Medical and Ethical Aspects of Hunger Strikes in Custody and the Issue of Torture

Extract from "Maltreatment and Torture"

1-01-1998 by Hernan Reyes, MD

Extract from the publication "Maltreatment and Torture", in the series Research in Legal Medicine - Volume 19 / Rechtsmedizinische Forschungsergebnisse - Band 19. M. Oehmichen, ed., Verlag Schmidt-Römhild, Lübeck, 1998.

Summary

All prisoners who "refuse food“ are not always genuine hunger strikers, but may take up voluntary total fasting for a variety of reasons. In countries where prisoners' rights are not fully respected, hunger strikes may be a last resort for prisoners wanting to protest against their situation The World Medical Association (WMA) has established Guidelines for doctors involved in hunger strikes. The WMA 1975 Declaration of Tokyo and the WMA 1991 Declaration of Malta both prohibit the use of force-feeding. Although these declarations may apply to different situations, they share the obvious common denominator of being concerned with the patient's welfare. It is essential for doctors working with prisoners to establish a relationship of trust with any hunger striking patients, so as to be able to act in their best interest. If a prisoner has clearly stated that he refuses to be force-fed, then the doctor must use his clinical and moral judgement to do his best for the patient without resorting to any form of coercion. Heeding the informed consent of a hunger striker, confirmed within the trust of the doctor-patient relationship, and respecting the intrinsic dignity of the fasting prisoner is certainly part of the doctor's duty in looking after the patient's welfare.

Introduction

Hunger strikes or cases of voluntary total fasting - to use the more explicit term - are regularly reported in many countries around the world. Usually, though not always, they are carried out by individuals or groups of persons in custody. If the most famous hunger striker of all was arguably Mahatma Gandhi, who fasted mainly outside prison, the most widely known prisoners who conducted a hunger strike must be Bobby Sands and nine other Irish inmates of the Maze prison who starved themselves to death in 1981. For the purposes of this paper, only hunger strikes involving prisoners will be considered here.

The reasons for fasting in custody can be extremely varied (Restellini

1989, Johannes Wier Foundation 1995), from protesting against perceived petty offences to higher moral, political or philosophical considerations. As will be seen, voluntary total fasting is in fact not always voluntary or total. The implications for doctors dealing with hunger strikers will vary considerably according to the type of fasting involved, and the real purpose behind the refusal to eat. In most cases, there will be no ethical dilemma, as the issue of force-feeding fasting prisoners will not arise. In other situations, however, forcible nourishment will be a crucial issue, and will lead to much soul-searching for the physicians involved. It is in these cases that existing ethical guidelines need to be examined.

The different types of hunger strike, and their ethical implications for doctors, will be discussed in this paper. The examples given are all taken from the field experience of the author and other doctors working for the International Committee of the Red Cross. The Geneva-based organization's visits to prisoners around the world are just one part of its varied work protecting victims of conflict and violence everywhere.

The links between situations of torture and hunger strikes in the context of imprisonment will also be reviewed, leading to a discussion on the two World Medical Association declarations that specifically deal with hunger strikes. Finally, it will make a case for respecting the informed decision to accept or refuse medical assistance made by prisoners whose fasting is a genuine last resort protest in custodial settings.

This was acknowledged by the World Medical Association in its Declaration of Tokyo in 1975. The declaration essentially forbids any medical participation whatsoever in any form of torture or cruel, inhuman or degrading treatment. It also states that doctors should not participate in the force-feeding of prisoners.

Defining categories and issues

It has already been said that hunger strikes do not just involve people in custody. Fasting has been used as a visible means of protest in many cultures at least since Roman times. The primary aim of the pressure thus exerted is to „shame" the authority into giving in to whatever demands are being made by the protesters as is described by WB Yeats in The Kings Threshold:

> ...if a man
> Be wronged, or think that he is wronged, and starve
> Upon another's threshold till he die,
> The common people, for all time to come,
> Will raise a heavy cry against the threshold,
> Even though it be the King's.

Hunger strikes by protesters not actually in custody can take various forms, but are not the issue here.

