type of treatment" is being given, the physician should not lie about it. To his immediate superiors he should explain his situation of intermediary, and not let them manipulate the situation either.

In another highly publicized hunger strike in Europe, a determined prisoner, who totally fasting lost more than 20 kilos but who knew *exactly* what he was doing, managed to manipulate into believing he was steadfast in his resolve not only the custodial authorities, but also the medical staff. The custodial authorities, in this case both prison and judicial, ordered the prisoner to be force-fed. The physicians refused, evoking the ethical principles in "Malta 2006". The nurses, however, took pity on the "poor old man"[1] and persuaded him (sic) to accept a naso-gastric tube. The hunger striker ascertained that if he were attached, he would yank it out. However, he then proceeded to help the nurses attach him.

This case was widely commented on and even went visually into the media. It is now clear that the prisoner had no intention of starving himself to death, but manipulated the authorities into ordering him force-fed; manipulated the medical staff into attaching him down, while accepting in fact the naso-gastric feeding; and even manipulated an outside higher authority into believing he *had* been *force*-fed. Once he obtained what he wanted, he quickly stopped fasting and walked out of custody a free man.

It is most important for physicians to maintain the high moral ground here, and refuse manipulation from *any side*. In the abovementioned case most of them refused to have anything to do with the prisoner, but some – and the nursing staff – were tricked into playing his game. It is essential the physician *not* let him/herself be manipulated by *any* side. Only this way a constructive medical role will be possible and hopefully calm down the situation and avoid coming to an impasse.

Painting Hunger Strikers Out of Their Corner

It was mentioned in the introduction to this paper that the hunger striker was sometimes "forgotten" in the heated controversies between the custodial authorities and the medical profession. Such confrontations, and their often very public "ventilation" in the media, put the hunger striker "on the spot", or more to the point, "in the spotlight". A lone hunger striker may all of a sudden find he has become a "star", talked about, held up as a "victim" or "martyr" as the case may be. From a hostage taker holding himself hostage, he effectively becomes a real one of the situation. Any "support" from outside or from the same media, may have the contra-productive effect of "painting the hunger striker into a corner". Finding oneself with the "star" or "martyr" status makes it very difficult to back out of a more and more difficult situation. Abandoning the hunger strike becomes impossible, even in exchange for lesser concessions that gladly might have been accepted initially. The hunger striker may fear the taunts from the prison guards if he now backs down; or the shaming of his family; or the reproaches of his fellow inmates who will fell "let down"… The hunger striker may thus feel obliged to fast beyond whatever limit he initially may have had in mind.

When the individual hunger striker, or group of resolute hunger strikers, gets into such a "showdown" position with the authorities, pushed by their new notoriety into radical positions they may have not initially intended to take, it may seem too late to find a useful alternative to impasse. However, even in the most politicised situations, letting the situation deteriorate and become confrontational is ***not*** inevitable.

The physician still can play a crucial role in finding a way out. It is important for the physician not to medicalize just any form of fasting during the first 72 hours, otherwise the precious time will be wasted on futile cases. The custodial authorities may certainly consult the doctor about a specific prisoner – to know whether there is a medical condition that would put him in danger very early on. As mentioned above, it is to be avoided to have the physician rush to each hunger striker's bedside before 72 hours. After this period of time, the physician can plan how to manage each situation, and first and foremost reaffirm a relationship of trust as soon as s/he can. The physician should proceed without fanfare, and most of all without pressure from any side, either from the custodial authorities or from the prisoner(s).

The Ultimate Goal: Preserving Human Dignity

A final point need be made here. It should be sufficiently clear that hunger strikers very rarely go to a final fatal conclusion. Those that do often fall into the "painted into the corner" category, i.e. a situation of impasse, created by those who have left the situation get out of hand. The Northern Ireland strikes were an exception, and no one can accuse the physicians of not having done all they possibly could to defuse a highly politicized situation. That hunger strike, like those embarked on by Mahatma Ghandi, had there been no concessions in his case, ended in fatalities. Such rare terminations of the ultimate way for prisoners to protest are rare, and it has been shown that they can be avoided in the majority of cases. However, force-feeding is not a solution, as it imposes refused medical treatment on the individual, from a non-medical authority, making the physician an accomplice of wrong-doing, if inhuman and degrading treatment. As already said, "Malta 2006" clearly states that force-feeding is never justified. A competent hunger striker can-

1 An authentic quote to the author from the interviewed medical staff…

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not be coerced, even were it to save his or her life.

