Hunger Strikes: Learning Objectives

Hunger strikes are a **way of fasting** that involves some form of protest. They are usually undertaken by prisoners or other persons in a custodial setting. There are different types of hunger strikes; some of them involve complex situations and conflicts. **Prison doctors** need to know about the **clinical** situations and physiology of fasting, but also have to be aware of the **ethical** issues at stake. This chapter discusses the issues at stake and presents the medical and ethical guidelines that concern hunger strikes that all doctors should know about.

Physicians should be able to answer the following questions after studying this module on hunger strikes:

- What exactly is a "**hunger strike**"? What are the **different forms of fasting** encountered among prisoners?

- What clinical frameworks should be defined for the **length and type of fasting** involved in "hunger strikes"?

- What are the different **motives** behind "hunger strikes"? Why and how are they relevant to the medical management of hunger strikes?

- What **pressures** are hunger strikers submitted to in the prison context? What influence do or should their **families** have on their fasting?

- What are the **duties of a physician** caring for hunger strikers? How does a prison doctor's loyalties differ from an outside doctor's?

- What **counselling** should a physician give to a hunger striker? Should a physician try to dissuade a hunger striker from his/her fasting? If so, in what circumstances?

- Are hunger strikes comparable to **suicidal behaviour** – and should they be dealt with as such?

- What are the different clinical **phases** of a full hunger strike? When should medical monitoring begin, and what should it consist of?

- What are the main **medical texts of reference** that give ethical guidance to physicians in prolonged hunger strikes?

- What is the difference between **artificial feeding** and **force-feeding**? When, if ever, are they justified during a hunger strike?

- Is **medical "paternalism"** ever justified in a hunger strike situation
- How does a physician implement **therapeutic resuscitation** when a hunger striker decides to resume nourishment?

Table of Contents

The chapter on hunger strikes is divided into the following five sections:

Introduction and terms of reference

The colloquial term “hunger strike” involves several different situations, which it is necessary to clarify. Just as important, it needs to be clearly stated what form of fasting **does in no way qualify** as protest fasting, as is the case when fasting is a symptom or manifestation of a psychiatric condition.

People in situations of coercion or custody, as has been stated, are the ones that most usually undertake hunger strikes. For the purposes of this module, only **prisoners** shall be referred to here. Obviously the ethical guidelines and clinical references will also apply to, for example, asylum seekers or immigrants in custody or any other hunger strikers.

Hunger strikes in **prisons** are always tricky situations, whether they involve common-law prisoners or “political” prisoners. In order to define ethical principles and guidelines for management, it is first necessary to understand the basic **clinical frameworks** that relate to the many different forms of fasting.

After setting down definitions, it is necessary to consider the different forms of fasting from the **prisoners’ perspective**. The motivations behind, and the perseverance in, a hunger strike can differ greatly according to the situations of the prisoners fasting.

Pressures can be exerted on hunger striking prisoners – not only by the prison authorities, but also by the internal prisoner hierarchy. **Family** members and peer groups also have their influence, one way or the other.

Physicians have ethical duties to respect when dealing with hunger strikers. Prison doctors need to be able to act independently from the prison authorities if they are to carry out their work efficiently. **Trust** is a key issue when dealing with hunger strikers. The physician will often have to act as mediator between prisoner, authorities and even family members. They furthermore have specific clinical duties to perform and will often be in a position to facilitate “face-saving” opportunities for the benefit of all involved.

Physicians have to know and fully understand the background to **international guidelines** for doctors set down by the **World Medical Association**. In some particularly complex situations, it will be necessary for physicians to use their sound and moral judgement so as best to help hunger strikers in their care – sometimes at the risk of being perceived as “paternalistic”.

Finally, physicians need to know the different **stages of total fasting**, so as to be able to give medical counselling to such hunger strikers. Issues such as when or when not to **resuscitate**; the difference between **artificial** and **force** feeding; when to medically monitor a hunger striker in hospital; are all issues that need to be clearly understood by any physician involved in caring for hunger strikers.

Definitions 1: food refusal versus hunger strike

The term **hunger strike** refers to a form of protest or demand associated to some form of **fasting**. A prisoner, or group of prisoners, decides at some point to stop taking nourishment and declare a **fast**, with the intention either of **protesting** against some action or circumstance, or with the intent of **demanding** something that would not otherwise be obtained without pressure. The term "hunger strike" is widely used to cover very many – and very different – forms of "protest fasting".

The term hunger strike is a misnomer. The sensation of "hunger" is only really relevant in the first few days of fasting – and rapidly diminishes as ketosis produced by the fasting "erases" hunger pangs. The refusal to ingest food and/or water is motivated by some form of protest – hence the syndicate-related term "strike" – which assimilates the protest to a kind of "industrial action".

Different forms of protest fasting thus come under the general **lay term** "hunger strike". Inversely, several forms of fasting do not usually qualify as protest fasting. The following conditions are **sine qua non** for any fasting person to be considered as a "hunger striker":

- The person has to be **sound of mind**, in full possession of his/her **mental faculties** and **free of any psychiatric or mental disorder**. By definition, any mentally unbalanced person refusing food should be considered as needing medical attention – and not as a hunger striker !

- Conditions such as melancholic depression, some psychoses, anorexia and suicide by starvation, and other similar disorders, that often involve fasting, therefore do **not** qualify as "hunger strike" situations.

- Fasting for religious reasons has been confused, often because of cultural ignorance, or perhaps language miscomprehensions, as "hunger striking", which it obviously is not.

Protesting by way of fasting – or what the general public, the media, and often the prison authorities commonly call "hunger strikes" – involves two main categories of prisoners, usually quite different in mentality and motivation:

- "**Food refusers**" are prisoners who fast and "make noise" about it. Alone, or leading groups of other prisoners in their action, their intent is to **protest and demand** something from the authorities, something they know they will not get unless they can apply pressure on them.

  Food refusers very often go on strike for what may seem like "petty demands". Sometimes they fast for reasons of principle. There may occasionally be major issues at stake. The main characteristic of this type of hunger strike is that the food refuser **has not the slightest intention of coming to harm** by the fasting. In this sense, they usually trust the prison doctor and may even request medical assistance in monitoring their fast.