It is for people being held in prison, or in any other form of custody, that the issue of hunger strikes takes on an additional dimension. The element of coercion in custodial situations, whereby the prison authorities have to define their position vis-à-vis a form of protest that is most likely to be against the internal rules, possibly even against the law of the land, substantially complicates the issue. This is particularly true in countries where individual rights, or even human rights in general, are perhaps not fully respected.

Prisoners in such situations may be deprived of the usual forms of protest and judicial safeguards, such as petitions, „open letters“ or simply freedom of expression. Fasting in such cases may become the only means of protesting against, or demanding attention from, the authorities.

For doctors working with prisoners or within a prison service, there is also the question of medical monitoring of fasting prisoners, and ultimately - albeit rarely - the issue of medical intervention to stop a hunger strike, mainly by force-feeding. The involvement of prison doctors in hunger strikes may take different forms, depending on whether the physician's main concern is the welfare of the fasting prisoner or rather the smooth functioning of the prison.

Before discussing the effects of fasting and its ethical implications, it is first of all necessary to define the very different situations involved. The term „hunger strike“ can refer to a wide variety of situations. Prisoners and prison authorities know this, and both may use the confusion created by this general and confusing term to their own advantage.

Not all forms of fasting by prisoners are what the public (and, in this day and age, the media) generally regards as being „real“ hunger strikes. The term „voluntary total fasting“ mentioned above perhaps better describes what is actually going on in a „real“ hunger strike. The French, „jeûne de protestation“ (literally: “fasting as a form of protest”) is arguably a better general term since it describes more accurately the motives behind the fast rather than the process of carrying it out.

Hunger strikes have always been associated with some form of protest. In early twentieth- century Europe, they were brought into the public eye by the suffragette movement in Great Britain. It was in this context that the controversial medical act of force-feeding was performed for the first time by court order (in 1909). In more recent years, there have been hunger strikes by prisoners on virtually every continent, with extensive media coverage in certain cases - such as the Irish hunger strikes in the Maze prison in the early 1980s, and most recently the prisoners' hunger strikes in Turkey over the summer of 1996 - because of the fatalities involved (ten fatalities in Northern Ireland in 1981 and at least twelve in Turkey in 1996).

The above-mentioned examples and other recent ones involve extreme cases of „protest fasting with drastic consequences for the health of those concerned. Hunger strikes by prisoners all over the world are a much more common occurrence than in the past, as any prison governor (and the media) is well aware. But should the general term „hunger strike“, be used to describe the whole spectrum of situations involving fasting by prisoners?

Not all so-called hunger strikes are the same. Although all involve a certain degree of fasting, they vary greatly in their impact on health and in the ethical dilemmas they may ultimately cause. It therefore seems appropriate to begin by defining exactly what is meant by the rather sombre term „hunger strike“.

To do this, taking account of the various situations in which prisoners stop taking food (...and sometimes drink, in the case of a “dry” hunger strike), it is first essential to rule out any ambiguous circumstances that definitely do not qualify for the generally accepted definition of voluntary total fasting.

Real hunger strikes involve actual fasting, which has to be voluntary and has to be pursued for a specific purpose. Fasting prisoners who are mentally ill or otherwise incapable of unimpaired rational judgement and decision-making cannot be considered real hunger strikers, whatever their own claims. Therefore any patients who, for example, try to starve themselves to death as a result of extreme depression are automatically ruled out. This is the crucial argument - to be pursued later on – which refutes the frequent assertion that hunger strikes are tantamount to suicide.

It should hardly be necessary to state that any form of religious fasting clearly has nothing to do with hunger strikes. It is mentioned in passing simply because it has sometimes been misconstrued owing to ignorance and cultural differences between captors and captives. The most immediate example is of Muslim prisoners who have refused food at the beginning of Ramadan and been accused in certain cases of going on hunger strike, unable as they were to dispel their captors’ ignorance because they did not speak the same language.

Then there are the „normal“, mentally able prisoners who decide to suspend their food (and sometimes liquid) intake for a certain period of time, most often for some personal reason or (rarely) on behalf of the group they may represent.

Are all such cases of fasting „genuine“ hunger strikes?

Certainly not. For the sake of clarity, fasting prisoners should be divided

into two quite separate groups, even if they all describe themselves as „hunger strikers“. Prisoners who refuse food may be just that - food refusers - and quite distinct from the other category, the real hunger strikers. The two categories represent completely different states of mind and have different aims. Each can be further divided into two sub-categories. It is important, particularly for the medical personnel involved, to differentiate these various types of prisoners from the outset, as the way the situation is approached and handled will also vary greatly in each case.

