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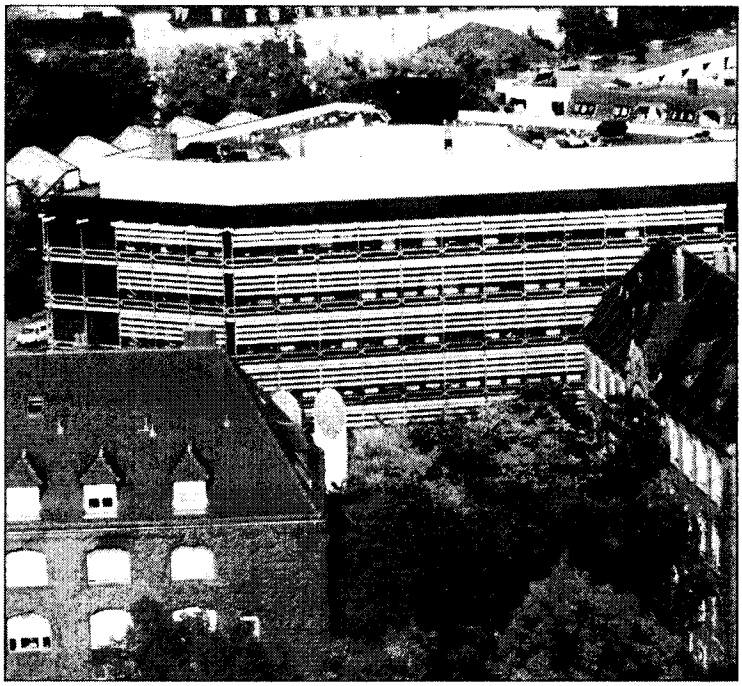

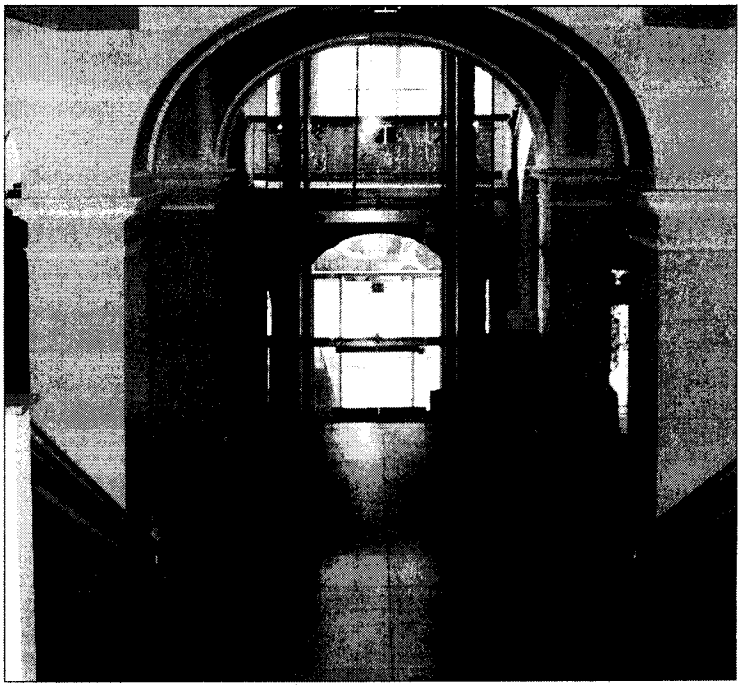

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WMA OFFICIAL JOURNAL OF THE WORLD MEDICAL ASSOCIATION, INC.

WMA Declaration of Malta

A background paper on the ethical management of hunger strikes

The following background paper and glossary of terms were prepared by the British Medical Association in association with the revision of the Malta Declaration currently being considered by WMA Council and National Medical Associations.
See also „glossary of themes", p. 41-42.

Introduction

Physicians need to understand the background to the guidance given in the World Medical Association's Declaration of Malta. This paper aims to set out that background and some authentic case examples are included to illustrate how complex this area of practice can be. These cases are taken from field experience in widely differing contexts and countries. They have been simplified and anonymised to protect individuals' confidentiality and they reflect how very different strategies may have to be adopted by physicians according to the circumstances of the case.

