Assistance in hunger strikes

A manual for physicians and other health personnel dealing with hunger strikers

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Assistance in Hunger Strikes is, as the publishers from the Johannes Wier Foundation have described it, "A manual for physicians and other health personnel dealing with hunger strikers". This useful instruction and description of some conditions and guidelines concerning hunger strikes is based on a seminar for which the Johannes Wier Foundation took the initiative in 1992. Contributions and discussions from the seminar covered clinical, ethical, and legal aspects and dilemmas, and when published they quickly became useful tools for doctors and health professionals in their further work with refugees. The manual's preface gives a detailed description of the circumstances of the publication, and of the persons involved in the seminar and the publication.

The editorial board of TORTURE has also found this concise and detailed account useful in its present form for its worldwide readers and wishes to thank the Johannes Wier Foundation for making it possible to print Assistance in Hunger Strikes as a supplement to TORTURE. Assistance in Hunger Strikes is published as in 1995. However, we have shortened chapter II: Introduction, which is a text from a BMA Working Party Report "Medicine Betrayed", because of this chapter's references to specific British conditions.

The Editors
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I. PREFACE

Hunger strikes and the role of the doctor who assists a hunger striker have increasingly gained the attention of the medical profession, politicians and the general public.

In the Netherlands in recent years there has been a dramatic increase in the number of hunger strikes. Hunger strike or “voluntary total fasting” is often called the “weapon of the powerless”, particularly those deprived of some basic human freedoms such as refugees and prisoners.

Voluntary total fasting affects the health and eventually threatens the life of an essentially healthy person, who ultimately turns his life into an appealing tool of protest, often of political nature, which is often compelling enough for his opponents to evoke strong reactions.

Many hunger strikes last only a few days; increasingly however doctors have to deal with hunger strikes which last much longer, particularly among refugees. In such cases, especially when accompanied by a thirststrike, the hunger strike is likely to lead to severe medical, ethical and social problems.

The hard and acute dilemma the doctor of a hunger striker faces is his professional obligation to preserve life as much as possible while he has to respect the personal autonomy of the hunger striker. This dilemma has led in the past, and in several countries still does lead to, forcible feeding against the expressed will of the hunger striker.


The prohibition of forcible feeding however, has not diminished the doctor’s dilemmas.

Since the 1970s there has, in the Netherlands, been a tradition that so-called “doctors of confidence” provide medical and psychological assistance to hunger strikers. They may be general practitioners or public health doctors, but they are always independent from the government or other authorities, like the administration of prisons or refugee centers. Some Dutch doctors have been “doctors of confidence” for hunger strikers in Northern Ireland (imprisoned members of the Irish Republican Army – IRA) and Germany (imprisoned members of the Red Army Fraction – RAF).

Since the beginning of the 1990s numerous hunger strikes have been undertaken by refugees in the Netherlands, mostly individuals but sometimes large groups are involved.

In 1991 a group of 180 Vietnamese refugees (spread over the whole country in centres for asylum seekers) started a long lasting hunger strike in the Netherlands. This widespread and widely media-covered action showed that the average physician lacked sufficient knowledge on the subject, and that appropriate information was not available.

These observations motivated the Johannes Wier Foundation for Health and Human Rights (JWF) to organise a seminar “Assistance for Hunger Strikers” in 1992 in cooperation with the Royal Dutch Medical Association (KNMG) and the Pharos Foundation for Refugee Health Care.

The meeting was attended by doctors, nurses and lawyers; the lectures and discussions of this seminar have been the basis for this manual, which is especially written for doctors and other health personnel involved in the assistance for hunger strikers. The Dutch version of this manual is currently being used in centres for asylum seekers and detention facilities.

International contacts learned that there is a need for an English translation of this manual.

The Johannes Wier Foundation decided to publish an English edition, edited for the international professional reader.

For the introduction chapter in this English edition we gratefully made use of the chapter on hunger strikes in the report "Medicine Betrayed" of the British Medical Association (BMA), published by Zed Books in 1992. The Johannes Wier Foundation owes acknowledgment to the BMA for its permission to use the text from its book.

II. INTRODUCTION*)

Hunger strikes present the doctor with a complex and difficult moral problem which can at the most serious extreme resolve itself to a choice between respecting the prisoner’s expressed will and perhaps watching him or her die a slow, distressing and avoidable death, or to override the prisoner’s expressed wish in order to preserve the prisoner’s life.

In general, hunger strikes are not carried out with the objective of the death of the hunger striker. Indeed, a hunger strike usually ends well before serious injury is done due to an intended limitation of the fast; change of mind of the prisoner; persuasion by family, lawyer or prison officers; or capitulation in the face of pressure, including forcible feeding, from the authorities. In certain circumstances the death of one or more prisoners may have been anticipated in advance and may even have represented an element in a confrontation with a government though this appears to be very rare.

In repressive societies where avenues for legitimate political protest are unavailable, the hunger strike assumes a quite important form of power for the prisoner. However, it is also the context where the prisoner will be most likely to have his or her rights disregarded. This may mean that doctors are brought into the conflict, not so much to save the prisoner’s life as a humanitarian endeavour but rather to inflict on the prisoner the will of the government. When the World Medical Association set out to codify its policy on torture and other cruel, inhuman or degrading punishments in the early 1970s, it included the hunger strike in this procedure. This was in part a response to the political context in which some hunger strikes were being carried out in the 1970s and the use of forcible feeding as a repressive arm of the state. It was clear that in some countries artificial forcible feeding was primarily administered as a government policy rather than be the outcome of a doctor’s clinical judgement. The World Medical Association’s 1975 Declaration of Tokyo included the following provision:

Where a prisoner refuses nourishment and is considered by the doctor 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 doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner. [Art. 5]

This has been the clearest international statement by the medical profession on the subject of hunger strikes. While this paragraph can form the basis of a coherent policy to-

wards hunger strikers\(^1\), it does not totally solve the problem, however, since there remains the question of the appropriate response in the absence of a prisoner's clearly expressed wish to fast to the point of death and in the situation where a prisoner has passed the point where an informed decision can be made. The WMA itself has suggested that doctors could feed hunger strikers in the absence of consent in certain circumstances and has given notice that it is continuing a discussion on the appropriate policy on the doctor and hunger strikes\(^2\). In November 1991 at the World Medical Association annual assembly in Malta, a set of principles was adopted (see chapter X).

**The difficult issue**

The hunger strike is without doubt a difficult issue for doctors and other health personnel. Those who carry them out for political reasons are usually young, committed people who, in other circumstances, would have everything to live for\(^3\). To watch such a person steadily deteriorate to the point of death, over perhaps a two month period, must represent a stressful experience for medical and nursing staff. And yet, at least in those cases where the prisoner has clearly expressed a wish to carry out such a hunger strike, the doctor's respect for the decision reflects acceptance of the prisoner's autonomy and right to accept or refuse medical care. A hunger strike to death cannot be equated with suicide. The latter represents a desire to end life. As a general rule, prisoners who refuse food do not do so in order to end their life but rather to put pressure on the authorities to change a policy. They may die as a result of the hunger strike but this is not its primary objective in most cases.