The important thing to remember is that all these categories of prisoners are often labelled as „hunger strikers“ by prison governors, the public and the media. The prisoners concerned often regard themselves, and claim to be, „legitimate“ hunger strikers. ICRC teams visiting prisoners are frequently told that „a hunger strike is on“. It is essential to know exactly what the situation is to be able to respond in the most constructive way and avoid making false assumptions.

Food refusers

The first type of food refuser is the reactive food refuser, arguably the most common sort of „hunger striker“ in prisons. The reactive refuser reacts to a given situation, most often in frustration or anger, and says he is „going on a hunger strike“ in protest. (Experience shows that the overwhelming majority of prisoners in this category are male, though no specific data are readily available.) This may be because of a refused appeal. It may be a local incident, such as a change of cell or cell-mate that the prisoner is unwilling to accept. It may be for a whole variety of reasons, but nearly always concerns only the prisoner himself, and is not part of a more widespread protest. This type of prisoner is usually well-known to prison governors as a constant „pain in the neck“, making an big fuss, and complaining to his family, lawyer, the board of trustees or anyone who is willing to listen. Many prisoners of this sort fast in protest on numerous occasions during what is often a long career within the prison system.

The key element here is that, for the „hunger strike“ to work, the reactive refuser has to make as much noise about it as possible. The idea is to drum up sympathy from any available sources, inside or outside the prison system. This will naturally only have a chance of working if it is widely known that he is fasting. Essential to this type of strike is that the prison regime be lenient enough to permit such open displays of protest, and - more to the point - allow news of the strike to circulate outside the prison despite the adverse publicity for the system.

This type of food refuser may indeed decline to take food for some time. He may even be genuinely convinced that he is a legitimate hunger striker. The difference between the reactive food refuser and the real hunger

striker is that the refuser has not the slightest intention of fasting to death, or anywhere near death. Indeed, he has no intention whatsoever of taking serious risks with his health. Consciously or subconsciously, according to context, culture and intellect, he will expect to be taken care of long before there is any danger to his health from fasting. In this sense the reactive food refuser will „cling“ to the prison doctor, whom he will expect to monitor him, preferably place him under observation in hospital, and take whatever measures are necessary to keep him in good health.

The reactive food refuser is relatively common only in countries where the basic rights of prisoners are largely respected. In truly coercive regimes, prisoners considered nuisances are rarely accepted, let alone allowed to spread their „nuisance value“ outside prison. In tolerant systems, they may tax the patience of both the prison authorities and the prison doctor. Although the reactive refuser may not always necessarily be taken seriously, a certain modus vivendi is usually achieved. The refuser's aims are in a sense partially satisfied, however, in that the authorities nearly always refer to him as a „hunger striker“, albeit perhaps an habitual one.

Prison doctors in relatively benign systems will carry out whatever medical duties are prescribed in such cases. Seasoned prison doctors, who have spent whole careers working in prison environments, will be best at handling such prisoners, carefully balancing respect for the patient with a firm approach on what they can and should do from a medical point of view. Usually there will be nothing for them to do, as the „hunger strike“ generally peters out by itself. Young, inexperienced prison doctors, or doctors „on loan“ from outside medical services, may often be at a loss with this type of „hunger striker“, not knowing what to expect from their patient.

Reactive food refusers have been said to „give hunger strikes a bad name“ (to quote a prison director in an Anglo-Saxon prison system), in that ultimately their „strikes“ are not taken seriously, and prison doctors find their empathy severely taxed when they are confronted repeatedly with such patients, who are usually very demanding.

The second type of food refuser is the determined food refuser. This type of prisoner can be male or female. The motive behind the refusal of food is completely different from that of the preceding category, as is also the way in which it is carried out.