Although the Malta Declaration sets broad international standards for managing hunger strikes in custodial settings, physicians still need to use their own moral judgement in particularly complex situations. To do this, they should be aware of the various different forms of fasting which stem from differing intentions on the protesters' part and which require different handling. Hunger strikers' motivations and their perseverance in a particular kind of hunger strike can differ greatly. Gaining their trust can be difficult but is crucial for doctors, who must be able to act independently from the detaining authorities. Physicians also need to be alert to the pressures which can be exerted on hunger strikers in custodial settings - not only by the authorities but also by peer group hierarchies and sometimes even by physicians themselves. For example, if doctors ask hunger strikers to give advance instructions at the start of a fast saying whether or not they would refuse resuscitation at a later stage, it may be difficult for the hunger strikers to do anything other than refuse artificial feeding, without losing face with their peer group. This may not be a truly valid and informed choice unless physicians can discuss it in private with the hunger striker. Physicians need to understand the clinical and moral criteria concerning when to resuscitate a protester and when to abide by such a refusal of treatment. The crucial differences between "artificial" and "force" feeding need to be understood. Physicians also need to be aware of the symptoms and the clinical physiology of the different stages of fasting in order to give accurate medical counselling to patients about what to expect. (Such advice can be found in the 'Course for prison doctors', chapter 5, by the World Medical Association, Norwegian Medical Association and International Committee of the Red Cross at http://lupin-nma.net). Health professionals often act as mediators between patients, authorities and other people such as patients' families. They can be in a position to facilitate face-saving opportunities which could bring the hunger strike to an end for the benefit of all involved. This paper seeks to help them do that.

Definition of "hunger strike"

As explained in the glossary, a "hunger strike" involves food refusal as a form of protest or demand. Such fasting is particularly undertaken by people in custodial settings who lack alternative means to gain attention and bring pressure to bear to obtain some goal. Short-term rejection of food rarely gives rise to ethical dilemmas as health is generally not permanently damaged as long as fluids are accepted. It is important, however, for physicians to have a clear frame of reference on how to define a serious "hunger strike".

Excluded here are short-lived fasts which peter out within 72 hours. If hunger strikers continue to refuse both nutrition and hydration for more than 48 hours, however, they risk significant harm. Dry fasting without any fluid intake which persists for more than a few days would fall within the definition of "hunger strike" used here but, fortunately, this is rare. As the body cannot survive more than a few days without fluid, death would occur within the first week which, from the protesters' perspective, is too short a period for negotiation to be effective. In short, the term "hunger strike" as discussed here refers to protest fasting without any intake of food but with ingestion of adequate quantities of water.

In the first days of fasting, the body uses its stores of glycogen in the liver and muscles. Ketosis occurs and is discernible clinically on the breath or by laboratory test in the urine. It subdues the voracious sensation of hunger experienced during the first days of fasting. It can be argued that total fasting (taking water only) for longer than 48 - 72 hours is the clearest definition on metabolic grounds for the term "hunger strike". Glycogen stores are exhausted by about day 10-14 and certain amino acids take over as the substrate for gluconeogenesis. Muscle, including heart muscle is gradually lost. Close medical monitoring is recommended after a weight loss of 10% in lean healthy individuals and major problems arise at a weight loss of about 18%. Hunger strikers need to be aware that dehydration is a risk as they lose their sensations of hunger and thirst.

1. The medical duty to establish competence and motivation

Assessing patient competence and gaining an understanding of the purpose of the fast is crucial for physicians. Good communication and trust are essential here. Fasting as a symptom or manifestation of a psychiatric disorder such as anorexia or depression requires a totally different approach, so assessing patients' mental health must be a first step for physicians. People suffering from any serious psychiatric or mental disorder likely to undermine their judgement need medical attention for their disorder and cannot be permitted to fast in a way that damages their health. Fasting for religious reasons should also not be confused with

protest fasting but should be respected. It is generally not health threatening and does not raise dilemmas when undertaken by an otherwise healthy person.

Two main categories of individuals embark on hunger strikes with quite different intentions and motivation. In potentially coercive contexts, (which include any situation of detention) it is important for physicians always to determine for themselves what are the exact motives for refusing nourishment.

Some food refusers fast to gain publicity to achieve their goal, but have no intention of permanently damaging their health. Their goal may seem relatively petty or it may involve reasons of principle. As they do not wish to die, these protesters often agree to artificial feeding being provided at some stage and may actually request medical assistance in monitoring their fast. Those who repeatedly make this type of protest can come to be seen as exercising a form of blackmail by the authorities, who then let strikes continue to test protesters' resolve. Physicians need to clarify privately with protesters, at regular intervals, how far they are willing to go and when they expect and desire medical interventions to be made to prevent lasting harm to their health.

