THE NORTHERN HOSPITAL

HUNGER STRIKERS

"Our revenge will be the laughter of our children", Bobby Sands (1954-1981). Funeral scenes, 5th May 1981.

Sunday 1st

I am standing on the threshold of another trembling world. May God have mercy on my soul.

My heart is very sore because I know that I have broken my poor mother's heart, and my home is struck with unbearable anxiety. But I have considered all the arguments and tried every means to avoid what has become the unavoidable: it has been forced upon me and my comrades by four-and-a-half years of stark inhumanity.

I am a political prisoner. I am a political prisoner because I am a casualty of a perennial war that is being fought between the oppressed Irish people and an alien, oppressive, unwanted regime that refuses to withdraw from our land.

I believe and stand by the God-given right of the Irish nation to sovereign independence, and the right of any Irishman or woman to assert this right in armed revolution. That is why I am incarcerated, naked and tortured.

Foremost in my tortured mind is the thought that there can never be peace in Ireland until the foreign, oppressive British presence is removed, leaving all the Irish people as a unit to control their own affairs and determine their own destinies as a sovereign people, free in mind and body, separate and distinct physically, culturally and economically.

I believe I am but another of those wretched Irishmen born of a risen generation with a deeply rooted and unquenchable desire for freedom. I am dying not just to attempt to end the barbarity of H-Block, or to gain the rightful recognition of a political prisoner, but primarily because what is lost in here is lost for the Republic and those wretched oppressed whom I am deeply proud to know as the "risen people".

There is no sensation today, no novelty that October 27th brought. (The starting date of the original seven man hunger-strike) The usual Screws were not working. The slobbers and would-be despots no doubt will be back again tomorrow, bright and early.

I wrote some more notes to the girls in Armagh today. There is so much I would like to say about them, about their courage, determination and unquenchable spirit of resistance. They are to be what Countess Markievicz, Anne Devlin, Mary Ann McCracken, Marie MacSwiney, Betsy Gray, and those other Irish heroines are to us all. And, of course, I think of Ann Parker, Laura Crawford, Rosemary Bleakeley, and I'm ashamed to say I cannot remember all their sacred names.

Mass was solemn, the lads as ever brilliant. I ate the statutory weekly bit of fruit last night. As fate had it, it was an orange, and the final irony, it was bitter. The food is being left at the door. My portions, as expected, are quite larger than usual, or those which my cell-mate Malachy is getting.

Bobby Sands,
Diary entry
1 March 1981

Robert Gerard "Bobby" Sands was the youngest ever elected member of the British Parliament, but never took his seat. He was also an Irish volunteer of the Provisional IRA. When elected he was a prisoner in HM Prison Maze. He died in prison in 1981 after 66 days on hunger strike at the age of just 27years. He led the hunger strike in which Irish republican prisoners protested against their removal of "Special Category Status". His death resulted in a renewed surge of IRA recruitment and activity and ignited days of violent rioting in nationalist areas of Northern Ireland. International media coverage brought world attention to the hunger strikers, and the Irish Republican Movement in general, strongly attracting both praise and criticism. To this day Bobby Sands remains a villain to some – but to others - the greatest of heroes. Over 150,000 people attended Sand's funeral.

HUNGER STRIKERS

Introduction

The **World Medical Association (WMA)** has established guidelines for doctors involved in managing people on hunger strikes.

The Declaration of Tokyo (1975) and the Declaration of Malta (1991) both prohibit the use of non-consensual force-feeding of hunger strikers who are mentally competent.

If called upon to treat hunger strikers, medical practitioners should be aware of their ethical and legal responsibilities, and that they should act independently of government or institutional interests. [1]

A long-established common law principle upholds the right to individual self-determination, including the choice to refuse treatment. Persons deemed to be of full mental capacity can refuse treatment, even if that act is tantamount to suicide. A medical practitioner who performs medical treatment without the patient's consent can be held to have committed an assault. This could give rise to a claim of damages. [1]

A decision not to intervene and to allow a person to die is extremely difficult for a physician to make. Fortunately, most hunger strikes end without fatalities.

It is imperative, however, that hunger strikers be fully assessed early in their strike to assess both their mental state and their genuine intentions, ideally in the form of a confidential advance directive.

For such a medical assessment to be legitimate, the hunger striker must feel convinced that the doctor is acting independently and impartially, and not only in his or her capacity as an employee of the detention centre or hospital.

The striker also must be advised in detail about the medical consequences of refusing food and about the value of supplementing the fast with essential minerals and vitamins to prevent irreversible neurological damage.

Pathophysiology

The medical literature indicates that death from hunger strikes can occur approximately between **40 and 80 days** of *complete* fasting [1]

Progression of decline:

- After about a week, the hunger striker experiences dramatic weight loss.
- In the following weeks, the liver and intestines atrophy, followed by the heart and kidneys.
- The pulse slows and blood pressure falls.
- Patients complain of fatigue, headache, faintness and dizziness.
- By about the 40th day, the striker becomes seriously ill, is bedridden and suffers concentration problems and apathy.

Clinical Assessment

Physical assessment

Assess:

- Vital signs
- Cognitive state
- Hydration status
- General physical condition, (weight, cachexia, mobility etc)
- Psychological status - in the public hospital setting this may be via the hospital CATT professional.