This type of refuser is generally the opposite of the reactive type. Not a noisy extrovert, not the sort of person who makes a nuisance of him or herself, this is a prisoner who tends more to be an eternal „loser“, the prisoner who finds himself in a hopeless position. (The masculine gender will be used exclusively from here onwards to lighten the text.) This may be because of the judicial situation or the prisoner's situation in the prison. It is often due to a shattered family situation: for example a wife's

demand for divorce, offspring who persistently refuse to visit any more, etc. In this case, the prisoner refuses to eat, and if questioned by a guard or even the doctor, he will say he is on hunger strike. In fact the dividing line between conscious protest and the onset of actual depression may be very hard to establish.

Another crucial difference is that, unlike the reactive type, the determined refuser makes little if any noise about his hunger strike. The term is used to justify the refusal of food, possibly to give it some sort of „noble justification“. In fact, this is the one type of „hunger striker“ whose action may perhaps - though not always - be legitimately described as being not unlike attempted suicide. (Comparisons with suicide, usually unjustified, occur frequently in discussions about hunger strikes.)

Doctors should be attentive to patients of this sort, as they may well be medical cases that require medical attention they do not actually ask for.

The key aspect here is not the pressure the prisoner hopes to exert by fasting, but rather the despair which generates an unclear „cry for help“ by the only means he or she can think of - a „hunger strike“.

Real hunger strikers: The „determined“ and the „not-so-determined”

Distinct from the food refusers are the actual hunger strikers, i e prisoners who undergo a substantial period of voluntary total fasting for a specific purpose. The reasons for a hunger strike are obviously as varied as the situations in which they take place. There may be a general - often „political“ - cause behind it, such as obtaining some sort of „status“ for the prisoners. There may be specific demands concerning prison conditions or the judicial process. Whatever the cause, several factors have to be considered when dealing with real hunger strikers.

Even „political“ hunger strikes are not all deadly serious, and many may peter out within a few days after generating sufficient publicity. In this they resemble fasting by reactive refusers. If, however, there is reason to believe that the fast really is serious, there are several issues that any doctor involved has to consider. One has to know whether the fast is genuinely voluntary, and not being imposed by certain prisoners on others. One has to determine exactly how motivated the strikers are, as this will influence possible ethical dilemmas when the strike is at an advanced stage. There is also a need to know whether there are any medical contraindications to fasting among the prisoners who undertake the strike, who then have a right to know of any negative implications for their health. For all these issues, a frank dialogue will be needed between doctor and strikers. This may be difficult or even impossible for the prison doctor himself.

A climate of trust is obviously essential here, as in any doctor-patient relationship. Physicians working in prisons, despite what may be their best intentions, may not be trusted by prisoners, and may be perceived, perhaps wrongly, as part of the „coercive authority“. Any advice they give may be interpreted by the hunger strikers as a ploy by the authorities to dissuade them from fasting.

As hunger strikes often occur among prisoners protesting in countries affected by conflict, ICRC doctors are often confronted with hunger strikers.

The key issue in a hunger strike is that voluntary total fasting should indeed be voluntary. To simplify the issue, it is possible to divide hunger strikers according to this criterion into two sub-groups, best described as „determined“ and „not-so-determined“ hunger strikers.

The issue of the fasting prisoner's consent warrants particular scrutiny, as it is a key factor in determining the actions doctors involved will have to take. Unlike the food refuser category, in which prisoners generally fast alone - with a lot of publicity, as in the case of the reactive refuser, or in silence, as in the case of the determined refuser - prisoners who go on real hunger strike often fast in groups, or at least have individual volunteers from the group take up a prolonged fast. How „voluntary“ such a strike really is, for those actually concerned, may not be so clear when a prisoner from a group „spontaneously volunteers“ to fast, but it must be determined, particularly if the fast assumes serious proportions.

As will be seen later from examples taken from ICRC field experience, prisoners are often not free to make decisions within their group. A prisoner who personally would not have wanted to take up fasting may have been „volunteered“ by the group leadership. Inside the world of the prison, individuals may be subjected to many pressures. An individual prisoner's margin of freedom allowing him to refuse „orders“ from his internal hierarchy may be slim or non-existent.

A doctor from the outside, such as an ICRC doctor visiting prisoners, can arrange to speak with individual hunger-striking prisoners in private, and thus be in a better position to determine the exact motivation behind the strike. More important, it will be possible to determine whether fasting prisoners have really agreed to fast, or whether they have merely been obliged to obey instructions from „the group“.