The other very different category consists of what might be seen as very determined hunger strikers who are not prepared to back down unless their goal is actually attained. Individually or in groups, they may differ in their mode of fasting but they share a determination to risk their health or their lives for a cause. Political hunger strikers often fall into this category. Unlike the food refusers who rely on medical help to prevent serious harm, this category of protesters often mistrust physicians, whom they see as belonging to the detaining system. Such protesters pose a serious challenge to medical ethics, as their willingness to take fasting to the extreme inevitably raises difficult questions about whether and when to intervene and the thorny ethical question of whether feeding contrary to patients' expressed wish can ever be justified. In this paper, we have rejected the term "death fast" which is sometimes used to describe a determined hunger strike. The term is unfortunate in that it appears to assume death is the inevitable outcome. By perceiving death as the objective of the fast, opportunities for constructive dialogue may be lost from the outset. It is seen by the authorities as establishing an unacceptable ultimatum with no leeway for discussion. This can deter doctors from even attempting to mediate.

2. The medical duty to attempt to establish "voluntariness"

"Voluntary total fasting" is a term often used, but fasts in detention are seldom total. Most protesters accept fluids and sometimes the rejection of food too is less than total. Participation can also be more coerced than voluntary, particularly in long collective hunger strikes. The authorities may want to stop protests by finding acceptable compromises but pressures may come inadvertently from staff, such as guards, whose taunts and derision of protesters can lead to a hardening of positions. Detainees may also suffer coercion from peer groups in subtle as well as obvious ways. These often complex situations can lead to the point where it becomes virtually impossible for a protester to cease fasting voluntarily. The informed and voluntary nature of individuals' food refusal are key aspects that physicians need to ascertain once mental competence has been established. Physicians must do their utmost to speak to each patient privately, out of earshot of all other people but with an interpreter if necessary. It is important that interpreters are not connected with the detaining authorities or the patient's peer group and that they are aware of the confidentiality expected of them. Those orchestrating collective hunger strikes are often reluctant to allow such talks, as this undermines their authority. This is possibly the most complex situation to deal with in determining whether hunger strikers are indeed genuine volunteers. The subsequent extent to which medical confidentiality can be guaranteed in custodial settings needs to be discussed with the patient. Physicians should do everything in their power to engage in frank discussion with patients and gain their trust. Where protesters appear to be fasting under duress, a solution may be to separate those individuals in hospital on a medical pretext, thereby extracting them from the influence of others and allowing them, if they agree, to resume nourishment on medical grounds. Pressure may still come from relatives or the media. Families often alert the media, hoping this will heighten the pressure on the authorities to make concessions but it can also increase pressure on the protester not to give way.

Physicians sometimes cannot gain the trust of patients. In such situations, it may be possible to bring in an external physician unconnected with the detaining authority or one nominated by the patient to ascertain whether the fast is truly voluntary. If the "voluntariness" of the decision appears to be established, protestors' decisions should be respected. It is likely that some cases of coercion go undetected, even if all reasonable precautions are taken, but in the absence of evidence to that effect, physicians must listen to and abide by what patients say.

Physicians can discuss with patients the flaws or lack of logic in their expressed wishes without exercising undue pressure. Experience shows that particularly in highly political hunger strikes, decision-making is far from simple. There may be situations where physicians need to challenge the patient rather than accept that person's views at face value. It is here that the importance of trust and the confidentiality of the individual interview become of paramount importance. There are cases in which physicians, confronted with an apparently fanatical hunger striker, can use their position of trust and medical authority to try to bring the protestor to reason.

Case example 1 -- Difficulties of establishing a hunger striker's real wishes

A physician, visiting a collective hunger strike involving many politically motivated prisoners, listened carefully to the story of a female protestor. She had suffered many hardships, including rape and the loss of family members. She was barely 20 years old and appeared politically motivated almost to the point of fanaticism. Her intention, she said, was to fast unto death to protest against oppression. The physician decided to test her determination as he was

not convinced her words reflected her real wishes. He took a firm stance, arguing that her apparent choice to die seemed wrong after all she had already endured and survived. In his view, her decision was ill thought out and he said that, as a doctor, he was unwilling to let her waste her life but wanted her to reconsider. The young woman was shocked as nobody -- not even she herself - had questioned her intention previously. She burst into tears but, on reflection, agreed that she did not want to die. As they talked, the doctor's careful reasoning and analysis of her situation helped her to identify her real wishes. The conversation between them was kept confidential but the woman agreed to accept nourishment which was given on a medical pretext to avoid pressure being brought to bear upon her by her peer group. The doctor's willingness to probe deeper than the woman's superficial statements allowed him to test whether her statements really were an autonomous expression of her views. Her readiness to hear his arguments made the hunger striker re-evaluate her intentions and realize that she had suppressed her true feelings. The example shows how complex such issues can be and the risks of accepting an individual's views without any question.

