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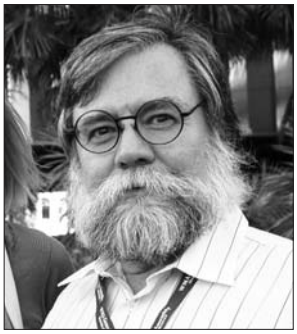
Physicians and Hunger Strikes in Prison: Confrontation, Manipulation, Medicalization and Medical Ethics (part 3) (part 1, 2 vol. 59 N 1, 2)



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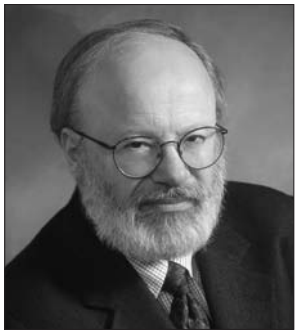

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In a previous publication[1], various actions have been suggested for the physician to implement during this quality time with the hunger strikers. The initial encounter with the hunger striker, for the history and exam, and initial evaluation, is the starting point. It is essential that the physician conveys from the start that he is ***not*** there as a prison official to try to convince them to stop their protest. He is there as their physician, to see to their health, to answer any questions they may have, to explain how fasting and metabolism work, but above all he is there to listen and maintain a constant line of communication with them. The physician has to convey genuine concern for health, and for providing professional care. This in most cases should counterbalance any qualms or legitimate fears the hunger striker may have about the doctor's role.

Without respect for the dignity of the patient, any medical practice is severely handicapped. In the case of a hunger strike, the physician should see to it that the patient is not placed automatically in a bleak or demeaning environment by the authority wanting to punish him. This is an aspect often neglected by doctors. If there is to be communication, and this is the key to a positive way forward, the patient has to be treated with respect. At the very least, the physician should clearly demarcate himself from any abusive attitude by the custodial staff and hierarchy. This is particularly important in settings where torture is occurring or is likely to occur.

The physician has to ensure his own clinical independence and autonomy. He has to firmly establish, with the custodial hierarchy, that he must have a free hand in dealing with all matters relating to health, in the broad sense of the term, as well as any medical interventions. If he is to try to influence the hunger strike so that extreme situations are not reached, he cannot be taking orders that go against medical common sense, let alone medical ethics.

This is easier said than done in many contexts. It is beyond the scope of this paper to examine the issue of "doctors, serving the state first and their patients second", as this easily spills over into "cultural", "traditional" and "political" discussions. The status quo of hunger strikes and forced feeding will likely continue unless there are deliberate steps to ensure respect of medical ethics[2]. National medical associations need to provide support for physicians confronted with such ethical dilemmas, and if necessary appeal to supra-national entities such as the WMA for guidance.

During the initial history, often a key moment for establishing the role he wants to play, the physician must ensure confidentiality, as in any doctor-patient relationship. This means there should be no presence of a guard during the discussion in private between the hunger striker and the doctor. This is easier said than done, and in recent situations, this was out of the question from the start because of "SOPs" not allowing such privacy. This has to be accepted. If security is a non-negotiable concern, then a guard should be at the very least out of earshot, so that privacy of exchanges between the hunger striker and the doctor are guaranteed. If there are microphones or other devices to monitor conversations, the physician should be transparent and tell the hunger striker that he, the doctor, is not in a position to impose their removal. Such communication can be achieved, if there is a common language, if necessary by scribbling on a pad.

Once this trust has been, however precariously, established, it is then up to the physician to use the four weeks ahead of them to asses the seriousness of the situation. How resolute exactly is the hunger striker? How determined is he to push his protest through? Can he accept a compromise solution that would allow the fasting to stop? What is behind the protest? Is

1 Allen S., Reyes H. *Clinical and Operational Issues in the Medical Management of Hunger Strikers*. In: Interrogations, Forced Feedings, and the Role of Health Professionals*;* ed. Ryan Goodman and Mindy Roseman, Harvard University Press, February 2009.

2 Annas, G. J. *'Dual Use,' Prison Physicians, Research, and Guantánamo*";, American Vertigo:, Case Western Reserve J. International Law 2011; 43: 631-650.