Article 11 of "Malta 2006" states:
"If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will."

This clause applies to cases where a prisoner may have been forced to sign such instructions under duress, in a repressive or dictatorial prison system for example. However, in a more normal situation, it also applies to those cases, such as the above mentioned Caucasian one, where the prison doctor has given a terminal hunger striker "one last chance". As has been said, this is admissible if the doctor who has been following the patient, and knows him, has the firm conviction there is good reason to believe the hunger striker really does not want to die. If the physician has in good faith misjudged the situation, he cannot be accused of unethical behaviour. What would *not* be admissible, it would be the physician's complicity with the coercive custodial authorities to play the game of allowing deliberate deterioration of the hunger striker's mental state through total fasting. In such a case, once the hunger striker was in a confused state and no longer able to make an informed decision, s/he would be in fact "force-fed, evoking the lack of resistance to such feeding. To thus justify "*artificial*" feeding (sic!), and then start over all again once the prisoner was resuscitated, is totally unacceptable. This type of situation actually occurred in the 1970s, in a North African country, several hunger striking prisoners submitted to what was assimilated to a "yo-yo" situation, which ended up lasting for some two years. "Malta" specifically says that a truly determined hunger striker should be allowed, if all ethical attempts to reverse his or her decision have failed, "to die in dignity."

Way Forward: How to Extricate Physicians (and their ethics) from the Imbroglio and Possibly Contribute to a Solution

How can the confrontational situations mentioned above be avoided? The authors of this paper are convinced the "Way Forward" that has been mentioned, specifically involving physicians, will work for the great majority of hunger strikers. It may not in the most extreme situations, but such cases are truly exceptional.

All physicians want to preserve life. They should do so respecting the dignity and rights of their patients, and respect for medical ethics will automatically follow.

Our analysis leads us to conclude there are many ways that physicians can act, consistent with medical ethics, to develop a true doctor-patient relationship with hunger-strikers. It is also critical that the custodial authorities do not act to undermine the fragile trust between the doctor and the patient for in doing so, they deprive themselves of the easiest solutions to the conflict. Positive and trusting therapeutic relationships will ultimately result in a reasonable outcome for all involved in the vast majority of cases. It must be recalled that hunger strikes, if they are to work, can only do so over a span of time. The key to finding a way out of the imbroglio is for the custodial authorities to realize that a hunger strike is *not* an emergency, let alone a medical emergency. If the physicians have done their job of excluding any potential cases with concurrent medical problems, there is no need for panic. There is at least a full month before reaching the stage when medical symptoms may begin to cloud the issue. These full four weeks are unfortunately seldom used to look for a solution. Instead, the custodial authorities tend to crack down from a viewpoint of mere "principle" ("Nobody kills himself in ***my*** prison!") that is when the spotlights turn on and confrontations begin.

Rigid standard operating procedures (SOP's) which decree that hunger strikers shall be force-fed already during the second or third week of fasting supposedly "to save their lives" are unethical nonsense and precisely what is to be avoided. A healthy young adult with no concurrent medical problems can usually go for a month taking only sufficient amounts of water, and have no serious health issue. The timeframe presented in this paper clearly shows that no serious medical complications of fasting will occur during this first month, leaving ample time for the physician to play a more useful role than merely monitoring blood tests, weights and blood pressures.

Paramount during this period is the meaningful discussion between the physician and the hunger striker. This whole concept of a constructive way forward is based on the physician-patient relationship. The proposed solutions and suggestions that follow have all to be seen from this perspective.

To be continued...

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