Food refusers who make a habit of "going on hunger strike" essentially make a wager on the credibility of their[1] strike, as the authorities may tire of what they see as blackmail and may end up calling their bluff. In the words of one prison doctor involved in "true blue" (political) hunger strikes: "habitual food refusers are the ones who give "hunger strikes" a bad name…" (as they habitually become an annoyance to the prison system for what are usually petty demands…)

There may be, however, **food refusers** (i.e. with no intention of fasting to death or even to the point where they may harm themselves), who nevertheless use strict fasting limited in time as a true form of protest. In coercive contexts where such protest is "punished" by, for example, a bout of solitary confinement (often in particularly uncomfortable settings…) food refusal will of course *not* have the same "bad name" as in the petty cases. The point here is that it is important for a prison doctor to always determine for him/herself what the exact motives for not taking nourishment are, and not dismiss fasting prisoners merely on hearsay or "reputation".

- "Real hunger strikers", or rather, those prisoners who go on what the general public perceives as "true blue" hunger strikes *à la Gandhi*, are willing to challenge the authorities by obstinately refusing nourishment and "going all the way". These prisoners are typically and almost always "political prisoners"[2]. Individually, or in groups, they may differ in the chosen mode of fasting. The most determined ones are willing to sacrifice their health and even their lives for a cause or for their principles. The less determined ones may choose different, "softer" forms of fasting. "Rolling" hunger strikes, where different prisoners skip different meals on a rota basis, are such a form of "soft" hunger strike.

  Political "hunger strikers" often mistrust – in some cases justifiably, and in some cases not – prison doctors, whom they see as belonging to the "repressive system". It is these prisoners who will pose a serious challenge to medical ethics, as their fasting will inevitably raise juridical issues, medical responsibility and the ethical question of force-feeding.

[1] Food refusers are essentially male.
[2] Increasingly, however, common-law prisoners are also undergoing such hunger strikes, whereas before this was very rare.

Definitions 2: Voluntary Total Fasting

The term "**voluntary total fasting**" is another term often used to describe hunger strikes'". All three components of this term need to be defined, as there are situations where the fasting may not be total, may not be voluntary, and may not even qualify as genuine "fasting".

The **voluntary** aspect should be self-evident, as it can be argued that a hunger striker can hold his or her body hostage only if s/he "agrees" to do so – all the more so if the fasting goes on for a certain duration.

In collective hunger strikes, and particularly when "political" prisoners are involved, the voluntary aspect of the fasting is a particularly "touchy" issue. Prisoners have been known to be forced by fellow prisoners to "go on hunger strike". Coercion may be exerted on fellow prisoners in more subtle ways than by mere force, obliging or blackmailing them to comply. In some cases, the pressures on hunger strikers are such that it becomes virtually impossible for a prisoner to quit of his/her own free will.

This "voluntary" aspect of a hunger strike is a key element to have in mind when evaluating the medical situation and making decisions. A prison doctor who suspects a -- or several -- hunger striker(s) is/are being submitted to coercion by fellow prisoners should insist on speaking to all fasting prisoners in private. In the confidentiality of a medical consultation, a prisoner being intimidated may – if he trusts the doctor – appeal to him/her to "do something" to get him "off the hook". Circumstances and background will obviously influence what action to take, but the duty of the prison doctor in this case will be to do everything possible to help the prisoner, without betraying this trust. In some cases the easiest solution may be to place such a fasting prisoner in hospital on some medical pretext – thereby extracting him from the influence of the others – allowing him to resume nourishment on "medical grounds".

Arguably, in some cases, prison doctors will *not* have the trust of prisoners. Sometimes this will be justified, but very often not. In such a situation, and if coercion of fasting prisoners is suspected, a prison doctor should seek to have an outside doctor, trusted by all parties, come in to ascertain whether the fasting is truly voluntary. Once all has been done to allow fasting prisoners to express their will freely, in the privacy of the medical consultation with a doctor they trust, their decision one way or the other should be respected. There may be, fortunately rare, cases of coercion that cannot be detected this way, but to open a loophole for such exceptions (by leaving the decision to intervene solely with the doctor's "gut-feeling") would be counter-productive in many more cases than it might be possibly useful.

The term **total**[3] can erroneously imply no ingestion of any solid or liquid during the duration of the "strike". In fact "**dry**" hunger strikes are quite rare. The body cannot survive more than a few days without any water, and death would occur within the first week in most cases.

[3] See Clinical framework 2: a diet scale for hunger strikes

“Total fasting” involves taking only water, in abstention of all foodstuffs. Salt (either NaCl alone or a combination of minerals) is often added to the water. Few are the “hunger strikes” that strictly respect **total** fasting. Sugar and other sweet substances (i.e. calories, e.g honey) are sometimes added as well, despite the contradiction with the notion of “total fasting”.

Such **partial** or **non-total** fasting may be intentional from the start, in the sense that the food refusers do not want to harm their bodies. It may be equivocal and culturally influenced by different notions of what fasting really implies. More often, it may be fully intentional, so as to be able to have more leeway for negotiations. Fully conscious that the moral pressure exerted by “hunger strikes” can only work over a certain duration of time, hunger strikers often decide to take some form of liquid nourishment (sugar, honey, …) and only abstain from solid food. Such partial fasting can, however, if prolonged sufficiently, also lead to death in the long run.

Such “partial fasting” is often considered “cheating” by the prison authorities – and sometimes even by physicians themselves. This may lead to some controversy over the principle and the “seriousness” of the hunger strike itself. Prolongation of the period of negotiation during the “hunger strike” may however often be beneficial to the final outcome, and help avoid deaths.

Clinical Framework 1: A "**diet scale**" for hunger strikes

When speaking about hunger strikes in the colloquial sense, it is necessary to define to the type of fasting involved. This is independent of the "seriousness" of the resolve behind the fasting. A "food refuser" may well refuse all forms of sustenance besides plain water – at least for a certain period of time. Inversely, a politically motivated "hunger striker" may decide to ingest quantities of milk and honey – and even nutrients such as eggs – all the while convincing himself that this qualifies as a genuine "true blue" hunger strike".

For reasons of medical credibility, there is a need to define which form or forms of fasting ("hunger strikes") truly "qualify" as **total** fasting.