Investigations

Where patient gives specific consent, *consider:*

- BSL
- Blood ketones
- FBE
- U&Es/ glucose

- Folate & B12

Considerations for psychological assessment

The course of physical and cognitive deterioration means that assessment of a hunger striker's mental state and intentions needs to be undertaken **early**, while they remain mentally competent.

In such an assessment, the evidence needs to be weighed up as to whether manifestations of despair and demoralisation are a realistic response or reflect a form of mental illness that in itself impairs competency.

If symptoms of despair and hopelessness are reality based, then standard antidepressant treatments may not necessarily be effective, especially if the environmental conditions generating the despondency (prolonged incarceration and threat of forced repatriation) are not alleviated.

The management guidelines following are those of the WMA Declaration of Malta on Hunger Strikers, revised Pilanesberg South Africa, 2006

Preamble

Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres).

They are often a form of protest by people who lack other ways of making their demands known.

In refusing nutrition for a significant period, they usually hope to obtain certain goals by inflicting negative publicity on the authorities.

Short-term or feigned food refusals rarely raise ethical problems.

Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians.

Hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. Physicians need to ascertain the individual's true intention, especially in collective strikes or situations where peer pressure may be a factor.

An ethical dilemma arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment.

The principle of beneficence urges physicians to resuscitate them but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made.

An added difficulty arises in custodial settings because it is not always clear whether the hunger striker's advance instructions were made voluntarily and with appropriate information about the consequences.

These guidelines and the background paper address such difficult situations.

Principles

1. Duty to act ethically:

   All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy.

   Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.

2. Respect for autonomy:

   Physicians should respect individuals' autonomy.

   This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear.

   Any decisions lack moral force if made involuntarily by use of threats, peer pressure or coercion.

   Hunger strikers should not be forcibly given treatment they refuse.

   Forced feeding contrary to an informed and voluntary refusal is unjustifiable.

   Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

3. "Benefit" and 'harm":

   Physicians must exercise their skills and knowledge to benefit those they treat.

   This is the concept of "beneficence", which is complemented by that of "non-maleficence" or *primum non nocere.*

   These two concepts need to be in balance. "Benefit" includes respecting individuals' wishes as well as promoting their welfare. Avoiding "harm" means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting.

   Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.

4. Balancing dual loyalties:

   Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients.

   Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient.

5. Clinical independence:

   Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement.

   They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.

6. Confidentiality:

   The duty of confidentiality is important in building trust but it is not absolute.

   It can be overridden if non-disclosure seriously harms others.

   As with other patients, hunger strikers' confidentiality should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm.

   If individuals agree, their relatives and legal advisers should be kept informed of the situation.

7. Gaining trust:

   Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimises harm to them.

   Gaining trust can create opportunities to resolve difficult situations.

   Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.

Management

1. Physicians must assess individuals' mental capacity.

   This involves verifying that an individual intending to fast does not have a mental impairment that would seriously undermine the person's ability to make health care decisions.

   Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers.

   They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health.

2. As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast.

   The medical implications of any existing conditions should be explained to the individual.

   Physicians should verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages.

   Physicians should also explain how damage to health can be minimised or delayed by, for example, increasing fluid intake.

   Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical.

   Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient to repeat back what they understand.

3. A thorough examination of the hunger striker should be made at the start of the fast.

   Management of future symptoms, including those unconnected to the fast, should be discussed with hunger strikers.

   Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted.

4. Sometimes hunger strikers accept an intravenous saline solution transfusion or other forms of medical treatment.

   A refusal to accept certain interventions must not prejudice any other aspect of the medical care, such as treatment of infections or of pain.

5. Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees.

   Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.

6. Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice.

   Hunger strikers should be protected from coercion.

   Physicians can often help to achieve this and should be aware that coercion may come from the peer group, the authorities or others, such as family members.

   Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike.

   Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike.

7. If a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal.

8. Continuing communication between physician and hunger strikers is critical.

   Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want to be done when they are no longer able to communicate meaningfully.

   These findings must be appropriately recorded.

9. When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life.

   Consideration needs to be given to any advance instructions made by the hunger striker.

   Advance refusals of treatment demand respect if they reflect the voluntary wish of the individual when competent.

   In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered.

Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution.

If well informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because the situation in which the decision was made has changed radically since the individual lost competence.

10. If no discussion with the individual is possible and no advance instructions exist, physicians have to act in what they judge to be the person’s best interests.

    This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health.

    In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.

11. Physicians may consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress.

    If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected.

    It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will.

12. Artificial feeding can be ethically appropriate if competent hunger strikers agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.

13. Forcible feeding is never ethically acceptable.

    Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment.

    Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

References

1. Mary A Kenny, Derrick M Silove and Zachary Steel; Legal and ethical implications of medically enforced feeding of detained asylum seekers on hunger strike, MJA 2004; 180: 237–240

2. WMA Declaration of Malta on Hunger Strikers:

   Adopted by the 43rd World Medical Assembly Malta, November 1991and editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992 and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006

3. www.bobbysandstrust.com

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April 2010