All this is clear in the case of prisoners able to express their choice before and during the hunger strike and where there is continuity in medical supervision.

There are circumstances where a hunger strike poses serious moral dilemmas. Two will be mentioned here. The first occurs when a prisoner is brought to a doctor in a coma-tose state and the doctor is unable to determine (or is unable to find out) the wishes of the prisoner. In such a hypothetical circumstance, we believe that the doctor ought to respond in the usual way when confronted by a seriously ill and unconscious patient who cannot be questioned. Treatment should be instituted to save the prisoner's life and to enable him or her, once resuscitated and able to communicate again, to inform the doctor of his or her wishes.

The second occurs when the doctor is faced with knowledge of the deteriorating prisoner's wishes to proceed with the hunger strike while the prisoner's family's actively-expressed wish is to preserve his or her life. This could be particularly poignant where there is discussion of an end to a politically-organized or group-supported mass hunger strike and where the doctor is aware that by the time the hunger strike is called off, one or more hunger strikers may be dead. In such a case we believe the doctor must balance respect for the prisoner's autonomy with developments since the prisoner's decision was made and in particular since the prisoner lost the capacity to express a clear, informed opinion. In cases where the original cause of the hunger strike has been resolved in agreement with the prisoner's view, treatment should be instigated immediately.

Also stemming from group hunger strikes is the problematic judgement which the doctor must make as to when the individual prisoner is genuinely and freely deciding to continue a strike and when he or she is continuing it due to irresistible group pressure. If the prisoner appears to the doctor to be likely to want to give up the hunger strike but cannot do so in the presence of striking comrades, should the doctor request that the prisoner be moved in order to ease the pressure and allow him or her to make a free choice? Given that such a move may be seen as a deliberate attempt to divide the strikers and thus break the strike, such a decision should be made with the utmost sensitivity to the prisoner's best interest. One way of helping to determine the prisoner's wishes could be the introduction of a scheme which applies in the Netherlands where "doctors of confidence" are made available to the striking prisoners allowing them direct contact with doctors outside the prison system. In many countries, however, the reality is that doctors will have to make such decisions on their own and will need the clearest available guidance.

During 1991, the WMA discussed the ethical response to hunger strikers. The detailed discussion document did not meet the perceived need expressed during discussions in the WMA Ethics Committee, and subsequently a revised statement of WMA policy was adopted by the general assembly of the WMA at its annual meeting in Malta (chapter X).

**Notes**


**III. MEDICAL BACKGROUNDS OF HUNGER STRIKES**

**Jeanne Smeulers, MD, PhD, internist**

Every doctor who is confronted with a hunger strike will be faced with some difficult decisions and dilemmas. As literature teaches us, there are no fully satisfactory solutions. However, it is possible to set a well-considered policy that is ethically sound and as fair as possible.

What strikes us first, is the panic of the environment against the peacefulness and clear determination of the person who refuses to eat. This also occurred in the Roman Empire during the government of Tiberius at the beginning of the Christian era. The empire was declining, murder and torture had become widespread. Nerva, the well-known lawyer and friend of the emperor, decided to go on hunger strike because he could no longer bear to see the misery around him. He wanted to die honourably before action would be taken against him. As soon as Tiberius heard this, he went to Nerva's bedside and begged him to stop. Tiberius' arguments are interesting: it would weigh heavily on him that he had known this, his reputation would be severely damaged, if his most intimate friend escaped from life without any motive, wrote Tacitus\(^1\).

Panic in those days and ever since. The argumentation of Tiberius also sounds familiar, although nowadays governments will usually not phrase it so openly and clearly. Amid this panic surrounding a hunger striker, it is the doctor's first duty to remain calm. He is expected to form a clear picture and acquire knowledge of what happens during a hunger strike and what should be discussed with the hunger striker.

Before we look at these aspects in detail, it might be useful to mention some examples from the distant and recent past. The seriousness of the problems will then become clearer. All
possible reactions to hunger strikes can be found: to ignore them completely (also by doctors); transport the prisoner and just tell him during the transportation “there are no hunger strikers”, “we do not recognize this”; compel doctors to force-feed a hunger striker; doctors who do so voluntarily; arrest and torture of doctors who object; let the hunger striker die without any concession of the government; imprison them, certify them insane; secretly video-tape the physical examination in order to suggest to the outside world that the exiled hunger striker is in good condition; a doctor who refuses to give advice when symptoms develop because his patients are on hunger strike; a government that releases hunger strikers from prison and re-detains them again once they have recovered a little (suffragettes in England in 1913, according to the so-called “Cat and Mouse Act”); doctors giving injections; people who tie the prisoner, laugh at him.

A sad and dreadful gamut.

A. What should the hunger striker know about the doctor
The hunger striker should be informed about the doctor concerned, his views, his willingness to follow him, so the striker can decide whether he wants to be assisted by this doctor.

Independence of the doctor
• Is he impartial in the conflict?
• Does he consider the hunger striker as his patient, independent of institutions or the authorities?
• Is he completely independent in his actions?
• Can he provide assistance from a medical-ethical point of view?
• What are the ethical principles of his country, does he follow them?
• Does he respect the inviolability of the person?
• Does he consider a hunger strike a suicide?
• Will he certify the hunger striker insane and put him in a psychiatric hospital?
• Will he surround him with all the necessary medical care?
• Will he inform him about the course?

See also B; the questions mentioned under A and B are of course related to each other.

B. What should the doctor know about the hunger striker
The doctor should make an inventory of the hunger strike and striker so as to inform the latter and make a decision about whether he is willing and able to assist the person or group.

Intention
• Is the hungerstrike intended to be limited or until death?
• Does the strike concern refusal of nourishment or also of fluid?
• Is it one person or a group?
• Does the hunger striker have confidence in the doctor?

State of health
• Are there any recent or past diseases?

Assistance
• Does the hunger striker allow physical examination, laboratory analysis of blood and urine, X-rays, measuring of weight, blood pressure and pulse?
• Does he want the doctor to take action when complications arise, does he want to take medication in those cases?
• Does he agree the doctor should visit him daily and inform him about the course?
• Does he agree to hospitalization if necessary?
• Should his relatives be informed?
• Does he agree to intervention in case of coma?
• Is he willing to take salt and potassium suppletion, possibly mineral water and vitamins?
• If relevant: does he want an interpreter, does he want to choose one himself?

C. What the doctor should know about the course of a hunger strike
It is essential to know the course, because otherwise medical assistance is not possible. A lack of knowledge will make it impossible for a doctor to keep the patient well-informed and therefore to meet the requirements mentioned under A and B.