3. The duty to provide accurate information to patients

Physicians need to explain to each protester the implications of fasting for that person. This entails first taking a detailed medical history and conducting an examination so that existing medical conditions are identified and discussed. They should objectively warn patients who suffer from ailments that are incompatible with prolonged fasting, not to embark on a hunger strike or to restrict themselves to a limited form of fasting. Conditions such as diabetes, gastritis, gastric or duodenal ulcer and many metabolic diseases are contra-indications to total fasting. Only if fully informed, can protesters make a truly voluntary and informed decision on whether to embark on a hunger strike. They only have a chance of obtaining their goals if there is enough time for the authorities under pressure to react. The likely duration of their fast is therefore of paramount importance to hunger strikers, especially if they have difficulties in making their plight known to those outside who can try to exercise influence. It will be essential for hunger strikers to know as accurately as possible how long they personally could fast. The fatal outcomes of total fasting were first documented during the 1980 and 1981 hunger strikes in Northern Ireland where death generally occurred between 55 and 75 days. Similar experiences have confirmed this wide time bracket. The three-week interval is due to differences in initial physical constitution and individual adaptation. It is not possible to predict any time span more precisely. Protesters need to be advised that death occurs some time after six full weeks of fasting and survival after ten weeks of total fasting is practically impossible. They also need to know that in the final clinical stages of fasting, they will no longer be capable of discernment and need to make clear in advance what they expect physicians to do for them then.

4. The duty to give counselling

Medical counselling may often be a key element in determining the duration of a hunger strike. Physicians often find that some patients do not believe them, even when they try to give objective counselling. Some people who are detained understandably mistrust physicians, whom they see as working for the authorities. Doctors can have a difficult task convincing hunger-strikers that they are acting on their behalf, partly because in many cases doctors are unable to show that they are neutral. In such situations, there is a role for outside physicians, not only to give medical advice, but also to act as neutral intermediaries in negotiations with the authorities. Doctors are often able to play a crucial role, but only if they obtain the trust of the patient. In some cases, transferring a hunger striker to hospital on the pretext of performing further tests may serve a humanitarian purpose, allowing the protester to resume nourishment on the doctor's orders. Detainees, however, confide in the physician only if they are convinced that medical confidentiality will be respected. The element of trust is here all-important.

To give accurate advice and counselling, physicians need to clarify the type of hunger strike that will occur. Most so-called "total fasts" involve protesters accepting water but abstaining from all foodstuffs. Different cultures, however, have different notions of how fasting should be defined. Salt (either NaCl alone or a combination of minerals) is often added to the water and possibly sugar or other sweet substances such as honey. Some cultures define fasting in terms of abstaining from solid food (substances that need to be chewed) or from food that is cooked or heated. They may discount the ingestion of milk, honey or even nutrients such as eggs but the duration of the fast remains the crucial element. Physicians need to make clear to hunger strikers that non-total or partial strikes, if prolonged, lead to death but at a much later stage than a total fast.

Some forms of partial fasting are considered as "cheating" by the authorities. This can lead to controversy about the seriousness of the protest. Prolongation of the period for potential negotiation, however, is often beneficial to the final outcome and helps avoid deaths. Therefore physicians can find themselves in an apparently counter-intuitive situation. They may see more advantages in terms of life-saving opportunities in a longer hunger strike which allows more time for negotiation rather than a short fast which is more restrictive in terms of what can be ingested and therefore more lethal. Physicians need to avoid implying to protesters or the authorities that non-total fasting is not serious or lacks credibility. They should not challenge partial hunger strikers on the non-total quality of their protest fast. Physicians need to understand that partial fasting for a lengthy period of time can be a legitimate form of protest which could provide more time to find a face-saving solution for all involved and thus be instrumental in avoiding fatal outcomes. They must not, however, let themselves be manipulated by either the authorities or the hunger strikers. Physicians must not give erroneous clinical testimony or advice. Prison doctors, for example, have been known to threaten hunger strikers with grave medical sequelae that are fictitious. In one example, doctors

told hunger strikers that fasting caused impotence, with the sole purpose of frightening them into giving up their fasting. This sort of action is completely unethical and undermines any trust that hunger strikers may have in the medical profession.

