



Canada



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**ASSISTANCE FOR THE REFORM OF THE PRISON SYSTEM  
IN BOSNIA AND HERZEGOVINA**

**HUNGER STRIKES AND ARTIFICIAL FEEDING**

**A GUIDANCE NOTE**

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## Introduction

The issue as to how to manage persons undertaking hunger strikes is deeply problematic from both legal and ethical perspectives.

When faced with prolonged, coordinated, protest hunger strikes two sets of conflicting considerations have to be reconciled.

Moreover, the two major groups engaged in the management of the situation, the state authorities and medical practitioners, albeit that they have complementary roles have different concerns and have to take account of different standards.

Both parties have to reconcile:

for the state authorities, the duty to preserve life with the duty not to treat people in an inhuman or degrading manner, or to torture them, and

for the medical practitioners their duty to care, promote health and preserve life with the ethical duty to base treatment on the wishes of the patient and to administer treatments only after informed consent has been given.

For the doctor, however, the dynamic of the treatment resolves around choices that are being made by their patient who, although in most cases they will not wish to die, will strongly assert a willingness to do so and, without the development of an effective therapeutic relationship with the doctor, may persist in withholding permission for treatment. The competent doctor will be seeking to create the conditions in which the patient will be able to give consent to sufficient treatment to maintain life. Although considerable international experience has shown that this is possible with the great majority of hunger strikers, it may not be possible with all.

For the state authorities, the situation is even more complex. Not only do they have to reconcile the legal duties to preserve life while not severely mistreating the person subject to their authority, they are also faced with the use, in a coordinated campaign, of the threat of death of persons over whom they are exercising authority, as an instrument in a blocked negotiation. In this respect, hunger strikes have many of the characteristics of hostage taking, except that the lives that are taken hostage by the perpetrators are their own.

Essentially, the guidance is that the state, when faced with such a situation should create the circumstances in which competent physicians can administer to their patients away from the pressures (state and protesters) that surround the situation.

The experience is that this approach has the greatest prospect of ultimate successful resolution of the situation.

It recognises, however, that occasions will arise when the best medical care will not lead to preservation of life and the state may wish to intervene. This may be achieved legitimately.

Guidance to medical practitioners is well developed. Legal and policy guidance less so.

This note reviews and comments on:

Existing legal provision in Bosnia and Herzegovina (BiH)

#### Observations of the CPT

- Report [CPT/Inf (2001) 31] of the visits of the CPT to Turkey in December 2000 and May 2001, paragraphs 32 and 33

#### Jurisprudence of the European Court of Human Rights (EctHR)

- Judgement of 5 April 2005 in the Case of Nevmerzhitsky v Ukraine (Application no. 54825/00)

#### The 'Malta' Declaration on Hunger Strikes of the World Medical Association and supporting guidance

- WMA 'Malta' Declaration on Hunger Strikes, (1991, revised 1992, revised 2006 (October)), and
- World Medical Association (WMA) (2006 (June)), "WMA Declaration of Malta, A background paper on the ethical management of hunger strikes" World Medical Journal, 52 No 2.

Medical practitioners caring for persons deprived of liberty who are engaged in hunger strikes may wish to consult the short course in this area of work developed jointly by the World Medical Association, the Norwegian Medical Association and the International Committee of the Red Cross and which can be found at <http://lupin-nma.net/> .

#### **Existing legal provision in Bosnia and Herzegovina (BiH)**

Article 64 of the BiH Law on the Execution of Criminal Sanctions reads:

*Medical intervention shall not be imposed on a pre-trial detainee or prisoner without his consent when there are medical indications for it, except in cases foreseen in the health care regulations.*

*Exceptionally from the provisions of paragraph 1 of this Article, if the pre-trial detainee or prisoner is in such mental condition that he can not reach a reasonable decision, doctor can intervene in the interest of the patient's life and health.*

*If due to mental illness the pre-trial detainee or prisoner has been transferred to a health care institution, as foreseen in Articles 101 and 107, he can be subjected to the mandatory treatment in accordance with the appropriate legal provisions.*

Article 50 of the FBiH Law on the Enforcement of Criminal Sanctions (of 1998) reads:

*Medical intervention shall not be imposed on the sentenced person without his consent when there are medical indications for it, except in cases foreseen in the health care regulations.*

Articles 150 and 151 of the RS Law on Enforcement of Criminal Sentences and Sentences for Minor Offences (of 2001) reads:

*If the sentenced person endangers his life and health by refusing to take food or refusing the treatment, necessary medical measures can be enforced even without his consent, if there are medical indications for it.*

*Establishment's management is obliged to inform the spouse or another close family member or other person designated by the sentenced person himself to be informed in such case about any serious illness without delay.*

That is, although the legal systems approach the issue slightly differently and regulation in the BiH law is somewhat fuller than in the entity laws, each jurisdiction allows intervention to artificially feed a person where there are 'medical indications' and as anticipated by the law.