Thirststrike as well
This cannot be continued for more than a few days, one week at the most. The physical condition will decline rapidly and it is very hard to carry on the thirststrike. Mrs Emmeline Pankhurst described her own experiences in 1913 very clearly:

The hunger strike I have described as a dreadful ordeal, but it is a mild experience compared with the thirststrike, which is from beginning to end simple and unmitigated torture. Hunger striking reduces a prisoner’s weight very quickly, but thirststriking reduces weight so alarmingly fast that prison doctors were at first thrown into absolute panic of fright. Later they became somewhat hardened, but even now they regard the thirststrike with terror. I am not sure that I can convey to the reader the effect of days spent without a single drop of water taken into the system. The body cannot endure loss of moisture. It cries out in protest with every nerve. The muscle waste, the skin becomes shrunk and flabby, the facial appearance alters horribly, all these outwards symptoms being eloquent of the acute suffering of the entire physical being. Every natural function is, of course, suspended, and the poisons which are unable to pass out of the body are retained and sometimes there is fever. The mouth and tongue become coated and swollen, the throat thickens, and the voice sinks to a thready whisper.

Risk groups
Risks groups include people who run the risk of having complications at an early stage during a hunger strike, which may cause problems regarding perseverance. This concerns people who suffered or still suffer from certain diseases, like cardiovascular diseases, kidney diseases, diabetes mellitus, epilepsy, gastric or intestinal haemorrhages, or people on medication.

Unknown kidney diseases may show at an early stage and lead to severe complications and early death if no action is taken. Women are more acidose-prone compared to men and loose weight more quickly.

Duration
Literature provides the duration in days before death occurred in 13 hunger strikers6,8,9: 45, 74, 79, 66, 59, 61, 61, 42, 69, 73, 59, 67, 61. This averages 63 days, variation 42-79 days.

Sixty days, or two months, should be regarded as the limit if no complications occur.

A normally nourished man has enough fuel for 80 days, even if he uses 2,000 calories a day. However, as hunger strikes never last that long, it can be concluded that the adaptation mechanism fails10.
The following data on weight loss in grams per day are known 4,10-12: 280, 680, 720, 318, 344, 333, 357, about 660 in the first week, then 269.

If we omit the 660 in the first week, the mean is 412 g per day. This would mean a weight loss of 12 kg per month.

Another deduction: Bersford 11 mentions weight loss in two hunger strikers: 11.3 kg in 32 days; 10 kg in 30 days. This is about 10 kg a month.

The degree of weight loss does not depend on the original weight. Rapid weight loss at the beginning is mainly caused by water and salt loss. The degree of weight loss is also dependent on fluid intake and salt use.

Fluid intake
It should be advised to drink 1 1/2 to 2 litres of water/tea a day. During the hunger strike, ingestion of this amount of fluid may become increasingly difficult. If so, it should be discussed whether intravenous fluid suppletion is acceptable to the striker. Non prisoners tend to accept this more easily 12.

Metabolic changes
In normal circumstances, brain tissue can only use glucose for its energy supply. When fasting, the supply of glucose in the body (liver) is exhausted after about three days, which would soon be fatal. However, an adaptation mechanism becomes effective, which aims to make the energy last as long as possible, preserve the brain metabolism, and spare the muscle tissue. Basically, the adaptation of the body includes the following 10:

- gluconeogenesis from the glycerol portion of fat and from amino acids (mainly alanine);
- decline in extracerebral glucose use. This causes a decline in blood sugar during the first days, after that it remains stable;
- the kidneys play an important role in glucose production and nitrogen retention: the end product is not urea but ammonia. As a result less water and nitrogen are lost;
- apparently, brain tissue can use not only glucose but also ketone bodies for its energy supply. Insulin plays an important role here, because this adaptation does not occur in diabetic keto-acidosis. Therefore, hunger striking diabetics will soon meet severe problems.

The degree of adaptation cannot be predicted, so neither can how long the hunger strike can be continued. It is possible, however, to note when adaptation fails and the energy required for the brain metabolism is not available any more. More information on this subject will follow below.

Course
The following data were compiled from several articles on fasting and hunger strikes 4,8,10-13.

The first week
The hunger strike is generally tolerated well. There are only few risks provided that the fluid intake is sufficient. Hunger pain and gastric spasms disappear after a few days, sometimes only after one or two weeks. The blood sugar level drops initially (0.6-0.8 mmol/l) and remains stable on a lower level.

Physical exercise is possible. It is important to provide sufficient possibilities to relax, like reading, music, radio, visitors.

The first month
In due course, a number of changes become important apart from the weight loss mentioned before, like orthostatic hypotension and Bradycardia. These impede mobility, causing dizziness and sometimes headaches. Fatigue occurs more quickly, as well as muscular pain during small exertions, difficulties with reading, decreased alertness. Decline of body temperature, sometimes abdominal spasms or hiccups.

After three weeks the condition may have deteriorated to an extent that hospitalization should be considered so as to enable better and more specialized care.

NB: Some symptoms mentioned below may already occur in the first month. There are no general "rules".

Sickness phase
The hunger striker starts to feel really ill, the turning-point nearly always occurs around the 40th day.

It is striking that the author Franz Kafka mentions exactly the same time limit in his story "A Hunger Artist" 14 written in 1921-22. The story concerns a professional hunger artist, hired by an impresario. He fasts and the people come to watch him. After 40 days the impresario wants him to start eating again, because after that day the audience loses interest. Kafka's story is remarkably correct: we now know that after 40 days a hunger striker obviously starts to feel ill. Therefore, it is increasingly embarrassing for the audience to look at him.

The general feeling of sickness can be accompanied by the following symptoms and signs: loss of hearing, deteriorating eyesight, double vision and (in the final phase) even blindness, nystagmus, ataxia, unclear speech, vomiting of bile, jaundice, dry scaly skin, decubitus, and gingival, gastrointestinal, oesophageal haemorrhages.

The psyche remains clear until the end. There is no mental deterioration, but concentration problems, difficulties in formulating, apathy, mental lability. These symptoms are certainly also caused by extreme fatigue.

The final phase
This is characterized by euphoria, confusion, followed by coma and death.

It all happens very fast: one should not think there is time left to "negotiate". Death will occur within a few hours. So there is no time to lose. A decision concerning medical intervention must have been made before this moment, a team of informed specialists as well as an ambulance should be ready.

The features of brain damage (Wernicke's encephalopathy) and the risk of irreversible damage were described by Frommel et al. 12 in one hunger striker on the 38th day: disturbances of eye mobility, vertical nystagmus, mild tremor, ataxia, diminished tendon reflexes, subnormal level of consciousness. At that moment intervention was started, with informed consent acquired previously of the person concerned: intravenous feeding and suppletion including vitamin B complex during three days. After six days he was able to feed himself by mouth, ataxia persisted for one month, dizziness for three months.

Complications
Although all symptoms mentioned above are complications, the following symptoms suggest additional risks in an early stage: decline of kidney function, gastric haemorrhage, hypokalaemia, convulsions, delirium.

Diagnostics during a hunger strike
What should a doctor know in order to be able to assist a
hunger striker and keep him informed about the course? The enumeration below only lists the most necessary items. During the hunger strike it will become clear what else is needed.