The very definition of "eating" varies between different countries and different cultures. In some places, "eating" implies ingesting something solid - i.e. something that has to be "chewed" before being swallowed. This condition often is followed by another one: "eating" implies ingesting some food that is "hot". Variants of these beliefs are to be found in different parts of the world[4].

Three main types of "hunger strike" food ingestion need to be defined:

- the **"dry" hunger strike**, i.e. no food or water of any kind…
- the "**total**" hunger strike, i.e. no solid food and **only water**, with or without salt… Normally this would mean also no sweetening of any kind either: i.e. no calories at all.
- the "**non-total**" hunger strike: which means practically any other type of fasting than the two strict categories above.

There should be no mistaken qualification of the seriousness of hunger strikes based **only** on the above criteria. The duration of fasting is the crucial element in any prolonged hunger strike. A "non-total" strike may be just as determined as a "total" one – and lead to deaths as well, only at a much later period.

The fact that a "non-total" hunger strike allows more time for negotiations is a positive – not a desultory – position. Physicians need to keep this in mind, and not malign "non-total" fasting as "cheating".

These distinction in diets need to be made here as a question of credibility for medical staff, notably the physicians who may find themselves involved in hunger strike negotiations, and need to have terms of reference. A physician who would claim hunger strikers had been on "total fasting" for "six months" would destroy his/her own medical credibility. S/he should however understand that partial fasting for such a lengthy period of time would provide that much more time to perhaps find a face-saving solution for all involved – and thus be instrumental in avoiding fatal outcomes

[4] It would follow that having cold vegetable soup followed by ice cream liberally doused with honey would not be incompatible with a "hunger strike" in some places.

Clinical Framework 2: A "**time scale**" for hunger strikes

If doctors involved in “hunger strikes” are to be in an authoritative position to state the ethical principles that apply to the situation, they need to have baseline definitions founded on nutritional physiology. Once the dietary requirements of **fasting** have been defined, it is necessary to define **time** limits at both ends of the hunger strike.

Skipping a meal or two may well be a form of “food refusal” – and therefore a form of protest – but such short-lived, episodic fasting does not qualify for the term “hunger strike”, which implies fasting over a longer duration of time.

There are no set criteria for the minimum duration for protest fasting, so reference should be made to physiology. A healthy, normally nourished adult, without any medical contra-indication to prolonged fasting, should be able to fast totally (taking only water) for 48 – 72 hours. The onset of ketosis occurs around this time. Ketosis is discernible clinically on the breath, and also by laboratory assay in the urine. Ketosis subdues the voracious sensation of hunger experienced during the first 2 – 3 days of total fasting. It could thus be argued that **total fasting** (i.e. taking water only) for longer than **48 – 72 hours qualify** on metabolic grounds for the term “hunger strike”.

This would eliminate the confusion with **short-lived fasts** – most of which peter out by themselves before 72 hours. Thus the term “hunger strike” would metabolically apply to both “food refusal” and “genuine hunger strikes” as defined previously. The crucial distinctions between these two forms are not readily understood by the general public, or even by many doctors. In many cases, it will not be relevant – or be even counter-productive – for physicians to insist on distinguishing between the two, as food refusers will not want to “lose face” by appearing to be less determined than “real” hunger strikers”…

Physicians involved with “hunger strikes” should not necessarily contradict or challenge “partial” hunger strikers on the non-total quality of their protest fast. Acting in the best interests of their patients may occasionally imply “looking the other way” as to how “strict” the fasting actually is. Physicians should not, however, let themselves be manipulated by either the authorities or the “hunger strikers and give erroneous clinical testimony to situations that obviously defy normal nutritional physiology. Physicians involved with hunger strikes should be familiar with the different stages of total (water only).fasting, thus helping them to avoid manipulation by any of the parties involved.

Defining a medical “time limit” for the beginning of a “hunger strike” is simple enough. There is also a time frame for the terminal end of total fasting, and doctors should know how long the human body can actually last when totally deprived of nourishment, and ingesting only water.

The fatal outcomes of terminal total fasting were first documented during the 1980 and 81 hunger strikes in Northern Ireland. Death occurred during these fasts anytime between 55 – 75 days. Similar experiences have confirmed this wide time bracket – the three-week interval being due to differences in initial

physical constitution, and individual adaptation. It is not possible to predict any time span more precisely.

It follows then that death occurs some time after six full weeks of total fasting (see further on). This corresponds to the final clinical stages of fasting during which the hunger striker may no longer be capable of discernment. It also follows that survival any time after ten weeks of total fasting is practically impossible. Here again, physicians need not insist on this fact, in the interest of on-going negotiations between hunger strikers and the authorities. It is important, though, that physicians not deceive themselves about the true time limits of total fasting, so as to retain medical credibility when communicating with other physicians.

Pressures on hunger strikers

[here comes figure 2: pressures on hunger strikers]

Prisoners who go on hunger strikes are submitted to many different "pressures" in the prison setting. Some of these pressures are quite obvious, as for example the prison authorities, who will obviously want to try to stop any form of protest they see as troubling "order and security".

Other pressures may come from prison staff, such as prison guards, who may exert influence o prisoners at a lower level. Taunts and derision from guards may target fasting prisoners, and lead to the "hardening" of positions. In some cases, hunger strikers may have to be removed from such pressures, for example to a medical facility, in order to "calm the situation" and facilitate constructive dialogue.

Pressures may and do also come from fellow prisoners *not* on hunger strike. This may involve the prisoner "hierarchy" – or just "peer" pressure in many ways symmetrical to the taunts and jeers from prison guards. In the case of the prisoner hierarchy, experience has shown that some prisoners are actually coerced into "volunteering" to go on hunger strike[5].

In prison hunger strikes, physicians should as far as possible strive to see and interview **all** fasting prisoners **individually**, so as to ascertain whether they are indeed fasting voluntarily. Prisoners who are being coerced by fellow inmates to join, or pursue, hunger strikes may then be counselled, and if necessary a medical pretext be found to get them off the strike. This may be the only way for such prisoners to avoid rejection, punishment or worse from fellow prisoners or from their internal "hierarchy".

This need for independent medical counselling implies being able to **talk in private** to all hunger strikers, and not just their "representatives". Prisoner "bosses" are often reluctant to allow such talks, as obviously this undermines their "authority" with the prisoners. This is possibly the most complex situation to deal with – how to know when hunger strikers are indeed genuine "volunteers". Such "boss" and peer pressures are very common in prisons.