In any group of hunger strikers who have decided on a serious fast as a means of protest, there will be other pressures in addition to the obvious „peer-group pressure“. Other prisoners will also be observing the „volunteer and this may considerably complicate his freedom of decision. This is particularly true when „politically motivated“ prisoners are involved.

Fasting prisoners will be in the spotlight; their every action will come under observation. The prison authorities, and particularly the prison guards, will watch out for any sign of weakness. Taunting and baiting by guards may trap a prisoner into an intransigent position, whereas he might otherwise have been willing to compromise.

Pressure on or from the family of a hunger striker may also cloud the issue, and the doctor will have to take this factor into account in any „negotiation“ with the fasting prisoner. Pressure from families may have opposite results, a family sometimes urging the doctor to put a „medical end“ to the strike, or conversely insisting that a prisoner's decision to fast should not be undermined by any medical „meddling“.

Finally, if the hunger strike gains attention from the outside, the media will also undoubtedly exert pressure on the situation.

All these external factors cannot simply be ignored. They must be taken into due consideration by any doctor who deals with the hunger strikers. If the physician is to act in their best interest, provided they have consented to a proper doctor-patient relationship, then these influences have to be known and discussed.

The motivation behind the strike might appear not to be an issue for the physician. Although this may be true in very politicized contexts, experience shows that there may be misunderstanding and intransigence in the relationship between the parties. If the doctor can gain the confidence of all involved, in some cases a compromise may be reached or an issue clarified through him that can lead to the end of the strike (see the example below involving the ICRC in Georgia).

Knowing the actual determination of the strikers is also essential, as the medical consequences of a hunger strike will differ according to how seriously the strike is taken. Medical contraindications to a hunger strike, such as metabolic diseases (diabetes, etc.), gastro-intestinal disorders (gastritis, ulcers, etc.) and others, will be particularly relevant here. In the author's experience, many a hunger striker has been convinced to stop fasting just by explaining that his underlying gastritis could lead to a perforated ulcer and consequently a dramatic end to the hunger strike. As the idea behind a strike is to try to „force“ the authority to make concessions on some point, this takes time. If a hunger striker perforates an ulcer after only a week, the whole purpose of the strike - in addition to his health - will be jeopardized to no avail. Whether hunger strikers abandon the fast or not, they have a right to know about all the implications for their health, including the physiological effects of fasting. The importance of doctors being aware of these effects has recently been stressed in two British Medical Journal articles (Kalk et al 1993, Peel 1997).

Hunger strikes may be against the rules in certain prison systems, just as

they may be tolerated in others. Whatever the situation, doctors will invariably be involved one way or another, and it is therefore essential that they are familiar with the relevant issues. The question of „force-feeding“ is a case in point, and this will be discussed further on. It is directly related to the issue referred to earlier, of a hunger strike being tantamount to suicide.

Hunger strikers are often criticized for using their physical welfare as an instrument of protest, the (debatable) argument being that this constitutes a form of blackmail. It is inappropriate to assert, however, that hunger strikers should be placed in the same category as persons intending to commit suicide. This is a simplistic approach to the issue which wrongly reduces it to purely medical terms: namely, that since any doctor would come to the assistance of someone who attempts suicide, so hunger strikers should be „assisted“ (i e force-fed) to prevent them from „killing themselves“.

This is certainly a misconception. Someone who attempts suicide is either appealing for help, as in the majority of cases, or he truly wants to end his life. (The “black-and-white case” often cited here is that of a general, found guilty of treason, who prefers to blow his brains out rather than face a shameful court-martial. Although some doctors would even argue for a case of acute and severe depression, it can be claimed that not all suicides are necessarily to be “medicalized”.) The clear-cut case of a politically motivated hunger striker is different. The striker does not want to die: on the contrary, he wants to „live better“, by obtaining something for himself, his group or his country. If necessary, he is willing to sacrifice his life for his cause, but the aim is certainly not suicide. (Soldiers charging a heavily defended enemy position also run the risk of dying. Are the suicidal too?} All too often hunger strikers who fast up to or beyond the limits of irreversible physiological consequences are labelled as suicidal. This naturally gives any prison or judicial authority the perfect excuse for ordering doctors to intervene forcibly.

For physicians working with prisoners, the World Medical Association has drawn up codes of ethics which give specific guidance on the issue of force-feeding.