5. The duty to maintain confidentiality

The duty of confidentiality is as strong in custodial situations as in the community. It is never an absolute requirement in either context if serious harm would result from non-disclosure and physicians need to make an evaluation about where the best balance lies. In situations where physicians are unable to maintain some aspects of a patient's confidentiality, this should ideally be made clear at the start of the consultation. Wherever possible, however, physicians should respect patient confidentiality as the maintenance of trust depends upon it. This applies to non-medical information given to physicians by patients. For example, physicians interviewing hunger strikers might learn the names of the ringleaders of the protest, but they would lose patients' trust and may put them at risk of reprisals if they disclosed that information to the authorities.

Case example 2 - Challenges in maintaining confidentiality

In a collective hunger strike, the physician realised that the hunger strikers needed to prolong their protest to allow time for the negotiation of their goals but none wished actually to risk their lives. As the protest was the focus of media attention, however, they could not be seen to be lacking in commitment and so while ostensibly refusing normal food, they privately agreed with the doctor to accept some nutrition and hydration intravenously. The physician maintained the trust and confidentiality of the prisoners by not disclosing the full situation to the prison authorities who, recognising that normal food was still being rejected, eventually threatened to end the strike by force feeding. The physician intervened and explained that he had the situation under control without force. Both sides in the protest were engaged in a drama where neither was willing to be seen to concede. The doctor's ability to agree privately with the prisoners to provide artificial feeding allowed time for both sides to reach an acceptable compromise without publicly losing face.

Hunger strikers also need to be aware that requiring a doctor to maintain their confidentiality can in some cases have potential disadvantages for them. Such aspects need to be discussed at an early stage.

Case example 3 - Challenges in maintaining confidentiality

A political prisoner on hunger strike complained to a visiting physician that he had been forcibly fed while semi-conscious contrary to his verbal advance instructions. The prisoner wished to register a formal complaint. Having listened carefully to the prisoner's story, however, the doctor had doubts as to whether the prisoner had indeed been fed against his will since although semi-comatose, he was a strong man who could have exhibited some signs of resistance. In fact the prisoner had made no effort to resist and later, in private, he confided in the physician that he was relieved to have been resuscitated but that these facts had to be kept confidential both from other prisoners and from the prison authorities. The doctor, therefore, was obliged to continue the pretence of taking the complaint seriously but in cases such as this, physicians also need to explain to hunger strikers the risks of such a deception since in future situations, it would be assumed that the hunger strikers did not want to be resuscitated unless they had made their real views plain. A hunger striker in this situation would have a particularly difficult dilemma if asked to sign a formal advance directive refusing future resuscitation since this would either force him to expose his real views or it would mean that he risked being allowed to die in future if evidence were lacking of his real feelings. In this case, as a last resort, the confidentiality of the prisoner's discussion with the visiting physician could arguably be breached to avoid that harm but this would really need to be discussed in advance with him.

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6. The advantages and disadvantages of communicating with families

Families may support detainees' fasting or try to get the authorities to intervene to save the prisoner's life regardless of that individual's views. Given, however, that people in custodial settings often have only limited ways of making their own genuine views known, physicians attending them can find it useful to communicate with their relatives. Direct contact with them may provide crucial background information allowing them to make the best decision. Cases also arise where physicians find themselves at odds with a family demanding intervention which the patient refuses. 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 their primary professional commitment is to the patient. Where families support the hunger striker or openly lobby for media attention, the authorities may be reluctant to allow family visits and physicians may have an important role as intermediary. Although pressures on hunger strikers should obviously be kept to a minimum, this should not be an excuse to suppress family visits.

7. Is there a duty to act as mediator?

The role of mediator is outside physicians' obligations in most circumstances but in the context of hunger strikes, they can be particularly influential in saving life if they are willing to do so and have the trust of both sides. They also need an objective view of the true situation. They may then be in a position to negotiate and possibly obtain concessions from both sides. They have to decide from the start, however, whether they can act as a medical intermediary between hunger strikers and the authorities and if they cannot, they need to make that clear to patients and not pretend to play the role. Prison doctors are likely to be in a privileged position if they have the trust of the prisoners and the confidence of the prison authorities. If hunger strikers trust and confide in them, physicians are able to evaluate how urgent is the need for mediation. Most hunger strikers desperately want to find a way out of the confrontation and

often stop fasting if they obtain some minor form of concession from the authorities. In such cases physicians may be in the best position to negotiate some compromise between the two parties. When the demands of hunger strikers are very obviously out of reach, prison doctors must not fall into the trap of pretending otherwise or insinuating that a solution is achievable through mediation. They should make clear that they are outside the negotiations but the crucial role of providing accurate information to patients about their medical condition should continue.