The original values are very important and should be recorded in the medical file at the onset.

*Daily:* Measure weight, blood pressure, pulse. Physical examination depending on symptoms.

*Weekly* or depending on symptoms and abnormalities: Laboratory:

- blood: glucose, sodium, potassium, creatinine;
- urine: volume, reduction, ketone bodies, if necessary 24-hour excretion of e.g. sodium (in hospital).

The decision about specialized treatment in hospital depends on the physical signs. Consultation of the confidence doctor should continue in hospital.

**Artificial feeding**

All hunger strikers, from suffragettes at the beginning of this century to recent prisoners in Morocco, experience and describe this as torture.[2] The same applies to bystanders, e.g. Daily Mail correspondents, who resigned in 1909 because they did not agree with the newspaper’s policy. “We cannot denounce torture in Russia and support it in England” they wrote to the Times.

It also applies to the doctors involved. In 1912, doctors in England offered resistance to their role in force-feeding imprisoned suffragettes on hunger strike.[2] In 1974, doctors did the same with regard to force-feeding four Irish prisoners including the Price sisters. In both cases, they published articles about the dangers. They were supported by the British Medical Association and in 1975 also by the World Medical Association (Declaration of Tokyo). Strikingly, the doctors’ motives in 1912 were not different from those in 1974, the journals in which they published their articles were also the same (The Lancet and British Medical Journal).[6,17-20] Doctors wrote to the British Medical Association that the same force-feeding methods were used in 1912 and 1974.[21]

This makes one wonder whether doctors fail to learn from the past, because both in 1912 and in 1974 the doctors only decided they did not want to force-feed any more when the procedure had appeared to be extremely risky. By the way, the risks had not changed either over the 62 years: death due to aspiration pneumonia, gastritis, asphyxia, arrythmia.

A different matter is that there are no data showing that doctors who proceeded to force-feed acted medically adequately, because the condition of the saved hunger striker was not exactly perfect after “the treatment”. They were seriously emaciated, tired, exhausted.[2]

An example is a prisoner in the United States who went on hunger strike four times in 250 days. Each time he was force-fed after a few days, and then started to eat voluntarily again. Still, emaciation was serious: a total weight loss of 14 kg.[2]

Apart from the medical-ethical issue about the violation of the rights of a person by applying force-feeding, it can be stated that medical practice shows that the method, to put it euphemistically, cannot be considered a perfect treatment.

**Convalescence**

When the hunger strike is terminated, a period of recovery begins. Depending on the duration of the hunger strike, the convalescence period will be short (for example after only one week without nourishment) or months if the hunger strike lasted much longer. In the case of a duration longer than three weeks, a convalescence of about three months should be expected. Only then is 85-95% of the original weight regained.

Severely undernourished people are usually able to take in food orally rather quickly, sometimes already after a couple of days. However, assistance remains necessary. Immediately after the termination of a hunger strike, one should be careful not to give too much carbohydrates, especially if there was no supplement of salt during the hunger strike. The resulting rapid increase in weight is not formation of tissue but mainly water. An example is the three prisoners, belonging to the German Rote Armee Fraktion, who went on a 44-day hunger strike in 1978 in a Dutch prison. During the first three days of refeeding, each person gained 3 kg. This is obviously too much.

The doctor’s responsibility does not stop when the hunger strike ends. Guidance should be continued for a few months, not every day but, for instance, weekly. Not only physical care is of importance, especially psychosocial guidance is often still as necessary as it was during the hunger strike.

Recent literature does not provide any data, because, understandably, ex-hunger strikers do not write about it. A description from the past is that by Vera Fichner from tsarist Russia, late 1900. The hunger strike was ended, because not all prisoners agreed to continue. After this, Fichner collapsed completely:

But though my system did not succumb to the great test during the actual fast, the after-effects were terrible. In addition to my mental depression, my nerves were completely disorganised; every controlling centre refused to act. In many ways my will-power seemed not to have become weakened, but to have disappeared entirely[9].

I know I have only discussed some aspects of a hunger strike. Hopefully, every doctor who becomes involved will find information in this outline which may improve professional assistance, both practically and medically as well as psychosocially, and not only during but also after the hunger strike, if – as all doctors hope for – it can be terminated in an acceptable way for the person concerned.

**Literature**

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ucerature (see below ) .

IV. DOCTORS

AND HUNGER

STRIKES; A LEGAL APPROACH

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Introduction

Hunger strikes - the refusal of nourishment in protest, usually by people in a dependent position like prisoners or refu­

gees - occur regularly in many countries. Occasionally, a hunger strike strongly attracts public attention, like the hunger strike among Vietnamese refugees in last months of 1991 in the Netherlands. This is, of course, related to the fact that a refusal of nourishment is not only emotionally charged, but also medically and socially. In addition, the aim of a protest often concerns socially controversial issues, e.g. granting political asylum.

Hunger strikes raise ethical and social questions, but also legal questions. These become increasingly prominent, just like ethical aspects, in prolonged hunger strikes when severe or even fatal consequences for the person concerned cannot be excluded. The most essential questions of hunger strikes concern the conflict between, on the one hand, the responsibility of public authorities and health professionals for the health of the people who are consigned to their care (or consign themselves to their care), and on the other hand the individual rights of a hunger striker based on fundamental values like human dignity and self-determination. Also from a legal point of view, this is the most essential area of tension. Against this background I would like to discuss whether a prolonged hunger strike may be ended by force-feeding, what applies if the hunger striker is no longer able to make an unimpaired decision, and finally the situation in which it is doubted whether the decision concerning the (continuation of the) hunger strike is free from coercion.

Forcible feeding

To what extent should we accept a refusal of nourishment? Is there a moment at which force-feeding is allowed? In the Netherlands coercion is generally rejected, in the government's policy as well as by assisting professionals and in literature (see below).

This does certainly not apply to all countries. The responsibility of the public authorities for the life and health of prisoners, or of doctors for their patients, is often considered more important than the right to autonomy. A typical example of this thought is Miller's view on hunger strikes in U.S. prisons. He also mentions the order in prisons as a justification for force-feeding, i.e. prisoners should not be allowed to manipulate the system by this means of protest.

According to the international declarations the principle is to respect to refusal of nourishment. However, there is no unanimity as to whether this position should be maintained to the bitter end.

Most radical is the Declaration of Tokyo (accepted by the World Medical Association in 1975), which is often mentioned in this context, about the role of doctors concerning torture and other inhuman or degrading treatment of prisoners. It determines that "where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially". However, the declaration does not explicitly state how a doctor should proceed if e.g. the hunger striker's mental capacity is undermined by confusion or reduced consciousness. Other declarations leave more room for force-feeding. According to the UN principles of medical ethics of 1982, health professionals should not participate in measures imposing physical force, unless such measures would be required to protect the health of the detainee, provided that application of the measures does not entail a risk to health. It is not clear whether force-feeding should be considered so risky as to fall outside the necessary protection measures as meant in this article.