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there some misunderstanding that could be easily corrected so as to defuse the situation? Is there peer pressure from other prisoners? …Or from within the group of hunger strikers themselves when it is a collective action?

During these first few weeks, a physician dedicated to his task should have sufficient time to determine whether the hunger striker is alone in his decision, or whether he is under pressure. For public consumption the solution the hunger striker wants to find may be a political statement, often a realistically impossible proposal… However, and this is what the physician should be able to pin down, the hunger striker will often be prepared to accept a fall back position, accepting much less than initially asked for. If he somehow, however indirectly, admits he does not really "want to die" then the door is open for the physician finding a solution. *What* solution, depends on a multitude of factors. It may be to convince the hunger striker to lower the bar of contention so that a compromise can be reached with the hierarchy. It may be to persuade the hunger striker to take vitamins and perhaps other nutrients, so as to allow plenty of time for negotiations. In extreme cases, which are rare, the hunger striker may agree to receive artificial feeding – thus allowing him not to lose face (by quitting the hunger strike) while getting him out of danger while a solution is found. If the patient is under pressure, moral or potentially physical from his peers, the physician may simply arrange for the hunger striker to being transferred to the sick bay, where (voluntary) "therapeutic feeding" may be undertaken. In most cases, this feeding will simply mean that the hunger striker quietly starts to eat again.

In a collective hunger strike, the situation may be more complex, a small number of "hard liners", or sometimes even just one leader, making it impossible for any other hunger striker to get out of line. The group may adopt an intransigent position – and the individual hunger striker may not be in a position to back out individually, even though he would like to. The key here is for the physician first to get to talk to each hunger striker individually. If the relationship of trust has been attained, some at least of the group will admit **in confidence** that they do not want to "go all the way". If the physician can get to know this, it is most of the time half the battle won. The next step will be to separate the hunger strikers from one another. This does not mean isolating them, putting them in solitary confinement, let alone punishing them actively or worse humiliating them (as has been the case these recent years in a well-known hunger strike.) Once the peer pressure relieved, the road to reconciliation is open.

Perhaps even more important, the physician has to strive to avoid the development of a clash between the custodial or judicial authorities and himself or his medical superiors. This will be over untoward medical intervention, and ultimately about force-feeding. In the first stage of a hunger strike, he has to calm things down so that there is no "hasty" decision to force a naso-gastric tube down the hunger striker's throat when there is absolutely no need for any medical intervention. The hunger strikers should be informed, officially, or perhaps "less officially" in some contexts, that the doctor is ***not*** going to force a naso-gastric tube into their throat. The physician should persuade the authorities that there is no risk before at least four weeks of total fasting. If the situation is one of non-total fasting, this limit can be pushed back even further. He has to convince the non-medical authorities, sometimes "itching for a fight" with the "hostage takers", that he will do his best to reach a way out well before that limit is reached. It may be at this stage counter-productive for the physician to brandish his ethical banner and declare that he will refuse to force-feed whatever the authorities decide. The physician *knows* his duty, and when the moment comes, he will know what to do, In the meantime, the point is ***not*** to push the "trigger-happy" custodial/judicial authorities to pull the force-feeding trigger. An open clash is also to be avoided at all times.

All the high publicity hunger strikes in the recent years have been very badly managed in this respect. Physicians have found themselves to be the instruments of the high-spirited and interventionist non-medical authorities. Some physicians, not having a solid ethical education, have simply "obeyed orders". Others, thinking to help the situation, have loudly protested and clashed openly with the non-medical authorities, which has poisoned the general atmosphere and often provoked a crack-down, with subsequent orders being given to force-feed, when there was no medical need whatsoever, thus dashing any hopes for a compromise.

The first month of a hunger strike eliminates all the "food refusers", and becomes premium time for the physician to genuinely play his role and to try to preserve life and dignity, and find the best solution for compromise. He has to have the trust of the hunger strikers, and also that of the custodial authority. He has to persuade the latter not to be hasty, and above all not to make decisions that are unwarranted, unsound and unethical. Prison Governors have been known to *up the ante* by taking decisions, or implementing new constraints that make it much more difficult for a prisoner to reflect and stop fasting, by withholding medical care for example. There have been concrete cases of ***physicians*** themselves knowingly giving out false "medical" information, so as to frighten prisoners into stopping their fast. In one specific case, a medical officer of a prison in the Middle East "let it be known" that going on hunger strike "caused impotency in the young male, which could be long-lasting." This was obviously deceitful information, and the use of medical authority in such a way obviously undermines any trust with the prisoners, already so difficult to obtain.