8. The duty to remain objective and independent

Medicalisation of hunger strikes often occurs and can threaten physicians' ability to act independently. Local law may require medical monitoring of the hunger strike and the status of a particular hunger striker can also influence the attention given to that person. Physicians may have to balance objective medical observations with pragmatic face-saving situations, in order to buy time for essential negotiations to produce results. They must avoid pandering to any particular interest group by giving medical information or advice that is scientifically questionable or inaccurate.

Physicians working for prison administrations or other detaining authorities sometimes cannot be really independent. Even if they are fully aware of the ethical implications of a terminal hunger strike, without external support they are often powerless to oppose administrative decisions imposed on them by the authorities. Medical associations have a duty to inform physicians of international ethical guidelines that should be respected at all times and to provide support for them. Independent physicians ideally should be permitted to counsel hunger strikers in the interest of all involved and in order 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.

9. Management of medical conditions during a hunger strike

The WMA's training module on prison health care contains a detailed account of the clinical stages undergone by hunger strikers between the first days of fasting and the final stage between 45 to 75 days later when death occurs from cardiovascular collapse or severe arrhythmias. As well as the physical aspects, physicians need to be aware of patients' mental and psychological disruptions. 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 (taking just water) with starvation in concentration camps. Among the symptoms experienced by long term hunger strikers are significant gaps in memory and inability to concentrate. They live for the moment. Total fasting forces the body to find substitute sources of glucose, essential for providing energy, to the brain in particular. Lack of calorie 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. If the fasting leads to medical complications, it is the duty of physicians to do more than merely take notes and monitor vital signs. There is need for them to enter into a serious discussion with each hunger striker. 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.

10. Artificial feeding, force-feeding and resuscitation

It is important that physicians understand the moral and practical distinctions between forcible feeding, artificial feeding and resuscitation. The WMA Malta Declaration 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. Force-feeding, however, is out of the question. If the protester's intent is to extend the fasting as long as possible, there should be advance discussion between the physician and hunger striker to clarify the expectations on either side. In particular, physicians need to be clear what actions they have patient consent for once the fasting has clouded the patient's mind and coherent communication becomes impossible. Physicians must discuss the crucial issue of artificial feeding and resuscitation before that stage. In some countries, patients' known wishes dictate what the physician does after consciousness is lost. In others, this is not an option and physicians may be prosecuted if they fail to intervene to save the hunger striker's life. Physicians need to know clearly what attitude to adopt and also make this clear to the hunger striker, so that they can reach a decision in common. If, for personal reasons, physicians cannot accept the patient's decision, they should say so and step aside so that another physician can act according to the informed decision of the hunger striker.

Artificial feeding should not involve coercion. It may be prescribed by a physician or be imposed by a judicial authority. This occurs usually at a stage when the hunger striker is no longer fully conscious and too weak to express a view. Artificial feeding involves administering nutriments and liquids parenterally or through a naso-gastric tube. Even when physicians agree to respect patients' advance refusals, some circumstances may justify a decision to resuscitate or artificially feed a hunger striker who has lost competence. A justification would be for example, that the situation has changed after the patient lost awareness so that the advance refusal may be considered inapplicable to the new scenario. If, however, when competence is regained, the hunger striker persists in the refusal of feeding or treatment, the physician should allow the person to die in dignity, without repeated resuscitations.

Physicians should never condone or participate in forcible feeding or any other enforced measures which may amount to cruel, inhuman and degrading treatment. When hunger strikes have a political component, the authority in charge may decide to end them by force and order the forcible artificial feeding of protesters. This may be decided very early on in the fasting, when there is no actual medical need to administer nutrition. It should be realized in this