Finally, pressures may also come from the "media", in situations where they are in the picture. Prisoners, or their families, may want to alert the media, hoping this will heighten the pressure on the prison authorities to make concessions – and thereby allow the hunger strike to stop.

[5] See comments on this issue in section "Definitions 2"

The role of the family in hunger strikes

Hunger strikers are also sometimes submitted to pressures from their families. Family pressure can either be in support of the prisoner's fasting or it may on the contrary try to get the authorities to actively intervene to "save the prisoner's life" no matter what the prisoner has determined.

Influence from family members is always possible, and physicians attending hunger strikers may find it useful to communicate with them whenever possible. Advice from, and direct contact with, the family may indeed give physicians crucial background allowing them to make the best decision.

There may be cases when physicians will find themselves at odds between a family demanding intervention and a prisoner refusing it. In many countries, the family of a prisoner on hunger strike has the legal right to require medical intervention. While keeping this in mind, physicians should never forget that they have a professional commitment to the patient first and foremost.

There will also be cases where families obviously support their prisoner's fasting, and indeed may be quite openly "lobbying" to get full outside attention for the hunger strike. In this case, the prison authorities may be reluctant to allow such family visits to continue at all. Here physicians may also have to play their role of "intermediary". Although pressures on "hunger strikers" should be kept to a minimum, this should never be used as an excuse by prison authorities to suppress family visits.

Prisoners' motivation 1: the reasons behind the hunger strike

There are some points that are common to all forms of protest fasting. The aim of a hunger striker is to exert **pressure** – mainly moral pressure – on an **authority** that is seen to be in a position to grant something, or to modify a situation the hunger striker (or food refuser) objects to. The pressure is to be exerted on this authority by outsiders perceived as being in a position to influence that authority. These "**spectators**" – who may be family members, politicians, members of the media or anyone else – are the outside element in this "**triangular situation**" common to all hunger strikes.

Prisoners who fast in order to protest, or demand something from the authorities, are (or see themselves) in a coercive situation that has little room for any protest. Most prison situations leave little leeway for complaints or dissent, and fasting may be the only form of remonstration left to prisoners. This is particularly true when "political" prisoners are involved.

Hunger strikes have a reputation of being a "non-violent" form of demonstration. In fact, if they are pushed to the extreme limits, they involve what amounts to a hostage situation, where the hostage-taker and the hostage are one and the same person. Thus many prison authorities consider hunger strikes as a form of aggression – an "**aggressive form of blackmail** cum **hostage**" situation. In this case the threat of violence is directed against the striker himself, and not directly against the authority in question.

If physicians are to act efficiently when involved with hunger striking prisoners, it is paramount for them to know what the true **motives** behind the protest are, and how serious the fasting is.

This will be possible only if they have the trust of the hunger strikers. Prison doctors in particular, if they have this trust, will often be in a position to "negotiate out of the spotlight", and perhaps obtain concessions from both sides, thereby avoiding confrontation. This is only possible if the physicians have the full story. Here prison doctors may be in fact in a privileged position. They should have the trust of the prisoners, and they should also have the confidence of the prison authorities. Outside doctors may have the former, but most often not the latter. This is a case where the often "maligned" prison doctor may play a crucial role, as long as he or she manages to keep the trust on both sides.

By knowing exactly how "serious" the hunger strikers are in their fasting, physicians will be able to evaluate how urgent the need for mediation is, and act accordingly.

When the demands of the hunger striker(s) are very obviously out of reach, the prison doctor should not fall into the trap of leading the prisoner(s) on, and insinuating that a solution is achievable through "medical mediation". The attitude to have then should be to clearly declare the medical staff outside the negotiations, and to clearly tell that to the hunger striker(s). In this way, the other, crucial, medical role of providing "enlightened information" could still be performed.

Prisoners' motivation 2: the physician's role as "mediator"

Learning the true motives behind the fasting is therefore often the key to finding a solution. A great deal of "**face-saving**" is involved in most hunger strikes – and it may often be the physician who is in a position to find a way out of what may otherwise be an inextricable show-down.

It will **not**, however, be the physicians role to betray the trust of the prisoners who confide in them. For example, physicians interviewing hunger-striking prisoners who would reveal the names of ringleaders whose identities would otherwise not be known to the prison authorities, would lose any trust placed in them by the prisoners. A physician has to decide from the start whether he or she can act as a medical intermediary between hunger strikers and the authorities. If this is not possible, they should certainly not abuse their medical function by pretending to be in such a position. In some cases, physicians may decide to offer prisoners "pseudo-medical alibis", such as transferring unwilling hunger strikers to hospital, away from the pressures of others.

Hunger strikes only have a chance of obtaining results if there is enough time for the authorities under pressure to react. In this sense, duration is of paramount importance to the "hunger striker", all the more so in a situation where the fasting prisoner may have difficulties in making his plight known to those outside who can try to influence the authorities.

The moral "coercion" of the hunger strike can only exert itself if the fasting lasts long enough. It may therefore be essential for hunger strikers to ensure as prolonged a fast as possible. "Dry hunger strikes" (no solids, no water) are definitely not useful in this sense. Even though one might think that the "threat" to the authority is greater – implying that "blackmail death" may occur sooner without water – the very short duration of such a "strike" would not be sufficient to force any decision.

Authorities recognise the importance of the time element as well. Different time lapses are defined in different countries, but generally speaking, authorities only acknowledge a fast by a prisoner as amounting to a "hunger strike" if it has lasted longer than 48 – 72 hours. This more or less corresponds to the criterion defined earlier. Many countries have strict reporting and monitoring procedures once the fasting has lasted this long. From the authorities' point of view, this is usually for reasons of accountability.

Medicalisation of hunger strikes often occurs, the custodial authorities often shedding responsibility to their medical staff. Medical monitoring may be legally required after "recognition" of the hunger strike as such, and be more or less sophisticated according to the setting. The VIP status of the particular hunger striker may often also influence the attention received.