### **Observations of the CPT**

The only substantive observation to date by the CPT was made following their visits to Turkey during the campaign of hunger strikes in 1990 and 1991.

They observe;

In general they were impressed by the management of hunger strikers in hospitals and prisons;

They welcomed the policy that the management of hunger strikers should be based on the doctor/patient relationship;

They noted, however, that the written instructions to doctors contained, "From the instant organ deterioration is noted, total parenteral nutrition is to be administered", and that

"... the Committee has considerable reservations as regards attempts to impinge upon that relationship by imposing on doctors managing hunger strikers a particular method of treatment."

Two comments should be made about this.

Firstly, the Turkish authorities authorise (actually require) physical intervention at the point at which "organ deterioration is noted". This is one of 3 possible standards. It is probably the most proactive. Less proactive would be, "when, in the opinion of the responsible medical practitioners, irreversible physical deterioration commences". Most restricted would be, "when withholding nutrition any longer will lead inevitably to death". (It will be noted, below, that it is this third standard that was applied in the jurisprudence of the ECtHR).

Secondly, the point on which CPT takes issue with the Turkish authorities is the limitation by the state of medical discretion. The principle they wished to establish is that medical care of patients in this situation must be allowed to proceed independently of state interference. In this situation the interference is in the form of a policy. Interference may also be in the form of pressure or instruction on a day to day basis. It is common ground throughout the guidance that on the grounds both of ethics and effectiveness the management of hunger strikes should be managed by doctors in a normal therapeutic doctor/patient relationship with the protesters and that there must be no interference with that relationship by the state authorities.

## Jurisprudence of the European Court of Human Rights (EctHR)

The leading case is *Nevmerzhitsky v Ukraine*. Judgement was given in April 2005. The case raises a number of issues of prison treatment amongst which is applicant's assertion that his being subject to forced feeding in the manner in which he was in breach of Article 3 of ECHR. It was found that it was.

The court develops the principles against which it considers the facts of the case in paragraph 94 of the judgement.

Firstly they assert the principle,

*"...a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The same can be said of force-feeding<sup>1</sup> that is aimed at saving the life of a particular detainee who consciously refuses to take food."*

They then develop 3 standards that must be met for force-feeding to be legitimate:

- *Medical necessity for the treatment must exist*
- *Procedural guarantees for the decision must be complied with*
- *The manner in which the person is force-fed must not be inhumane.*

Although the state authorities may not have a policy or may not intervene to require the responsible medical practitioner to force-feed the hunger striker, they may, in the circumstances that the court describes, legitimately do so themselves. Taken with the CPT comments, this judgement clearly establishes a need to separate the ongoing medical care of the patient from any duty on the state that it may wish to exercise in meeting its legal duties.

The *Nevmerzhitsky* case should be interpreted in the context of the judgement in *Keenan v UK*, which itself developed the jurisprudence in *Osman v UK*.

In the *Osman* case, Mr Osman had been murdered by a school teacher who had formed an infatuation for Mr Osman's son. The question that was at issue was what duties Article 2 placed on the state authorities to protect Mr Osman's life and whether they had been effectively exercised in the circumstances. The Court ruled that Article 2 placed a 'positive obligation' on the state to take 'effective action' in circumstances in which an 'imminent and foreseeable' risk to the life of anyone in its jurisdiction existed. They did not, on the facts of the case find a breach of Article 2, but they established the clear possibility of such a finding in comparable circumstances.

In the *Keenan* case the principles developed in *Osman* (and other) cases was examined in the context of a mentally ill person who committed suicide while in prison. While, once more, they did not find, on the facts of the case, that the UK

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<sup>1</sup> The Court here uses the term 'force-feeding'. In its consideration of the issue, the World Medical Association distinguished between 'force-feeding' and 'artificial feeding'. Force-feeding is the feeding of someone against their active resistance – often achieved by physically or mechanically restraining the person being fed. Under the WMA Tokyo Declaration, medical practitioners are ethically forbidden from participating in force-feeding. They may, however, either with a person's agreement or if, when the person no longer able to grant or withhold informed consent, they consider it is in the person's clinical interest, administer artificial feeding either through supplements to drinks or by other means.

authorities had breached the requirements of Article 2, they asserted that the principle of positive obligation to take effective steps when a foreseeable and imminent risk of the death of a person subject to the jurisdiction of the state authorities – and especially when that person is deprived of liberty and subjected to conditions imposed by the state - applies to the circumstances in which the person takes his own life.