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The physician has to stretch out a hand to the hunger striker, to allow him to confide in the doctor, and in the majority of cases find a way out of what should never become an inextricable situation.

In the very rare event of a hunger strike in a Bobby Sands-type situation, where intransigence on both sides is impossible to break, the physician must know when to back off himself. As clearly stated and explained in "Malta 2006" and its comprehensive background paper, it is never ethically acceptable to force-feed anyone. The physician should never lend himself and his medical skills to such abusive practice. In the specific case of Guantánamo Bay, Navy reservist physicians were "vetted" before being sent to the Base. Any doctor strongly against force-feeding was not sent there[1].

Conclusions: Medical Ethics

In managing hunger strikes, no one seems to realise exactly how counter-productive the confrontation between the custodial/judicial authorities and the medical doctors can be towards the goal of resolving the hunger strike. By shining the spotlight of publicity on this clash between professionals, both sides are helping to paint the hunger striker into a corner. They also prevent the physician from playing a crucial role during the first weeks of the strike, when there is time and no danger. The hunger striker thus finds himself in the limelight, which may "force his hand". The hubbub around his case, the fact that his "determination" becomes common knowledge, the fact he is placed on the pedestal of "heroism" or "martyrdom," may well end up pushing him into actually wanting to become one.

Management of fasting, possibly taken to its extreme limits, will seem to involve a conflict between the duty of health professionals to preserve life and the right of the patient to make an informed refusal of a medical intervention[2]. The main point we have tried to make here is that there has been far too much focus on the "Endgame"[3], and "saving lives", when in the vast majority of cases, hunger strikers do not intend to get that far and most often need only to obtain some of their goals. Time is wasted, and, worse, radical positions are taken and hunger strikers can be thus "painted into corners" when it becomes extremely difficult to get out of. That there are many weeks before a situation warranting *any* medical intervention will arise, is just not grasped by most physicians, let alone the non-medical authorities.

The Declaration of Malta does not categorically forbid resuscitation. There may be room for some legitimate debate in individual cases when the health of the hunger striker is so critical that death is imminent, and the individual's real intentions are not clear. But this is a decision for the physician, not the prison officials. Policies, however, of force-feedings of groups of hunger strikers *en masse* before clinically indicated for reasons of intimidation or punishment, as have been reported at Guantánamo, is without question in violation of basic human rights, including the provisions against cruel and inhuman treatment in the Geneva Conventions.

The use of emergency restraint chairs for force-feeding can never be ethically, legally, or medically justified. A patient who must be forcibly restrained in such a device to be fed is certainly strong enough to be in little or no health danger from continuing a fast. The primary justification for the use of this device for force-feeding would seem to be for punishment, control and humiliation rather than for legitimate medical care.

The main conclusion is that medical ethics is consistent with a type of ***ethical pragmatism*** in dealing with the vast majority of hunger strikers. This means doctors treating each one as a patient and finding a way to establish at least a minimum of trust in the context of what will always be a difficult and confining the doctor-patient relationship. To this end, we have drawn up here a series of practical recommendations which would most certainly "calm things down" and encourage an ethical, pragmatic and humane way to defuse the vast majority of difficult hunger strikes. The WMA "Malta 2006" is very clear in its prohibition of any form of **force**-feeding of a competent patient, but it gives generous leeway for the bedside clinician, and **only** that physician, to address the situation and take the final best decisions for the patient.

Finally, in the specific case, again of Guantánamo Bay, President Barack Obama's Executive Order (EO) of March 7, 2011, unfortunately makes it at least likely that the detention facility there will remain open indefinitely. The EO ignores the whole hunger strike issue and the ongoing force-feedings of at least some prisoners. Solutions and approaches based on the patient trust in the military clinicians are by now impossible because of the past practices. For the reasons stated, the issue is ***not***, at the present time, how to end the on-going force-feeding, but rather how our suggestions and observations could be useful to prevent another Guantánamo force-feeding scenario in the future, there or elsewhere.