Physicians may have to balance objective medical observations with pragmatic face-saving situations, in the pursuit of **time,** essential for negotiations to produce results. On the one hand they should not seek to qualify the strictness of the fasting at all costs, and risk making either side lose face, which could lead to the breakdown of negotiations. On the other hand, they should avoid pandering to any particular interest group by giving medical testimony that is scientifically questionable or downright wrong.

Medical counselling to hunger strikers

Medical counselling may often be a key element in determining the duration of a hunger strike. Physicians giving advice to hunger strikers should objectively warn prisoners who suffer from ailments or illnesses that are incompatible with prolonged fasting, **not** to embark on a hunger strike – or at the very least not on a "total" fasting sort of hunger strike.

Medical conditions such as **diabetes**, **gastritis**, **gastric or duodenal ulcer**, many **metabolic diseases** and other affections are contra-indications to total fasting. Physicians should make an objective evaluation of each case, and duly inform those persons of the risks involved in a total hunger strike, so they are able to make an informed decision.

Counselling hunger strikers freely and in a professional way, providing them with the information on fasting physiology they need to know, constitutes a major duty of any physician dealing with fasting prisoners. Only if fully informed can a prisoner make a truly voluntary and informed decision on whether to embark on, or to continue, a "hunger strike".

It has been said that physicians need to know the background behind the hunger strike. Experience has shown that knowledge about the causes, and about the true "determination" of the fasting group of prisoners, has been useful for doctors to be able to "smoothen" negotiations between prisoners and the authorities.

Prison doctors will often find that prisoners do not believe them, even when they give try to give objective counselling. Prisoners sometimes understandably mistrust physicians, whom they see as working for the prison administration, whatever advice they may give. Prison doctors will often have a difficult task convincing hunger striking prisoners that they are acting on their behalf. In many cases, unfortunately, prison doctors are indeed not in a position to manifest such medical neutrality.

In such situations, there is definitely a role for outside physicians to play, not only to give medical advice, but also to act as a neutral intermediaries in negotiations with the authorities. Doctors will often be able to play a crucial role, but only if they obtain the trust of the fasting prisoners, and if they respect that trust, which is implied in any "doctor patient" relationship.

In some cases, transferring a "hunger striker" to hospital on the pretext of performing "further exams" may thus serve a humanitarian purpose, allowing the prisoner to resume nourishment "on the doctor's orders". Prisoners will however confide in the physician only if they are convinced that medical confidentiality will be respected. The element of trust is here all-important!

Artificial feeding, force-feeding, and resuscitation 1

The physician responsible for the hunger striker should make sure that s/he knows exactly what terminal fasting may entail. If the intent is to push the fasting “as long as necessary”, the doctor should ask the hunger striker to clearly state what s/he expects from the doctor once the fasting has clouded his/her mind, and coherent communication becomes impossible.

The physician will have to discuss the crucial issue of artificial feeding and resuscitation **before** meaningful communication becomes impossible. In many countries, the will of the patient will dictate what the physician does even after consciousness is lost. In other countries, this may not be an option, and the physician may be prosecuted if s/he does not intervene to safe the hunger striker’s life. The physician has to know clearly what attitude s/he shall adopt, and make this perfectly clear to the hunger striker, so that they can reach a **decision in common**. If, for personal reasons, the physician cannot accept the decision reached, s/he should say so, and step aside so another physician can act according to the informed decision of the hunger striker.

Even if a physician has consented to abstain from treatment, there may be **circumstances** under which s/he makes the decision to resuscitate the dying hunger striker anyway. If the outside situation changes – e.g. if a political decision is reached after the person has become unconscious. There may be other circumstances as well, and **any doubt should benefit the patient**. If, however, on revival, the hunger striker persists in his/her demands for non-intervention, the physician should then step aside and allow the person to die in dignity, and not be submitted to repeated forcible resuscitations. Physicians should never be associated to such forcible measures, which may amount to **cruel, inhuman and degrading treatment**.

Artificial feeding, force-feeding, and resuscitation 2

Reanimation of a person in a terminal stage of total fasting is not the only issue here. The first distinction that needs to be understood by all physicians involved in hunger strikes is that such feeding in a coercive situation is not always decided on medical grounds – nor even necessarily by a physician.

When a hunger strike has a "political" component, the authority in charge may decide to put a stop to it, and issue an order to artificially feed the protesters. This may be decided very early on in the fasting, when there is no medical need to administer any nutritional treatment. It may even be decided to feed prisoners who resist by active coercion, tying down their limbs, and forcibly inserting a naso-gastric tube (hopefully) into the oesophagus. This **coercion** is what is **defines force-feeding**. The act itself will have to be performed by medical staff, often medical orderlies, as doctors often would refuse to.

Artificial feeding does not involve this element of brutal coercion. It may be prescribed freely by a physician, or be imposed on the physician by a judicial authority (e.g. a judge), whether the fasting person agrees or not. This occurs usually at a stage when the hunger striker is no longer fully conscious and too weak to protest or offer any resistance, but may be decided well in advance. By definition – and usually by default – means that there is no element of active coercion, as is the case in "force-feeding".

Artificial feeding involves administering nutriments and liquids parenterally or through a naso-gastric tube. There may be a medical indication for such feeding if the fasting has gone on long enough, and the aim is to save the person's life.

This raises however the crucial question, and ethical dilemma, of whether a physician should do anything and everything possible in order to save a person's life, or whether on the contrary s/he should respect the right of individuals to dispose of their bodies as they please. Should a physician, duly informed of a hunger striker's intention to fast indefinitely, "cheat" on his patient once the hunger striker is no longer conscious enough to resist or understand what treatment is being applied to him?

This question is highly controversial, and is often further complicated by religious issues. The law of the land may legally require physicians to intervene, even against their will, if a hunger striker's life is at stake. In this case, it is up to the physician to decide whether to bow to "the law" and flout the trust of the hunger striker, or to refuse to obey the law – and possibly have to accept the legal consequences for such a refusal.

International guidelines for physicians involved with hunger strikers

The **World Medical Association** (WMA) has issued two declarations that deal with force-feeding and hunger strikes. The 1975 **Tokyo** Declaration – which sets down that physicians should never condone or participate in torture – clearly states that hunger striking prisoners should not be force-fed in order to be sent back to torture. This is the meaning behind article 5 of the Declaration, which should thus be taken within this specific context.