The most recent declaration is the one adopted by the World Medical Association in 1991 in Malta which deals specifically with hunger strikes. It includes many rules worth considering concerning careful management and respectful treatment of hunger strikers. According to the declaration, however, if the hunger striker is unable to make an unimpaired decision, the doctor is free to do what he considers to be in the best interest of the patient. Still, he should clearly state beforehand whether or not he is prepared to refrain from intervention in emergencies. If necessary, the hunger striker can still choose another doctor. The European Convention on Human Rights is of great importance for Europe. Art. 3 prohibits inhuman or degrading treatment. As appears from decisions of the European Commission this does not imply that hunger strikers have an absolute right to be protected against force-feeding. In a decision in 1985 concerning force-feeding of a prisoner in Germany, the Commission considered that "force-feeding of a person does involve degrading elements which in certain circumstances may be regarded as prohibited by Art. 3. Under the Convention the High Contracting Parties are, however, also obliged to secure to everyone the right to life as set out in Art. 2". When the right to life clashes with the right to physical integrity, the Convention allows prevalence of the first within the laws of a State, according to the Commission, provided that the decision-making was careful and no more coercion is used than necessary.

Another decision of the European Commission in 1977, concerning extradition of a hunger striker from the Netherlands to Ireland, shows that public authorities are at least obliged to withhold any action that may deteriorate the hunger striker's condition. However, they are not obliged to counter the consequences of a self-imposed refusal of nourishment e.g. by force-feeding. Indeed, the decisions of the European Commission regarding art. 3 of the European Convention do not compel to, but at least allow the viewpoint that the decision to refuse nourishment should be respected by public authorities and professionals even in serious cases.

This is the general view in the Netherlands. It is important that it is also endorsed by the government, as appears from the guidelines of the Ministry of Justice of 1985 concerning prisoners on hunger strike. Legally, the standard
that no force-feeding should be applied can be based on art. 11 of the Dutch Constitution which stipulates the right to inviolability of the human body. Indeed, the Constitution offers the possibility to restrict the right to physical integrity, but legislation which allows physical force in the field of health care hardly exists, which is no coincidence. In our legal system, the right to autonomy is considered a fundamental right that should nearly always prevail. This is also established by rules that apply to situations other than hunger strikes, but similar in the sense that someone puts his life at risk. Dutch law recognizes the right of a patient to refuse life-sustaining treatment, in principle it also respects the refusal of life-saving intervention after a suicide attempt.

Does this also apply to situations in which the government is expressly obliged to protect health and life, as in prisoners? According to Miller, to whose opinion I referred before, the nature of imprisonment implies that prisoners have fewer rights than other civilians: “denying a prisoner the right to refuse force-feeding may be just one more right which is curtailed”. The view held in the Netherlands, however, is that conviction should not impose any restrictions on the prisoner’s autonomy other than those inherent to imprisonment. In this view, force-feeding is no more justified during detention than in other situations. I have dwelt on this issue, because it is so fundamental, and because internationally the opinions vary considerably.

Finally, it should be noted that not only the recognition of the right to autonomy is important, but also the practical interpretation. I refer to various issues important in the management of hunger strikers, such as the way they are treated, the possibility to be supported by someone they trust, avoiding undue pressure, etc. These issues are partly very subtle and impossible to deal with in legislation. Nevertheless, they are important to a doctor who becomes involved in a hunger strike. More details are provided in the Declaration of Malta.

Whether the decision to refuse nourishment and the person of the hunger striker is really respected, does not only depend on withholding force-feeding, but also on a careful and respectful management.

Incompetence resulting from the refusal of nourishment
Is intervention by artificial feeding allowed if, in consequence of his action, a hunger striker becomes confused or has even lapsed into a coma, and has lost his capacity to make a judgement? As stated before, the international declarations give precedence to the protection of health and life, or at least leave room for it. Some protection of the autonomy of the hunger striker is offered by the Declaration of Malta. It expects the doctor to clearly state his course of action, thus enabling the hunger striker to choose another doctor if he wishes so.

In the Netherlands, also in this matter the wish for nonintervention is usually respected. An example is the above-mentioned guidelines of the Ministry of Justice, which also point out the risks of artificial feeding in comatose patients. Literature sometimes mentions different views: one should intervene, or at least bring the hunger striker back to consciousness once again to enable him to reconsider his decision. Legally (and I think also ethically) these views are not tenable. If it is decided to refuse intervention, this should be respected, just like in other areas of health care the known wish of a presently mentally incapable person is respected even if it may have severe consequences or be fatal. However, it must be unquestionable that the hunger striker was willing to accept the far-reaching consequences when he was still capable of making a judgement. There is no absolute certainty that he would make the same decision if he could choose again. Nevertheless, if we go by former expressions of will, it implies that we accept a degree of uncertainty, however small this may be. The law accepts this uncertainty, because otherwise autonomy would not apply to people who have become mentally incapable.

It is therefore very important that the will of a hunger striker is perfectly clear when he is still capable of making a decision. For this purpose it is necessary that – I refer to the Guidelines of 1985 concerning prisoners and the Declaration of Malta of 1991 – the hunger striker is regularly and gradually informed and has the possibility to make (and reconsider) his decision. The decision of a hunger striker who is determined to refuse intervention when he becomes mentally incapable due to refusing nourishment should be recorded in an official report or medical file. The permanent wish for nonintervention can also be evident from a written statement of the person concerned. This nonintervention statement is legally not absolutely necessary. Also, a written statement should not replace gradual information and consultation. One should be careful not to make the hunger striker feel bound by his statement. On the other hand, a nonintervention statement can provide clarity about what the striker does refuse and does not refuse. Such a statement should in principle be considered lawful, like e.g. living wills are recognized as lawful. The law also accepts, for example, that a nonreanimation statement found with someone who has attempted suicide is respected (court of Zwolle, 13 December 1989).

According to literature and jurisdiction these statements are to meet certain requirements. For example, they should not be open to misinterpretation and should be applicable to the real situation. Cases in which a written statement is not readily accepted (as in the above-mentioned judgement by the court of Zwolle) mainly concern situations where there is nothing else but such a statement. In the case of a hunger strike, however, it is possible (and necessary) to provide information and consider the issue beforehand. An oral confirmation of the statement can be asked, if necessary without the presence of others who might influence the decision of the hunger striker.

A personal, free decision
This takes me to an issue I have not discussed so far, but still deserves attention. Apart from incompetence resulting from the refusal of nourishment, there are other factors that may cause doubt about the hunger striker’s capacity to make free and personal decisions, for example presumed mental incapacity or undue influence of group members or fellow-strikers. If one is prepared to accept the far-reaching consequences following from the principle of autonomy, one should also make sure that the hunger striker is able to make his own free choice regarding the continuation of the hunger strike.

The principle of law is that all people are considered competent, unless otherwise proven. This also applies to decisions that are considered undesirable by other people. In recent years, there has been increasing attention in the law for criteria to decide on incompetence (and the legal protection of such a far-reaching decision). In order to determine competence, it has been proposed to apply as a basic criterion that the person concerned should be able to understand the relevant information or to assess the foreseeable consequences of his decision. This approach seems justified, also in this case.