Recommendations

→ *Conform to established medical ethics*

The WMA's Declaration of Tokyo very clearly anticipates the exact scenario of hunger strikes undertaken at places like Guantanamo Bay, and the declaration represents the established ethical guidelines for

1 Okie S. *op. cit.*

2 Allen S., Reyes H., *op. cit.*

3 *Doctors attack US over Guantánamo*; BBC NEWS; *http://news.bbc.co.uk/go/pr/fr/-/2/hi/americas/4790742.stm*, accessed March 2012.

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physicians. The use of torture during interrogations, or in cases where the very conditions of confinement constitute a form of torture, were envisaged when writing up "Tokyo", as a central and direct cause for the initiation of the hunger strikes. As mentioned, it was this that ultimately led the WMA to specifically condemn force-feeding itself. In 2006 in an editorial explaining the AMA's endorsement of the WMA's Declaration of Tokyo, Duane M. Cady, MD, chair of the AMA's Board of Trustees quoted from the WMA itself "… 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 shall not be fed artificially."[1]

In addition, efforts to circumvent medical ethics by pre-deployment screening of health professionals to exclude those who might object to the policy of force-feeding at Gtmo does not excuse ethical misconduct by either the health professionals or the detaining authority.[2]

Physicians deployed to provide detainee and prisoner care should be appropriately trained in the ethical management of hunger strikes, as well as international standards of medical care for detainees and prisoners. Credentialing for work in detention facilities should emphasize and address humane treatment and familiarity with the accepted standards of care in prison and detention facilities.

→ *Don't undermine detainee trust in physicians*

The foundation of effective medical practice is trust between the doctor and the patient. This is especially true in the scenario of hunger strikes where the doctor's ability to engage with the patient to find an acceptable resolution to the hunger strike is entirely dependent on the patient's ability to trust the physician. For that reason, practices that may undermine the trust between the patient and the physician must be eliminated. These include the practice of assigning some health professionals to support the interrogation procedures. These health professionals quite obviously did ***not*** act in the detainee's interest (that wasn't their assignment), and their presence in support of interrogation clearly undermined any detainee's trust in the clinicians working outside of the interrogation setting. In a 2005 Memo, DoD Assistant Secretary for Health Affairs William Winkenwerder established differential ethical duties for "clinical", as opposed to "non-clinical", medical personnel. This goes against the very essence of medical ethics: a physician is a physician is a physician! In addition, the use of medical personnel or even psychologists for activities such as identifying psychological vulnerabilities so as to advise interrogators, constitutes a serious breach of medical ethics.[3] Moreover, failures of health professionals to document and report evidence of abuse and torture undoubtedly undermined the trust between the detainee and the health professionals.[4] Trust between health professionals and patients in custodial settings is unavoidably challenging from the outset. Effective correctional health professionals overcome structural barriers to trust slowly by developing trust with the patient over time largely by the integrity of their actions in treating the patient. Policies that ask health professionals to undermine their own credibility and integrity must be avoided. Making physicians force-feed detainees destroys any possible trust between the doctor and the patient.

→ *Respect clinician autonomy (clinical decisions to be made by clinicians)*

Key clinical interventions such as whether or not to use forced naso-gastric feeding must be left exclusively to the treating clinician. While there will unavoidably be a role for non-medical chain of command and courts, the clinical approach must be determined by the treating clinician within the frame of accepted ethics and clinical practice.

→ *Minimize coercive practices that infringe on patient autonomy*

From a psychological perspective, it is important to understand the act of a hunger strike as an act by the patient to assert his or her autonomy over the basic act of eating. This is not only an act of autonomy as an ethical issue, but as a practical issue. The reason food refusal is often chosen as the act of assertion of autonomy is that often all other areas of autonomy have been removed as options. In the case of Guantanamo, the development of widespread hunger strikes cannot be separated from the authorization and widespread application of practices that infringed on the autonomy of the prisoners and have now been recognized as ill-treatment and torture.