ICRC experience of hunger strikes

Several examples will be given from actual field experience to illustrate the different types of situation encountered when dealing with hunger strikes. In its work over the years with prisoners throughout the world, the International Committee of the Red Cross (ICRC) has come across many different types of hunger strikes - and „food refusal“ too. No further comment will be made on the latter, however, as they do not have the same implications as hunger strikes for medical action and ethics. ICRC physicians, as independent „outside“ doctors, often have a crucial role to

play as medical intermediaries in such situations.

Hunger strikes were relatively frequent among „political“ prisoners in Latin American countries during the 1980s and early 1990s. How serious these strikes actually were depended on various factors. The cases of „rotating strikes“ will not be considered, as they cannot be viewed as protests that the authorities or medical personnel could take seriously. (In these, some prisoners skipped breakfast, some lunch and other dinner, with all of them saying they were on hunger strike.) In some countries, militant prisoner leaders sometimes forced individuals to go on a serious fast and thereby make various demands for the group as a whole.

The author was confronted on various occasions with prisoners with whom he established a certain „doctor-patient relationship“ of trust, within the secrecy of the medical consultation. In many cases, they wanted to know more about what they were getting themselves into, and requested information about the effects of hunger strikes.

(In the few cases where prisoners were threatening to go on “dry” strikes, i e with no intake of water either, the author was always able to persuade them not to do it and to limit their fasting to solid foods, as a dry strike could very quickly produce serious and perhaps irreversible health problems. Without the author being seen as an “adviser” on how to conduct hunger strikes, it was explained to them that a strike only had a chance of attracting attention if it lasted a certain length of time, and that inviting early renal complications through a “dry” strike was not the best way to go about it).

In these situations prisoners were usually wary of any advice given by the prison doctor himself. This mistrust was not always unfounded. One typical prison doctor made it known early on to hunger-striking prisoners that, because of his profound religious principles, he would not tolerate any prisoner starving himself to death, and would not hesitate to order them to be force-fed at an early stage (in a country of Latin America in the late eighties). This doctor was deeply convinced that any serious hunger strike was tantamount to suicide, and so there was no question of respecting the autonomy of such a patient. In many of these hunger strikes prisoners decided to abandon their fast, after receiving medical advice on their specific conditions. Others discreetly requested medical assistance, for example in the form of a transfer to the sick-bay, where they could resume nourishment without losing face, since an intervention of this sort from an outside doctor was viewed as acceptable.

Any such „outside intervention“ was totally unacceptable in the (northern) Irish hunger strikes of 1980 and 1981. Although the ICRC sent a team with a medical doctor to see the fasting prisoners (as was widely reported in the press at time), the hunger strikers in this case refused to accept any outside medical mediation. As soon became clear, the hunger strikes

in Ulster were deadly serious, with a total of ten prisoners dying over several months. The prison doctors respected the expressed will of the hunger strikers, and force-feeding was not envisaged at any time. (This position based on respect for a patient's integrity and his right to refuse treatment, was the exact opposite of the attitude held earlier in the century, when political hunger strikers were force-fed by court order in 1909.)

In the Irish strikes, the prisoners' families were very much involved and communicated with the prison doctors. In a few cases, it was the families of prisoners who asked doctors to intervene at an advanced stage to save their sons' lives, a request that was complied with. The bottom line in the doctors' position was that a prisoner's expressed will (not to be nourished) would be respected as long as he was mentally fit to decide, but that families could obtain medical assistance for their fasting relatives if these were no longer in a position to express a refusal. (This sometimes led to bitter arguments, with some hunger strikers telling their families they would never forgive them if they broke the strike by asking for medical assistance on their behalf. Most families, in fact, supported their sons or husbands on the strike.)

In other very politicized cases, for example in the Middle East and Turkey, „collective" hunger strikes sometimes involving hundreds of prisoners or even more have assumed drastically different dimensions. Some of these strikes have not been very determined at all, despite claims to the contrary. The attitude of certain doctors to these collective strikes has sometimes been just as politicized as that of the striking prisoners. One prison doctor in the Middle East told the author: "When such a large number of prisoners" (over 2.000 in this particular case) "go on a hunger strike, of course I have to order them to be force-fed to save their lives ... ". This type of intervention, particularly after a mere 10 to 12 days of fasting, has to be seen as coercive and not medical. Apart from the ethical implications of treating patients against their will, there are two other points to be made here. First, there is no medical reason to force-feed a physically and mentally healthy person who has been fasting for only 10 - 12 days. Second, the act of feeding through a forcibly introduced naso-gastric tube can be dangerous in itself, as was demonstrated by two deaths in the region in the early 1980s.