Mostly, the competence requirements will be fulfilled. If not, it implies that, also according to the Declaration of
Tokyo, intervention is allowed in emergencies resulting from prolonged resistance to take nourishment. It is evident that even in this situation intervention is still a problem, if only because of the risk involved in forced feeding. Pressure by group members will often raise doubt about the freedom to choose. A person who chooses to (continue to) refuse nourishment should of course not become a victim of group coercion. In practice it may be difficult to distinguish this from (legitimate) group support and solidarity. This resembles the doubts that may occur when a Jehovah’s Witness refuses a life-saving blood transfusion. In practice I think this difficult issue has to be solved at one’s own discretion. Sometimes there are – at least legally – possibilities to separate the person in question from the group, especially if it concerns prisoners. In other situations, one should look for ways to guarantee that the participants have room for decision, e.g. by talking to them individually and having them to confirm their wish to refuse nourishment without other people present.

Finally, I would like to say something about minors. Young children are represented by their parents. If they refuse nourishment, a measure to ensure child protection is obvious, regarding the threat of physical destruction. In older minors (Dutch law draws the line at 12 years) the will of the child plays a role. If the child wants nourishment, the refusal of the parents may be ignored. Most difficult is a situation where an older minor himself refuses nourishment. It is possible that this refusal has to be respected too. In my opinion a lot depends on the concrete circumstances: what is the parents’ opinion, to what extent should the child be considered competent to make its own decision, how dangerous is the situation?

**Final remarks**

I have described some important legal principles with regard to hunger strikes and issues that should play a role in the assistance of hunger strikers by doctors. On balance, it can be stated that the present law offers a clear frame for this assistance. However, it does not release doctors from all dilemmas that may occur during a prolonged hunger strike and for which they still have to consult their own conscience and professional ethics.

**Notes**

2. These principles also concern the role of doctors in protecting prisoners against torture. Like the Declaration of Tokyo, they are included in the – “Gedragsregels voor artsen” (“code of conduct for physicians”) (issued by the Royal Dutch Medical Association).
3. Editorial alterations have been made at the 44th World Medical Assembly in Marbella (1992).
4. For jurisdiction by the European Committee in this matter see: de Blois M. Het recht op de persoonlijke integriteit in het internationale recht [The right to personal integrity in international law], Thesis, Amsterdam 1988, esp. p. 229-235. De Blois himself argues that force-feeding cannot be rejected when the life of the person concerned is at risk.
5. Published in Nederlandse Jurisprudentie 1987, nr. 381.
7. Circular letter of 4 December 1985, Penitentiaire Informatie 1986, nr. 31. The matter had actually been discussed for years before this stand was taken.
8. According to Art. 15 Section 4 of the Dutch Constitution, he whose freedom has been legally abridged can be limited in exercising his basic rights when they are not compatible with the situation of detention. 9. Tijdschrift voor Gezondheidsrecht 1990/63.
11. See also the Declaration of Malta, 1991.

**V. THE “DOCTOR OF CONFIDENCE”**

The role of a doctor involved in a hunger strike is usually not limited to his specific expertise. The dependent position in which most hunger strikers, like asylum seekers and prisoners, find themselves implies that the relationship between the hunger striker and his doctor is not necessarily based on trust. After all, the doctor is often employed by the authority the hunger striker is opposing. It will not always be understandable to refugees, often coming from countries with repressive and violent governments, that their doctor is employed by the government which is in conflict with the hunger strikers. The conflict between the interests of his patient and those of his employer can also cause difficulties for the doctor (see also contributions by Smeeulers and Gevers).

It needs no explanation that hunger strikers need medical attention and treatment, which can be provided by the Medical Officer of the detention facility or the health authority responsible for asylum seekers.

In some cases it may be advisable to appoint a “doctor of confidence”, who is completely independent from any authority such as the Prison Administration or the Government Department responsible for refugee matters.

The feasibility of such an appointment and the decision of which doctor to invite depends much on the conditions of the country involved, the legal regulations and the preference of the hunger striker, who ultimately has to decide.

Experience in the Netherlands has taught that suitable “doctors of confidence” usually are general practitioners and public health doctors (e.g. from a District Health Authority) who have sufficient independence.

**Conditions for the proper functioning of a “doctor of confidence” are:**

1. **Total medical independence**

This implies: freedom to treat for the benefit of the hunger striker(s); organizational and informative freedom, also with respect to the management and staff of the organization the doctor is working for. This independence should be unquestionable, which is especially important if the organization (also) has a different and potentially conflicting relationship with the hunger striker.

2. **Willingness of the hunger striker to trust this doctor**

A confidence doctor does not necessarily agree with the aim of the hunger strike. He takes up a neutral position. However, this doctor promotes the medical and social interests. This also means that he will encourage communication: open contacts with the management (of asylum seekers centre or penitentiary) and media, receiving visitors and mail, good contacts with legal representative.

3. **Coping with dilemmas**

The “doctor of confidence” should be aware of and fully accept the very difficult, at time emotional and time-consuming involvement which his job may require. This involvement implies solving ethical dilemmas, providing empathy while
shunning political identification, showing creativity in contacts with legal advisers, authorities and media, and withstanding pressure to give in to political pressure.

VI. GUIDELINES FOR MEDICAL AND NURSING SUPPORT

1. Make sure the communication with the hunger striker is optimal. If necessary, call in an independent interpreter.
2. Assess whether a confidence doctor is needed, whose independent position should be stressed.
3. Try to get a clear picture of the cause and the objective of the hunger strike. Is it also a thirst strike? How long do they want to continue the strike? Have they been engaged in a hunger strike before, for example in the country of origin, if so, was it successful?
4. Is it a group strike? If so, is there a spokesperson? Are there any relatives? Are there any minors or pregnant women? Does the group allow the individual hunger striker to make his own decision? (Important to talk to everyone individually).
5. The non-medical interests can be taken care of by another agent: the lawyer or a representative of an organized interest group.
6. Suggest that this agent is always present when the hunger striker talks to the authorities opposed by the action or the media. Establish that this agent will act on behalf of the hunger striker, if the latter has become mentally incapable.
7. As a doctor, provide information on the mental and physical consequences of a hunger strike as soon as possible but no later than the third day, and in case of a thirst strike on the first day. A confidence doctor should have been appointed by then (if the hunger striker wishes so).

See chapter II for more information.

If the doctor of the refugee centre or detention facility is absent, the medical service of the institution (e.g. nurse) should call in a locum. This applies especially when risk factors (see 8) exist or in case of a thirst strike.

The importance of sufficient fluid intake (2 l/day) and good physical care should be stressed.