→ *Develop alternative means of addressing grievances*

"Indefinite detention" as applied in Guantánamo Bay is the major grievance, and as has been stated, one of major reasons the internees initiated hunger strikes there – a situation that hopefully will not be repeated in most hunger strike cases. Fundamentally, the act of hunger striking is a form of stating a grievance. It is more likely to be employed as a means of stating a grievance

1 O'Reilly, Kevin B. *Physicians Speak out on Prisoner Force-feeding http://www.ama-assn.org/amednews/2006/04/03/prsc0403.htm*; April 3, 2006., last accessed March 2012.

2 Okie S, *op. cit.*

3 *http://www1.umn.edu/humanrts/OathBetrayed/Winkenwerder%206-3-2005.pdf*

4 Iacopino, V., Xenakis, S. *Neglect of Medical Evidence of Torture in Guantánamo Bay: a case series*.In: PLoS Medicine. 8(4): e1001027. doi:10.1371/journal.pmed.1001027. Available at: *http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001027*

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when alternatives to resolution of grievances are not available. Here it should be noted that the custodial authorities hold "all of the cards," so to speak. The non-medical officials have the power and authority to negotiate, address and where possible resolve all prisoner grievances (and do not require a medical intervention to do so).

→ *Individualize care*

Develop emphasis on individualized resolution of the hunger strike before clinical deterioration occurs. The rapport established between the bedside clinician and the hunger striker can be a crucial element starting to resolve the conflict and developing a dialogue between the authorities and the prisoner- patients.

→ *De-medicalize the early stage*

Hunger strikes are predicated on the assumption that the assertion of autonomy by the detainee will result in a response from the authority. In societies where it is known that the authority will not intervene, hunger strikes are rare to non-existent. One way to reduce incentive to a hunger strike is to avoid intervening too early. The earliest hours and days of a hunger strike pose little or no health risk in the patient without significant underlying health problems. In fact, from a clinical perspective, there is little or no justification to monitor or intervene in any way during the first 72 hours of a hunger strike. Accordingly, in the case of the U.S., its Department of Defense Standard Operating Procedures should be redrafted to emphasize clinically appropriate care. Health professionals must not be exploited to assert control over the patient even for national or prison security purposes.

→ *Reduce peer pressure*

In settings such as Guantanamo, the potential for a prisoner to undertake a hunger strike as a result of peer pressure from other prisoners is a genuine concern. Ideally, peer pressure must be reduced or eliminated. Removal or transfer of the prisoner to a health setting may provide some mitigation of peer pressure issues. Allowing access to family and community supports would, of course, be another.

→ *Don't punish or further limit other areas of autonomy*

Efforts by the detaining authority to limit and control other areas of personal autonomy make it all the more likely that the detainee will use food refusal as a means of asserting some autonomy and as a form of grievance. In this equation, the detaining authority actually has almost all the control over the other areas of autonomy and must not lose sight of that fact. Such broad control provides options for creating alternative paths for the detainee to food refusal. Accordingly, routine use of the restraint chair cannot be justified and must be discontinued.

→ *Improve conditions of confinement*

Conditions of confinement are often a leading cause for grievance. Indefinite detention and prolonged social isolation often are the drivers of the kind of desperation that produces hunger strikes.

→ *Employ outside expert clinicians*

No matter how good the facility medical staff is at establishing trust with the detainee, access to a doctor who can offer impartial and independent expert advice to the patient is essential in developing options for resolving a hunger strike. There should be no prison in the world that does not permit a prisoner to be seen and examined by an outside medical consultant at their request or the request of their family.

→ *Involve family, clergy, and community*

Outside community supports can be effective in providing support needed to achieve a successful resolution of a hunger strike. In addition to dissipating a sense of isolation and entrenched conflict, community and family influences can counter-balance peer pressure from fellow detainees.

→ *Develop honest informed consent procedures and advance directives*

It is essential for the clinician to know the intentions of the hunger striker. To formalize it early on in a written declaration, however, may be the start of painting him into a corner. More important is the reverse of the coin, which leaves the *final decision* in the hands of the bedside clinician, who is to act ethically (and not follow any diktat from Judges, prison authorities or any others) but also take into account the situation he has assessed in his bedside care of the patient. Knowing this, and it is carefully spelled out in "Malta 2006", the clinician can devote all his time and efforts to find the proper, individual, ethical solution best suited to the patient, including death.

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