The 1991 WMA **Malta** Declaration deals specifically with hunger strikes and gives some leeway to the treating physician, who should have the final word in deciding what is best for the patient, all factors being taken into consideration. Any force-feeding is out of the question – the most a physician can decide, according to **Malta**, is to artificially feed a hunger striker no longer capable of sound judgement because of the advanced fasting, so as to give him or her a "second chance".

The Malta Declaration does not give guidance as to what is to be done in such a case – admittedly a rare situation. If after reanimation, the person on the hunger strike still decides to pursue total fasting, the physician should not artificially feed the person again, thereby creating a "yo-yo" situation amounting to a form of medical coercion. It would arguably be best, in such a case, for the physician to step back and let the hunger striker die in dignity. Some doctors, however, for personal or religious reasons, refuse to let a hunger striker die, and reject such a solution. In many cases, these doctors (mistakenly) see total fasting as a form of suicide. This point is taken up further on.

It should be realised in this respect that prison authorities more often than not have specific agendas in mind when ordering doctors to artificially feed (or force-feed) hunger strikers. While claiming to want to save the hunger strikers lives, some coercive authorities clearly intend to repress the very principal of protest. Thus, for example, the case of a prison director who "decides" to force-feed hunger strikers after a mere two weeks of fasting, when there is no immediate medical need to intervene.

The medical guidelines mentioned above are based on the rights of the individual to determine what is done to his or her body. Where such individual rights are respected, a "genuine" hunger striker will have a chance to have his decision to fast totally – whatever the final consequences – respected. Where the rights of the individual are considered subservient to those of the State – or where religious considerations are paramount – such individual rights will not be respected.

Physicians in the latter situation may find themselves in difficult situations if they want to comply with the international guidelines. They should in such cases be able to appeal to their national associations or directly to the WMA for guidance and support.

Medical "paternalism" in dealing with hunger strikers: Is it ever justified?

Recent developments in hunger strikes have given rise to rethinking some of the guidelines regarding physicians' attitudes towards hunger strikers.

It should be clearly understood that in the vast majority of hunger strikes, prisoners do not want to die. Food refusers by definition have no intention of fasting themselves to death, and count on medical support to spare them from harming themselves. Most hunger strikers also would prefer to find a way out of the confrontation, and often will stop fasting if they obtain some form of concession from the authorities.

In the latter case, as has been stated, physicians may be in the best position to negotiate some sort of "deal" between the two parties.

There remains the case of truly "determined" hunger strikers, whether or not they are "totally" fasting, who refuse any form of treatment, and clearly state they are willing to suffer the final consequences of their protest. It would seem that the logical ethical attitude for physicians in such situations would be to respect the international guidelines, and abstain from trying to influence the hunger strikers.

Experience has shown, however, particularly in highly "political" hunger strikes, that decision-making is anything but simple. While in most cases medical "paternalism" would be improper, there may arise situations where physicians may resort to precisely such an approach.

It is here that the importance of **trust** and the **confidentiality** of the individual interview become of paramount importance. Experience has shown that there definitely *are* cases in which a physician, confronted with a young, sometimes "fanatical", hunger striker, can use his position of trust and medical authority to try to bring the protestor "to reason".

A recent authentic case, where a physician "refused" to accept a hunger strikers "desire to fast unto death" – arguing that such a position was simply "unjust", and that as a physician "he refused to let her die uselessly", having weighed all the circumstances of her story! In the specific case considered, such a "forceful" position – which might have seemed "out of place" elsewhere – was enough to make the young person come to her senses, and tearfully realise that she indeed didn't "want to die". It took such a "paternalistic" position to make her realise that she had been blindly following a movement while refusing to listen to her true inner yearnings. She duly accepted to receive nourishment and sincerely thanked the physician for his attitude.

Such extreme examples are fortunately rare, but this particular one is given to show how complex such issues can be. Even international guidelines need to be contextualised, and the ethics involved considered case by case by the physician on the spot.

Suicide and Hunger Strikes

Hunger strikers, as defined in the introduction, are **not** suicidal. If a prisoner wants to be self-destructive, there are many other ways he can inflict violence on himself. “Slashers” and “swallowers” are found in abundance in prisons – and are not the same prisoners who go on hunger strikes. Self-mutilation is another, more radical, but certainly different form of protest.

Hunger strikers with the stated intent to “go all the way” unless they obtain satisfaction, by definition do *not* want to die. They want to live – for their cause, for their comrades, for their political ideals: for whatever reason – and want to obtain something to this effect. Prison authorities, however, often qualify hunger strikes as a form of “**aggressive blackmail-form-of-suicide**”. The “suicide” element intends to imply that hunger strikers have pathological personalities, thereby giving the authorities a “**medical alibi**” for intervention.

Equating a total fasting to the intent to commit suicide thus provides the authorities with a “medical fig-leaf”, transferring the responsibility of the case to the physician. Indeed in many countries, force-feeding of hunger strikers is only allowed, “**if deemed necessary by the doctor**”. It is also the doctor who can be held responsible for the untoward death of a prisoner “in his keeping”. This “**catch 22**” situation is unacceptable, as it lays the blame squarely on the physician, whatever decision he or she may take.

The pathological personality of the genuine suicidal person can (in most cases) indeed be argued. The true-blue hunger striker is however **not** such a case. A hunger striker has to be sound of judgement, and otherwise by definition will be a medical case. Hunger strikers furthermore have to implicitly trust that the outside society will respect and prefer their **“altruism”** (“willingness to die in the name of a cause”) to any **self-centered ego-centrism**. Hunger strikers have to believe that outside society will not tolerate their death[6]. They must believe that the “spectators” to the fasting will do all they can to exert pressure on those responsible for negotiations, to try to find a compromise solution – thereby avoid the death of the hunger strikers. This is certainly *not* the attitude of persons intending to commit suicide.

A hunger strike thus involves reciprocal threats. The fasting persons threaten to harm their health – and thereby implicitly threaten to harm the “authority’s” reputation. Hunger strikers tacitly demand some form of negotiation – something the authorities usually refuse to accept under such pressure.