In Turkey, in the summer of 1996, hundreds of „political" prisoners went on hunger strike, protesting about various issues concerning their imprisonment. These simultaneous strikes (as opposed to the individual, consecutive strikes by the Irish prisoners) left at least 12 prisoners dead and many more with neurological and psychiatric after-effects, never previously observed in such a large number of prisoners surviving fasts of over 60 days. (Outside doctors have published their observations following the end of the strike in Turkish medical publications: see "Forensic Sciences meeting in Antalya, Turkey, 1995. See also "Ismir in the last

hunger strikes" Dr. Zaki Gul, in Toplum ve Hekim, Eylül-Aralik 1996.) Since the ICRC has never been allowed to visit Turkish prisoners, its doctors were not involved in these cases, and much of the medical information on the strikes is still to be made available.

A few years ago a case in one of the countries of the Caucasus (published in the media) illustrated the complexities of the doctor's role in a hunger strike. A „political" prisoner on hunger strike was eventually force-fed, as stipulated by the prison rules inherited from the former Soviet Union, once he was semi-conscious and too weak to resist an intravenous drip. When telling the author about his experience, he first protested vehemently at not having his wishes respected by the prison doctor. After making his point, however, he quietly admitted that he was, in fact, happy to be alive.

Force-feeding and the link with torture

The issue of force-feeding constitutes the link with situations of coercion and torture. As is well known, the World Medical Association (WMA) Declaration of Tokyo of 1975 prohibits any participation in torture, whether actively, passively or through use of medical knowledge, by a medical doctor. Article 5 of the Tokyo Declaration also stipulates that prisoners on hunger strikes shall not be force-fed, though few doctors know exactly why this clause is included.

One common interpretation is that force-feeding is viewed as a form of torture, which indeed it may be on occasion. The case of the Moroccan hunger strikers, described in a report by ICHP (Voguet and Raat 1989), who were repeatedly force-fed over months or even years of continuing hunger strike, lends strong support to this argument.

The real reason for Article 5 is, however, different (personal communication by Dr. André Wynen, former and Honorary Secretary-General and founding member of the WMA). The ban on force-feeding relates to the background to the declaration, i.e. situations of torture. If a prisoner undergoing torture decided to protest against his plight by going on a hunger strike, a doctor should not be obliged to administer nourishment against the prisoner's will and thereby effectively revive him for more torture. This was the key issue behind the inclusion of Article 5 relating to hunger strikes.

A case involving the application of Article 5 which occurred in South Africa in 1989 attracted widespread comment. In Johannesburg Kalk and Veriava (1991) treated 33 prisoners who had gone on hunger strike to protest against their conditions of detention. Once the prisoners were in hospital, they were duly informed of Article 5 of the Tokyo Declaration and told that there would be no force-feeding. Moreover, Dr Kalk considered that their detention without trial constituted a form of torture, and refused to discharge the patients back into detention after they had recovered from

the effects of the hunger strike.

This act by a doctor, which has become known as „Kalk's refusal", is an example of precisely what was intended by the hunger strike proviso of the Tokyo Declaration. It was also doctors from the South African Medical Association (MASA) who initiated a WMA review of ethical guidelines on hunger strikes, and contacted the author on the subject in 1990. Feeling that „Tokyo" did not give enough guidance to doctors on performing their ethical duties in the event of hunger strikes, they proposed to amend and expand the declaration. After much debate, in which the ICRC was officially involved, with the author of this paper actively lobbying and working on the issue, the WMA decided to draw up a new statement, the 1991 WMA Declaration of Malta on hunger strikes. This refers to prisoners and voluntary total fasting outside any situation of torture (see: WMA Handbook of Declarations, WMA Ferney-Voltaire, France). Although the Malta Declaration again makes the case against any force-feeding, it also stipulates that doctors should ultimately act for the benefit of their patients. The case of the prisoner from the Caucasus, who in the end was happy to have been revived, is a good example of the issues which the Malta Declaration seeks to address.