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Declaration of Malta Glossary **To be read in conjunction with the background discussion paper on management of hunger strikes.**	
Advance instructions/advance directive	Mentally competent patients can give consent or refusal in advance for future medical interventions, in order for their wishes to be known if later mental impairment leaves them unable to express a view. Advance instructions are a useful indicator of an individual's views but only if the person making them is aware of the implications and not pressured to make a certain choice. These criteria can be hard to meet in custodial settings but are not invariably absent. Physicians need to be aware that at the start of hunger strikes, there can be pressure for hunger strikers to prove that their intentions are serious which may push them into making an ill-considered advance refusal of resuscitation. Where possible, physicians need to discuss this privately with hunger strikers and ascertain their real intention. Some advance instructions truly reflect the individual's wishes but others do not. Physicians need to assess the evidence. Advance instructions can be written or verbal but have no value if made under duress. They may also be invalid if the situation has undergone significant change since the individual lost competence and it is no longer what he or she expected it to be. (See WMA statement on advance directives, Helsinki 2003).
Artificial feeding	Although often seen as synonymous, artificial feeding is not the same as forcible feeding. All force-feeding is artificial but not all artificial feeding is forced. Artificial feeding in hunger strikes can be a solution for hunger strikers who do not want to endanger their health but who refuse to take nourishment normally for reasons of their own. Artificial feeding is acceptable if hunger strikers make known their agreement to it by any means or, if incompetent, they have not refused it in advance.
Force feeding	Force feeding not acceptable. It involves use of force and physical restraints to immobilise the hunger striker. Although described as life saving, it is sometimes implemented as a coercive measure to break a hunger strike
Autonomy	Physicians should respect patients' autonomy by not overriding their voluntary, informed and competent decisions. In the case of hunger strikes, this means physicians should respect patients' refusal of feeding. It is important for physicians to explain accurately to hunger strikers the potential health impact of prolonged fasting and to advise them on how to minimise the harmful consequences by for example, increasing fluid and vitamin intake. Consent and refusal are invalid if the result of coercion. Autonomy is one of four key principles that are frequently portrayed as core to modern medical ethics.
Beneficence & Non-maleficence	The duty to benefit (beneficence) and not harm (non-maleficence) are also part of the four key principles but need to be interpreted holistically. Imposing treatment in the face of valid patient refusal is seen as a harm not a benefit. In custodial settings, this raises questions about whether prisoners or detainees can make such free choices.
Best interests	Physicians are morally obliged to act in patients' best interests but this does not mean prolonging life at all costs. An assessment of best interests must be a balance between seeking the best medical outcome and a consideration of the patient's own views, values and preferences. Physicians do not act in patients' best interests by overriding patients' strongly held wishes.
Confidentiality	All patients, including detainees, have rights of confidentiality but these are not absolute rights. Consent to disclosure should generally be sought from competent individuals. Information about incapacitated individuals can be disclosed if it is in their best interests. For all patients, disclosure is also permitted if it prevents serious harm to others. In hunger strikes, information about the patients' views and medical condition should be shared among health professionals providing care. Information can be given to other people such as relatives and lawyers with hunger strikers' consent.

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Dual loyalties	Physicians supervising the management of hunger strikers often have contractual duties and obligations to other agencies, such as prison authorities. The WMA strongly emphasises that medicine is a privilege that invariably carries certain responsibilities. All medically qualified individuals must demonstrate the professional duties of beneficence and non-maleficence even when they have dual loyalties and even if their work does not involve the actual provision of care. This means that all people who have been trained as care givers have the same ethical duties of care givers even when not employed to provide care.
Eating/fasting	Good communication depends on all parties understanding common terms in the same way. Different cultures have very differing views on what constitutes fasting or accepting nutrition. This is addressed in the WMA background paper and also in chapter 5 of the WMA's Internet course for prison doctors on www.lupin.nma.net.
Hunger strike and „Voluntary Total Fasting"	Refusing nutrition takes different forms. The terms "hunger strike" and "voluntary total fasting" are sometimes used inter-changeably even though fasting may be neither voluntary nor total. The" voluntariness" of the individual's decision is a key issue for physicians in assessing whether to abide by it. Partial or short-term food refusal rarely raises ethical dilemmas. The most accepted definition of a hunger strike is total fasting (taking only water) for over 48-72 hours. Salt, minerals or sugar may be added to water. Dry fasting where all nutrition and hydration are refused is uncommon and leads to death within a week. A hunger strike is not equivalent to suicide. Individuals who embark on hunger strikes aim to achieve goals important to them but generally hope and intend to survive.
Justice	Justice is another of the commonly cited four key principles of medical ethics. In this context, it is the requirement for physicians to treat hunger strikers fairly, by listening to their views and trying to minimise undue coercion from any source.
Physician/physician assistant	The WMA primarily addresses its guidance to physicians but in the context of hunger strike management, other health professionals are likely to be involved and should be encouraged to abide by the Malta Declaration. Professional guidance for other groups such as nurses and paramedics, for example, generally reflects the same principles.
Undue pressure/coersion	Informing hunger strikers of the implications of their decisions and encouraging them to reflect are essential and do not constitute undue pressure. Attempting to dissuade them from fasting by threats, including the threat of forcible feeding, is not acceptable.

respect that the authorities often have specific agendas when ordering doctors to artificially feed (or force-feed) hunger strikers. While claiming to want to save lives, some coercive authorities clearly intend to repress the principle of protest. For example, the authority may decide to force-feed hunger strikers after two weeks of fasting, when there is no immediate medical need to intervene. It may also be decided to feed prisoners who resist by brute force, tying down their limbs and forcibly inserting a naso-gastric tube. This coercion is what defines force-feeding. It is not necessarily carried out by medical staff but may involve medical orderlies if doctors refuse.