8. Determine whether there are any risk factors like diabetes, epilepsy, gastric disorders. A hunger strike can also be discouraged on strictly medical grounds in pregnant women or children.
9. Stress the importance of good medical and nursing support and make clear arrangements about it. This applies to physical examination, laboratory analyses, use of medicines and vitamins. Is only intravenous fluid supplementation accepted or also drip feeding?
10. It is sensible to make arrangements in an early stage about what should be done if the physical condition deteriorates or if the hunger striker lapses into coma.

Preferably, these arrangements should be put in writing.

If the hunger striker indicates not to accept artificial feeding – including forced feeding – or any medical treatment until the aim is achieved, it is necessary to point out that you cannot make such an important decision on your own. According to the guidelines (Declaration of Tokyo) you should insist on the opinion of an independent other doctor (the "second opinion"). If the mental capacity of the hunger striker is doubted, a judgement of a psychiatrist is required at an early stage.

A model for a "statement of non-intervention" is provided in chapter VII.

It is important to note that the doctor's professional secrecy applies to such a "statement of non-intervention". If a doctor wants this statement to be known to others, he requires the permission of the hunger striker. One should be particularly aware of this when dealing with the press and media (see 5: contact with the media by a non medical agent).

As the "statement of non-intervention" is meant to be used when the hunger striker is not able to express his own will any more, it is inherent to the statement that, if necessary and when the hunger striker is in coma, the statement can be made public by the doctor of confidence. This is inevitable in order to reach the purpose the hunger striker aims for by means of the statement.

11. The "statement of non-intervention" should regularly be evaluated in consultation with the hunger striker to allow changes (which may well occur due to circumstances or change of will).
12. Visit the hunger striker at least daily, pay attention to his physical condition. Parameters such as weight, fluid balance and blood pressure can also be determined by a nurse.

When and which laboratory analyses should be done, depends on the condition and pathology of the person concerned before the hunger strike began (especially disorders of the kidney functions). See chapter III for more information. If necessary, a local internist should be consulted.

A detailed medical file should be kept as well as a nursing report.

13. If a hunger strike lasts longer than, for example, one week, it is advisable to inform your colleagues (including locums, other GPs and specialists in the local hospital) about the strike.
14. If the doctor of confidence is not the hunger striker's GP, inform the latter – with permission of the hunger striker – about the course of the strike.

Indications for hospitalization

Firstly, it is important that the decision to hospitalize the hunger striker is made according to his wish. Therefore, it should be timely discussed.

The following parameters can be examined in a non clinical setting and each may give cause for hospitalization:

- weight loss of more than 10% of the original weight (more in people with extra reserves)
- disorders in consciousness/psychological decompensation
- signs of heart failure (dyspnea, oedema)
- signs of severe dehydration and kidney failure: orthostatic hypotension (difference in systolic pressure between recumbent and standing position of more than 25 mmHg)
- severe hypothermia: less than 35.5C
- severe bradycardia: less than 35/min, or irregular pulse

What to do after the hunger strike

15. Advise on refeeding: small frequent portions of easily digestible food, about 3,000 kcal a day.
16. Evaluate the hunger strike with the hunger striker. Repeat this after, for instance, one week (depending on the mental condition and the "result" of the hunger strike).

It is up to the doctor of confidence to decide about the desirability of a written statement in which the doctor states that he refuses to accept liability for any permanent damage in the hunger striker. A doctor of confidence in Germany has been charged to be responsible for sustained damages. The legal status and desirability of such a statement depends on the situation and the legal circumstances in the country concerned.

Such a statement formulated by a doctor still does not protect him against all liability. The concrete actions of a doctor will still be essential. It seems to be more important to act according to the professional standards and to report everything in a file, than to have a statement as mentioned above. If the damage results from a mistake by a doctor, he is responsible, with or without a statement.

In the case of death of the hunger striker, it is an unnatural death. Therefore, postmortem examination should be performed by a medical examiner or the coroner. In general autopsy will not be necessary if all medical data are recorded.
VII. MODEL FOR A "STATEMENT OF NON-INTERVENTION"

Date: 

Interpreter: 

Today I, the undersigned ______________________ (name, date of birth) 
declare that I have refused nourishment/fluid since ____________________ (date) 

My motive for doing so is the following: 

(mention motives and courses followed so far). 

I have informed my ___________ (family) and lawyer of my decision. 

I declare that I sign this statement by my own will and that I am aware of the consequences of the refusal of nourishment/fluid for my health. 

If I lose consciousness as a result of the refusal of nourishment/liquid, I want my doctors to know the following: 

□ A. I want all means to be applied in order to restore me to health. This implies that my refusal of nourishment has ended. 

□ B. I want to be hospitalized for observation and nursing, but not to receive artificial feeding. I want to continue my refusal of nourishment also in this situation. 

• I do allow ☐ / not allow ☐ administration of fluid by drip or stomach tube. 

• I do allow ☐ / not allow ☐ administration of medically necessary medicines. 

□ C. I do not want to be hospitalized under any circumstances. I do want medical support, including artificial feeding. 

□ D. I do not want to be hospitalized under any circumstances. I also do not want to receive artificial feeding. 

• I do allow ☐ / not allow ☐ administration of fluid per drip or stomach tube. 

• I do allow ☐ / not allow ☐ administration of medically necessary medicines. 

I agree that my doctor will regularly evaluate whether this statement still represents my opinion. 

I do give ☐ / do not give ☐ permission to my doctor to make this statement public, when I am no longer able to express my own opinion, if necessary to secure the purpose of this statement. 

Signature: 

_________________________  ___________________________  ___________________________ 
Hunger striker  Doctor of confidence  Psychiatrist 

Independent doctor 

Evaluation of this statement 

Date: __________________ Confirmation/alteration: __________________

Date: __________________ Confirmation/alteration: __________________

*: tick where appropriate
### VIII. DATA RECORDING PROTOCOL

| Name: _______________________________ |
| Date of birth: ______________________ |
| Country: ___________________________ |
| Language: __________________________ |
| Interpreter needed: __________________ |

**On hunger strike since:** __________________

**Motive:** __________________

**Aim:** __________________

**Relatives on strike:** __________________ / not relevant

**Spokesperson of the group:** __________________ / not relevant

**Lawyer/agent:** __________________

**Medical history / risk factors / medicines / previous hunger strikes:** __________________

**Conclusions physical examination:** __________________

**Information on the consequences of a hunger strike, etc., provided on:** date: __________________

**Laid down arrangements regarding assistance in writing, date:** __________________

**Daily measurements by nurse:**
- weight __________________
- **RR** __________________
- pulse __________________
- temp __________________
- liquid intake/frequency __________________
- general impression/clinical appearance __________________
- complaints __________________
- mental condition __________________

**Recommended laboratory analyses about 7 days after the beginning of the hunger strike:**
- Blood: Hemoglobin, color indices, WBC, Glucose, Albumin, Creatinine, Potassium, Sodium, TSH (in prolonged hunger strikes)
- Urine: (24h.) quantity, sugar, ketones, protein

The analyses should be repeated depending on the symptoms.
IX. ADDRESSES AND PHONE NUMBERS

[Chapter IX's text has not been included in this supplement. We refer readers to the original booklet which can be obtained from the Johannes Wier Foundation.]