That jurisprudence is relevant to the obligations faced by a state when confronted with a campaign of potentially fatal hunger strikes. There is a positive obligation on the state to take effective action to protect the lives of those who threaten to kill themselves when death is foreseeable and imminent.

What such effective action might be is well discussed in the guidance of the World Medical Association that follows.

### **The 'Malta' Declaration on Hunger Strikes of the World Medical Association and supporting guidance**

The Malta Declaration itself, taken with the background paper produced by the World Medical Association, constitutes essential guidance to any practitioner who has to manage someone undertaking any other than a token hunger strike and should be required knowledge of any medical practitioner working in a prison. Physicians managing prolonged hunger strikes should receive special training. In the immediate situation they might be referred to the course jointly prepared by the WMA, the Norwegian Medical Association and the ICRC which can be found at <http://lupin-nma.net/>. The Malta Declaration is referenced by the ECtHR in the Nevmerzhitsky judgment.

The very brief summary I give below should not be considered in any way as a substitute for attention to the guidance of the WMA, which is attached.

The guidance is premised on the understanding that hunger strikers will be managed by medical practitioners in an unambiguously doctor/patient relationship. Their management will have the following characteristics;

Any doctors engaged in this work will have specialist competence in the following areas;

- The physiological consequences of prolonged hunger striking;
- The psychological consequences of prolonged hunger striking;
- The ethics of medical practice in relation to hunger striking.

The responsible medical practitioner will undertake thorough physical and psychological diagnosis of each patient and will be expert in the consequences for the progress of hunger striking of pre-existing medical and psychological conditions.<sup>2</sup>

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<sup>2</sup> The practitioner will also have good knowledge of the consequences for the management of patients of varying motivations for hunger striking: token actions, psychiatric conditions that predispose to self-harming behaviour, extreme fasting justified through religious conviction, protest fasting. Compounding of any of those reasons by any of the other reasons. For protest fasters they will understand that few either wish or, autonomously, would be prepared, to die, they would differentiate between actions designed to arouse publicity and those in which the patient is mentally prepared to continue the action until or unless the goal of the strike is met.

The practitioner will see his role not as someone seeking to persuade the striker to give up (which may be counter productive) but as someone who gives accurate information to the striker on the likely consequences of their action, counsels them and assists them in making a properly informed choice for themselves.

The practitioner will take effective steps to ensure that the patient is managed in an environment in which he is as free as can be achieved from coercion or influence (by either peers or the authorities) and in which they can make an informed personal choice.

The focus of the practitioner's skills will be on building trust with the patient. In achieving this he will demonstrate:

honesty in the information he gives – both about the consequences for the patient of the actions he is taking and in informing the patient of any actions the practitioner will take and

confidentiality – though he will make clear that confidentiality has limits and that he will honestly advise the patient of any circumstances in which he would pass information gained within the relationship to other parties.

There must be no interference by the state authorities with the free conduct of the doctor's management of the case.

The doctor will throughout his management respect the informed choice of the patient. The emphasis here is on the word 'informed'. The doctor is likely to have to make a judgement, at any point of the progress of the strike, as to how capable the patient is to make a choice that is 'informed'. To the extent that the doctor reaches the conclusion that the choice expressed by the patient is other than informed he has some limited freedom to substitute his clinical judgement for the expressed wish of the patient. Many hunger strikers, however, are making clear and rational choices about their own health and safety. Where this is the case it is the ethical duty of the doctor to respect their wish. There is extensive guidance in the background paper on the management of the such situations in a way that promotes the possibility of informed choice being made by the hunger strikers.

### **Recommended immediate action**

Having considered this guidance during the week, I would advise that, as a matter of urgency, the responsible Ministries consider the following actions:

Establish independence of medical care from the institutions of the state and prison management.

Invite applications from independent physicians for this role;

Appoint an independent medical commission to oversee the provision of medical care

Ensure the competence of the responsible physicians and their compliance with established medical ethics in this area of work.

Training and seminars in the implementation of the Malta Declaration and the associated guidance;

Continuing mutual support and learning between all practitioners working in this area.

Issue guidance to prison staff on cooperation with the physicians given this responsibility.

Develop, pass and publish a legislative and regulatory framework within which the state and prison authorities will exercise any responsibilities the government of BiH would wish to give them in this situation.

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