Case example 4

In a collective hunger strike, the degree of commitment to the fast varied considerably among the hunger strikers. It was clear to the visiting physician that some prisoners were absolutely determined to fast until they died. These prisoners not only refused all nourishment and drank only water but they resisted all attempts to provide nutrition by naso-gastric tube. If tubes were inserted against their will, they used them to suck out any nourishment that had gone into their stomach. Other prisoners in the same strike however, told the doctor privately that they were willing to accept an intravenous line or naso-gastric tube as long as they could maintain the pretence publicly that these interventions were done against their will. Since all the prisoners were saying publicly that they were unwilling to be artificially fed (even though privately some were saying the opposite), the first task for the doctor was to separate the

prisoners from each other without in any way indicating that some were willingly accepting nutrition. Eventually, however, it was bound to become clear which prisoners were determined to fast to death since the physician recognised that it would be unethical to force feed those who were genuinely resistant. He hoped that by separating them, each of the prisoners would have some opportunity to reconsider their decision away from the influence of the peer group in a situation of privacy. For those who maintained their fast, their decisions were respected.

11. Gaining support from professional associations

Physicians can themselves in difficult situations if they want to comply with the international guidelines which are in conflict with local legislation. They may face the dilemma of whether to do everything to save a person's life or respect the right of individuals to dispose of their bodies as they please. This question is often further complicated by religious or legal issues. Local law may require physicians to intervene, even against their will, if a hunger striker's life is at stake. On the other hand, international ethics guidelines focus on the rights of individuals to determine what is done to them. Where individual rights are respected, hunger strikers have a chance to have their decisions respected. Physicians encountering difficult dilemmas should appeal to their national associations or directly to the World Medical Association for guidance and support. It may also sometimes be necessary to have help from a perceived neutral organization, such as doctors from the ICRC (International Committee of the Red Cross), Council of Europe CPT (Committee for Prevention of Torture and Inhuman Degrading Treatment and Punishment) or similar organizations.

From the Secretary General's Desk

"What do we expect from the next WHO Director General?"

On the day he was supposed to open the 59th World Health Assembly on May 22nd this year, the Director General of the World Health Organization (WHO) tragically died following a sudden illness. The World Health Assembly decided to hold an extraordinary session later this year to determine the next Director General (DG).

Dr. Lee was committed to give more power to the regional organizations of WHO. Certainly all health care is local and coming closer to place of need was logical and necessary. He headed a difficult institution, because a political organisation is struggling between opposing political interests, increasing challenges for health and an always inadequa te budget. This task is like squaring a the circle – there is no final solution.

Geneva is the home of the Red Cross, the United Nations Commission on Human Rights, the first assembly place of a supranational organization preceding the United Nations. The Conventions regulating minimal human behavior in wars have the name of this city and what ever is connected with it has the bonus of being of high moral standing. But that is an illusion. The WHO is a good example of an institution which many people believe it to be a moral authority for health care. Something it never was, and most likely never will be.

The organization was build right in the middle of a political minefield between the east and the west. In times of cold war it was one of the green tables where leaders of the political blocks could meet and discuss, without pretending to like each other. The old demarcation lines have gone. In time of globalisation, trade determines the rules. But the borders and frontiers are not gone. They are now more complex, sometimes invisible and often blurry. Players in the globalisation game often don't know whether they are friends or foes. And all may be different tomorrow. The problem is: "the old mines are still hot".

The WHO is a governmental organization and it is only as good as the governments it represents. No government of this world is made of Saints, no government is without mistakes, yet many deserve our respect. But many others have no democratic background – they are not elected leaders of their people. Many governments of this world deny their people basic rights, the freedom of speech, the right to work, the right to move, the right to build coalitions. Many governments deny their people even the right to live, they torture and abuse their own people. Yet they sit in the World Health Assembly, the highest deliberative body of the WHO.

WHO has driven many health campaigns: The fight against small pox and polio are wonderful success stories, much of it Dr. Lee's achievement. The WHO works successfully on tobacco control and fights tuberculosis world wide, it has programmes on injury prevention and disaster relief, it supports medical reference centres and provides administrative guidance for the recognition of education and training. In other words there are many, many things the WHO has to be praised for. If it wasn't there, we would have to build it.

But then it is a political organisation with the parameters described above, excluding many people from cooperation just for political reasons: Taiwan is a good example of this. Its basis of work are the decisions of the World Health Assembly and reports, facts and figures provided by the countries – or better their governments. How much do we trust reports from countries without