X. INTERNATIONAL RULES CONCERNING HUNGER STRIKES AND FORCED FEEDING

Declaration of Tokyo (World Medical Association 1975)

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinctions as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make confession, or for any other reason.

Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.

5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement 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 judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors, to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

Declaration of Malta on Hunger Strikers (adopted by the 43rd World Medical Assembly in Malta in 1991 and editorially revised at the 44th Assembly in Marbella in 1992)

Preamble

1. The doctor treating hunger strikers is faced with the following conflicting values:

1.1 There is a moral obligation on every human being to respect the sanctity of life. This is especially evident in the case of a doctor, who exercises his skills to save life and also acts in the best interests of his patients (Beneficence).

1.2 It is the duty of the doctor to respect the autonomy which the patient has over his person. A doctor requires informed consent from his patients before applying any of his skills to assist them, unless emergency circumstances have arisen in which case the doctor has to act in what is perceived to be the patient's best interests.

2. This conflict is apparent where a hunger striker who has issued clear instructions not to be resuscitated lapses into a coma and is about to die. Moral obligation urges the doctor to resuscitate the patient even though it is against the patient's wishes. On the other hand, duty urges the doctor to respect the autonomy of the patient.

2.1 Ruling in favour of intervention may undermine the autonomy which the patient has over himself. Ruling in favour of non-intervention may result in a doctor having to face the tragedy of an avoidable death.

3. A doctor/patient relationship is said to be in existence whenever a doctor is duty bound, by virtue of his obligation to the patient, to apply his skills to any person, be it in the form of advice or treatment. This relationship can exist in spite of the fact that the patient might not consent certain forms of treatment or intervention.

Once the doctor agrees to attend to a hunger striker, that person becomes the doctor's patient. This has all the implications and responsibilities inherent in the doctor/patient relationship, including consent and confidentiality.

4. The ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare. However, the doctor should clearly state to the patient whether or not he is able to accept the patient's decision to refuse treatment or, in case of coma, artificial feeding, thereby risking death. If the doctor cannot accept the patient's decision to refuse such aid, the patient would then be entitled to be attended by another physician.

Guidelines for the management of hunger strikers

Since the medical profession considers the principle of sanctity of life to be fundamental to its practice, the following practical guidelines are recommended for doctors who treat hunger strikers:

1. Definition

A hunger striker is a mentally competent person who has indicated that he has decided to embark on a hunger strike and has refused to take food and/or fluids for a significant interval.

2. Ethical behaviour

2.1 A doctor should acquire a detailed medical history of the patient where possible.
2.2 A doctor should carry out a thorough examination of the patient at the onset of the hunger strike.

2.3 Doctors or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon him suspending his hunger strike.

2.4 The hunger striker must be professionally informed by the doctor of the clinical consequences of a hunger strike, and of any specific danger to his own particular case. An informed decision can only be made on the basis of clear communication. An interpreter should be used if indicated.

2.5 Should a hunger striker wish to have a second medical opinion, this should be granted. Should a hunger striker prefer his treatment to be continued by the second doctor, this should be permitted. In the case of the hunger striker being a prisoner, this should be permitted by arrangement and consultation with the appointed prison doctor.

2.6 Treating infections or advising the patient to increase his oral intake of fluid (or accept intravenous saline solutions) is often acceptable to a hunger striker. A refusal to accept such intervention must not prejudice any other aspect of the patients health care. Any treatment administered to the patient must be with his approval.

3. CLEAR INSTRUCTIONS

The doctor should ascertain on a daily basis whether or not the patient wishes to continue with his hunger strike. The doctor should also ascertain on a daily basis what the patient's wishes are with regard to treatment should he become unable to make an informed decision. These findings must be recorded in the doctors personal medical records and kept confidential.

4. ARTIFICIAL FEEDING

When the hunger striker has become confused and is therefore unable to make an unimpaired decision or has lapsed into a coma, the doctor shall be free to make the decision for his patient as to further treatment which he considers to be in the best interest of that patient, always taking into account the decision he has arrived at during his preceding care of the patient during his hunger strike, and reaffirming article 4 of the preamble of this declaration.

5. COERCION

Hunger strikers should be protected from coercive participation. This may require removal from the presence of fellow strikers.

6. FAMILY

The doctor has a responsibility to inform the family of the patient that the patient has embarked on a hunger strike, unless this is specifically prohibited by the patient.
Dear reader,
The Johannes Wier Foundation for Health and Human Rights (JWF) would like to know your opinion about this manual and be informed about your experiences in the assistance to hunger strikers. We would therefore appreciate if you would fill in this evaluation form and send it to:

On this manual:

Do you think this manual is useful? □ yes □ no
Do you have comments or suggestions for this manual? □ yes □ no
Please specify which:
Could you use the manual in a case of assistance to hunger strikers? □ yes □ no
If you missed anything in the manual, please specify:
How have you been informed about the existence of this manual?

On your experience in the assistance to hunger strikers:

Could you identify country and place?
Did the hunger strike take place in a detention centre/refugee centre or other place?
Could you please describe the hunger strike (duration, number of persons, fatalities)

Did you have, as a doctor, professional independence? □ yes □ no
Did you experience pressure to influence the hunger strike? □ yes □ no
If so, please describe what kind of pressure?

Have you been asked/forced to apply force-feeding? □ yes □ no
If so, please describe how this took place:

Did you receive support from your professional organisation? □ yes □ no
Did you receive support from any other organisation? □ yes □ no

PLEASE TURN OVER
If you have any other information about your experience in assistance to hunger strikers, please describe:

_________________________________________________________________________

_________________________________________________________________________

Name and address:
Please fill in your name and postal address:

_________________________________________________________________________

_________________________________________________________________________

Thank you very much for returning this form. Your information will be kept confidential, and is useful for us in updating the manual.

We would like to express our appreciation for your cooperation by sending a free copy of one of our mission reports: please indicate your choice:

☐ Health and human rights in Romania (1992)
☐ South Africa 1991 - Apartheid and health care in transition
☐ Yugoslavia - Mistreatment of Ethnic Albanians (1991)
☐ Albania - Health and Human Rights (1992)
☐ Tazmamart, fort-militaire secret du Maroc (1993)
The Rehabilitation and Research Centre for Torture Victims is an independent, humanitarian, non-political organization established in 1982 to help victims of torture and to contribute to the prevention of torture. Its main objectives are to rehabilitate persons who have been subjected to torture, to rehabilitate their families, to instruct Danish health professionals in the examination and treatment of persons who have been subjected to torture, and to carry on research into the nature, the extent and the consequences of torture.

The International Rehabilitation Council for Torture Victims is a private non-profit foundation, created in 1986 by the RCT. The objectives of the foundation are, on an international basis, to support research into all aspects of torture, to support education and training of health professionals and of other relevant personnel in the medical, social, legal and ethical aspects of torture, and to serve as an international clearing house for information about torture activities.