Conclusions

Individuals held in custody may go on hunger strikes for a variety of reasons. In many cases, fasting will be limited to a short period of time, the main idea being to attract attention and try to put pressure on the authorities for a specific purpose. Many prisoners who „refuse food" are not really hunger strikers, and have no intention of endangering their health. In fact they rely on the prison doctor to intervene and take any action necessary to keep them in good health.

In cases of real voluntary total fasting, usually by politically motivated prisoners or prisoners supporting a specific cause, be it ethnic, religious or otherwise, there may be a will to „go all the way" and accept the physiological consequences of a prolonged fast. In countries where prisoners' rights are not fully respected or even completely disregarded, and where torture is practised; hunger strikes may be a last resort for prisoners wanting to protest against their situation.

The World Medical Association drew up the Declaration of Tokyo in 1975. Taken up since then by many official bodies, including the United Nations in the 1984 Convention against Torture, it expressly forbids any doctor to participate in any form of torture. Article 5, which deals with hunger strikes and specifically prohibits force-feeding, was meant to provide support for doctors confronted with prisoners who were victims of torture. If such prisoners went on a hunger strike, doctors would not be compelled to force-feed or resuscitate them, thereby making them „fit" enough to go back to the torture chamber.

The World Medical Association has since adopted the 1991 Declaration of Malta on hunger strikes. This deals exclusively with the issue of voluntary total fasting and the doctor's role vis-à-vis prisoners in such circumstances, without making any reference to situations of torture.

Although „Tokyo" and „Malta" apply to very different situations, they share the obvious common denominator of being concerned with the patient's welfare. Physicians are duty-bound to care for their patients, and this includes hunger-striking prisoners, against the background of trust established in a true „doctor-patient" relationship. If the prisoner has clearly stated that he refuses to be force-fed, then the doctor must use his clinical and moral judgement to do his best for the patient. Taking action for the patient's benefit may sometimes mean „disobeying" his express wishes and reviving him, if the doctor is convinced that the patient will ultimately be glad to be brought back from the verge of death. „Malta" offers doctors the opportunity to give the fasting prisoner a last chance. If, however, a prisoner at an advanced stage of a hunger strike is restored to consciousness or to a physiological situation where there can be no doubt about his state of mind, and that prisoner clearly indicates disapproval of the doctor's action, then the doctor should be prepared to step back and not intervene again. In such cases it can be argued that ensuring the patient's welfare means allowing fasting prisoners the last possibility of freedom of action, and letting them at least die with dignity.

Doctors should never be party to actual coercive feeding, with prisoners being tied down and intravenous drips or oesophageal tubes being forced into them. Such actions can be considered a form of torture, and under no circumstances should doctors participate in them, on the pretext of „saving the hunger striker's life". Heeding the informed consent of a hunger striker, confirmed within the trust of the doctor-patient relationship, and respecting the intrinsic dignity of the fasting prisoner he is treating is certainly part of the doctor's duty in looking after the patient's welfare.

References

- Johannes Wier Foundation for Health and Human Rights (1995) Assistance in hunger strikes: a manual for physicians dealing with hunger strikes. Amerstoort/NL

- Kalk WJ, Felix M, Snoey ER, Veriawa Y (1993) Voluntary total fasting in political prisoners: Clinical and biochemical observations. South Africa Med J 83: 391-394

- Kalk WJ, Veriawa Y (1991) Hospital management of voluntary total fasting among political prisoners. Lancet 337: 660-662

- Peel M (1997) Hunger strikes: Understanding the underlying physiology with help the doctors provide proper advice. Brit Med J 315: 829-830

- Restellini J P (1989) Les grèves de la faim en pénitentaire. In Staempfli (ed) Revue Pénale Suisse (Bern), Vol 106

- Voguet D, Raat A-M (1989) La faim pour la Justice. Mission Report for the International Comission of Health, Professional for Health and Human Rights.

(1) Verlag Schmidt-Römhild, Mengstr. 16, D-23552 Lübeck
Tel.: +49-451-70 31 01 Fax: +49-451-70 31 2 53