This very obviously has nothing to do with the “call for help” present in most cases of attempted suicide, nor with the “acute” self aggression of those who successfully commit suicide. In many cases, the “suicide alibi” is merely an excuse used by the authorities to medicalise intervention to stop the strike. In other cases, religious principles equating any form of self-aggression as “attempted suicide”, further cloud the real issue. Physicians should not be led astray by either argument, and should maintain their objective apparaisal of the hunger strike situation.

[6] A similar case would be that of “Greenpeace” demonstrators sailing their boats into an area where a nuclear test is to be performed. They have no intention of killing themselves – but are willing to take the risk, hoping that their altruism will force those carrying out the test to step down and cancel it.

Dual loyalties and false medical counselling

Pressures may also be exerted by the prison authorities on the prison doctor in a hunger strike situation. Even in democratic regimes, prison authorities often do not accept a situation of protest that challenges order and security in their custodial setting. The pressure may be to try to influence the prison doctor to either stop the hunger strike, or, worse, to have him threaten force-feeding – or actually carry it out, in the most extreme situations.

Hunger strikes obviously only "work" in those countries where human rights are respected. A **totalitarian** regime will usually never allow a hunger striker to "advertise" protest fasting. Any "spectators" (if tolerated at all) would not be in a position to exert any pressure either. A fatal outcome of a hunger strike under such a regime would not bear any moral pressure at all on authorities in a society where the **individual's life** has little value.

Physicians working for prison administrations are most often *not* independent. Even if they are fully aware of the ethical implications of a terminal hunger strike, they will often not be in a position to oppose administrative decisions imposed on them by the prison authorities, or possibly from even higher up.

Outside medical associations, *a fortiori* international ones such as the **World Medical Association**, have a duty to inform prison medical personnel of existing ethical guidelines that should be respected at all times – and to provide support for them when they do so! At the local level, independent physicians ideally should be permitted to counsel hunger strikers, in the interest of all involved, and obviously to try to avoid any fatal outcome. Some countries do allow this, and these physicians' independent status ensures their credibility as acceptable intermediaries for all parties concerned.

Prison doctors placed in such situations of **dual (or divided) loyalties** often flout medical ethics – either intentionally, or forced to do so by their authorities. Prison doctors have been known to threaten hunger strikers with grave medical sequelae that are simply fictitious. In one example, doctors spread the word amongst hunger strikers that fasting caused impotence, with the sole purpose of frightening them into giving up their fasting. This sort of action is unethical, as it abuses prisoners' trust in the medical staff, and uses medical influence trough trickery and **false medical "advice"**.

For these reasons, doctors' roles in hunger strikes in prison settings are often ambivalent. On the one hand, food refusers with no intention of harming themselves may see prison doctors as their "saviours", providing timely artificial feeding before any harm is done. On the other hand, political prisoners may see physicians as "doctor tormentors", prescribing and implementing force-feeding at the instructions of the coercive authorities, and thereby betraying their roles as physicians.

Outside doctors and medical associations should give support to all doctors working in positions of "dual loyalties" (Army, prison, police doctors…). Medical ethics should apply across the board to the whole medical profession, and doctors in such situations should not have their own sets of "ethics". Such doctors should be able to appeal to a higher medical authority if they receive orders from their "employers" that go against the basic principles of medical ethics.

The clinical stages of total fasting

The refusal to take sustenance leads to a clinical syndrome that resembles, but is not equivalent to, starvation. In the latter case, body depletion is a dragged out process, with little caloric intake, but still minimum absorption of vital elements such as vitamins or proteins. It is this intake that differentiates total fasting in a hunger strike situation (just water) with, starvation in concentration camps.

Death by terminal total fasting occurs by acute depletion of thiamine, causing fatal arrhythmia and/or cardiac arrest, roughly two months after stopping food. As few "hunger strikes" involving true "total fasting" have been documented, there is little reference material for this in the medical literature. What follows is drawn from experience by doctors who have attended "hunger strikers"[7].

Total fasting forces the body to find substitute sources of glucose, essential for providing energy, to the brain in particular. Lack of caloric intake disrupts the usual pathways, and complex mechanisms kick in to replace the external energy source. The body begins to "digest itself", breaking down the various tissues so as to have a constant supply of glucose.

Schematically, the following physiological events occur during total fasting (absorption of water only: around 1.5 - 3 l/day):

- **Glycogen** stored in the liver and in muscular tissue is the source of energy during the first few days of total fasting. Glycogen reserves are used up after 10 – 14 days. It is then that amino acids are called up to provide glucose through gluconeogenesis.

- The **gluconeogenesis** process leads to the massive breakdown of protein, i.e. muscle tissue, including the heart muscle tissue.

- **Fatty acids** coming from the breakdown of fat tissue (lipids) are broken down into ketones, which also provide energy. This phase begins early on in the fasting, and the **ketosis** suppresses hunger pangs after 2 – 3 days.

- Protein is catabolized but is "spared" by the body, providing only 10% of the energy source. Once all lipid reserves are used up, what remains of muscle tissue is tapped. This theoretically leads to a catastrophic situation, but other complications usually appear before this.

[7] Physicians working for the International Committee of the Red Cross, for example, have visited many hunger strikers in prisons around the world. Se also: Peel, M. "Hunger Strikes: Understanding the underlying physiology will help doctors provide proper advice" BMJ Volume 315 4 Oct 1997 829-830

Weight loss:

- Significant weight loss occurs at the very beginning of total fasting, mainly from glucagon-induced loss of fluid (natriuresis)[8].

- Medical monitoring is generally recommended after 10% weight loss in non-stout individuals, or once a Body Mass Index of 16.5 is reached[9].

- Major problems arise roughly when weight loss is around 18 – 20 % of the initial weight.

The first week

- fasting generally well supported, as long as water intake is sufficient
- hunger pangs and stomach cramps disappear after the 2nd – 3rd day

After 15 – 18 days

- the HS suffers from dizziness and "feeling faint"
- severe ataxia
- standing up may become difficult to impossible
- bradycardia
- orthostatic hypotension
- "lightheadedness"[10] or inversely "mental sluggishness"
- sensation of cold[11]
- general sensation of weakness
- fits of hiccoughs
- loss of the sensation of thirst[12]

At the end of the first month, symptoms may be severe enough to warrant hospitalisation. Hydration needs to be particularly monitored. Too much supplement of NaCl may lead to hypokalemia.

Between 35 – 42 days

- troubles of ocular mobility due to progressive paralysis of the oculo-motor muscles:
  - ==> uncontrollable nystagmus
  - ==> diplopia

[8] See Kalk, W.J. et al SAMJ Vol 83 June 1993 "voluntary total fasting in political prisoners – clinical and biochemical observations"
[9] The Body Mass Index (BMI) of an individual is body weight in kilos over the square of the height in meters. BMI values are independent of physical constitution or ethnic build. Over 20 corresponds to "well-nourished". Under 16 for men (15.5 for women) corresponds to malnutrition.
[10] Due to electrolyte imbalance. See "Peel, M." endnotes
[11] Blood thyroxine levels remain stable throughout fasting, but tri-iodothyronine is converted rapidly into an inactive metabolite, thereby reducing thyroid function, and base metabolic rate. Ibid, Peel, M.
[12] Ideally, water should be supplemented with 1.5 g of NaCl per day (one half a teaspoon salt)

- ==> extremely unpleasant sensations of vertigo
- ==> incoercible vomiting
- ==> extremely difficult to swallow water
- ==> converging strabismus

This has been described as the most unpleasant phase by those who have survived prolonged fasting, and is the phase most dreaded by potential hunger strikers.

One week after the « ocular » phase

- once paralysis of the oculo-motor muscles is total ==> nystagmus ceases and with it all associated problems (vertigo, vomiting…)

From ~ 42 days onward

- progressive asthenia
- torpitude
- increasiningly confused state
- concentration becomes difficult or impossible
- somnolent state
- anosognosia
- indifference to surroundings
- incoherence

At this stage, it is impossible to evaluate intellectual functions and to determine what the hunger striker's state of mind is. Any decision made to ascertain what the hunger striker wants done by the medical staff at and after this stage will have to have been made beforehand!

Further even more serious complications follow:

- loss of hearing
- blindness[13]
- diverse forms of haemorrhage : gingival, gastro-intestinal, oesophagal
- the body "shuts down" progressively: extreme bradycardia, Cheyne-Stokes respiration, all metabolic activity diminishes…

Between 45 – 75 days

. death occurs from cardio-vascular collapsus and/or severe arrythmias[14]

[13] From hemorrhage in the retina.
[14] Mainly due to acute depletion of thiamine (Vitamin B_1)=> systolic heart arrest .

Death and the Hunger Striker

Hunger strikers by definition do not *want* to die. Political hunger strikers also fast for a cause, but in some cases are willing to accept death if they do not get it. Food refusers merely want to protest.

The term "**death fast**" has been used increasingly in political hunger strikes, to designate a prisoner's willingness to fast until death if necessary. The term is unfortunate, because it gives a foregone conclusion to the protest fasting. This is often reinforced by authorities, the media or even prisoners themselves all – for different reasons – eager to proclaim the prisoners are going to "starve themselves to death".

This frame of mind and terminology only contributes to the already-mentioned troublesome confusion between hunger strikes and suicides. It wrongly instates "death" as the objective of the fast, which distorts any constructive dialogue, and may well turn off physicians otherwise willing to mediate a solution. Worse of all, it hastens a stand off and is most often seen as an unacceptable ultimatum, leaving little or no leeway for discussion. Physicians need room for "bedside" manoeuvrability, particularly in complex political – or politicised – situations.

If the fasting lasts long enough for there to be medical complications, it is the duty of the bedside physician to do more than merely take notes and monitor vital signs. There is need for the doctor to do his or her best to enter into a serious discussion with each hunger striker. As has been said, this may not be possible with a prison doctor. Access to prisoners by an independent, outside doctor may not be possible. It cannot be stressed enough that the privacy of the medical consultation is of paramount importance, so as to avoid any meddling or coercion, from any side, and for physicians to be able to play their role. When neither inside nor outside local doctors can play this role, it may be necessary to have help from a perceived "neutral" organisation, such as doctors from the ICRC, Council of Europe CPT or similar organisations.

The patient's best interests are difficult to quantify, and will differ according to the situation. The balance between medical paternalism and objective counselling is a difficult one. Physicians with personal, or religious biases that conflict with the providing of sound, humane and in some cases simple "caring" advice should abstain from getting involved in hunger strikes.

Physicians caring for resolute prisoners on terminal hunger strikes may be confronted with impossible dilemmas. Some prisoners may resolutely refuse any medical treatment – or even dialogue – in the pursuit of their objectives. A prisoner's right to decide whether or not she or he wants medical intervention should be respected, with the caveat mentioned above (see medical "paternalism"). The **WMA** Malta Declaration stipulates that the physician – and not a non-medical authority – should have the final say in deciding what to do, with, and only with, the patient's best interests in mind. This may mean allowing a hunger striker to die – or it may mean resuscitation if the physician truly believes the prisoner wanted to live.

Clinical example: exercise

As the new prison doctor, I was led to the hospital cell where P---- was being held, on the 18th day of his hunger strike. My older colleague, the outgoing prison doctor wearily explained that P---- was on his fourth hunger strike, "Always for the same reason – once again not being on the Presidential Amnesty list."

"He always ends up quitting his hunger strike – and asking us doctors to help him recover", said the doctor sounding a bit irritated. "Everyone knows he cheats on his strike – so why all the fuss?" he added.

In the hospital cell P---- was lying in bed, covered by a dirty blue sheet. He had a water bottle on his night table that seemed almost full. When he heard us come in he raised himself up on one elbow feebly, and seemed to try to swallow his saliva with difficulty. What one could see of his body was lean – very lean, almost wasted. His lips were cracked and he seemed gaunt and dehydrated. But what struck me most were his sunken eyes, piercing and very much alive and defiant.

My colleague and the guard who had accompanied us looked at me, waiting to see how I was going to react. P--- said not a word, but kept making swallowing movements with his parched lips, waiting for me to break the silence.

How was I going to handle this situation now?

<u>Questions:</u>

- The prisoner is on the 18th day of his fourth hunger strike. What can be deduced from this and what needs further scrutiny?

- The prisoner is said to be "cheating on his hunger strike". What does this remark call for?

- From this very brief first impression, what can be deduced and what needs further scrutiny?

- How should the new doctor proceed, at the present time, and in his future dealings, with the prisoner?