Medical and ethical aspects of detention and hunger strikes

The following article, written by Professor J Kalk of the Department of Medicine at the University of the Witwatersrand examines the complex ethical problems created for health workers by the hospital presence of detainees on hunger strike. It argues that the doctor's role in the management of such patients is not a passive one.

Indefinite detention may have severe effects on a person's physical and mental health

Dawn Eliot (R) is reunited with family after 11 months in detention - the impact of detention extends beyond detainees, to their families and friends

The major health impact of detention without trial is psychological and psychiatric. Thus long-term political detainees are regularly brought to the psychiatric services in Johannesburg. Experience in working with these patients has led to the development of the concept of "chronic traumatic stress disorder or syndrome". "Traumatic Stress" is defined as a stress beyond the range of normal human experience. Here in South Africa, it occurs in detainees who have been in detention for long periods of time and who have been denied easy access to family, friends and the usual social support systems. Traumatic stress results from the interruption of normal, regular life activities which include normal food, work, study, exercise, leisure and sleep environments. Common symptoms are those of depression with insomnia (inability to sleep) and nightmares. Multiple complaints, including vague aches and pains, eye problems, skin complaints (pimples), headaches and abdominal pains are also often reported. Some women have reported changes in their menstrual cycle. The symptoms lessen as soon as the stress factor is removed - for example, when people suffering from such stress are admitted to hospital.

Detention is an injury to all

It must be remembered, however, that the impact of detention is not confined to the detainee him/herself. Each detainee has a family that is directly affected; each detainee is part of a community, often in a leadership role. Thus, the damage caused to society as a whole is felt far beyond the detainees themselves.

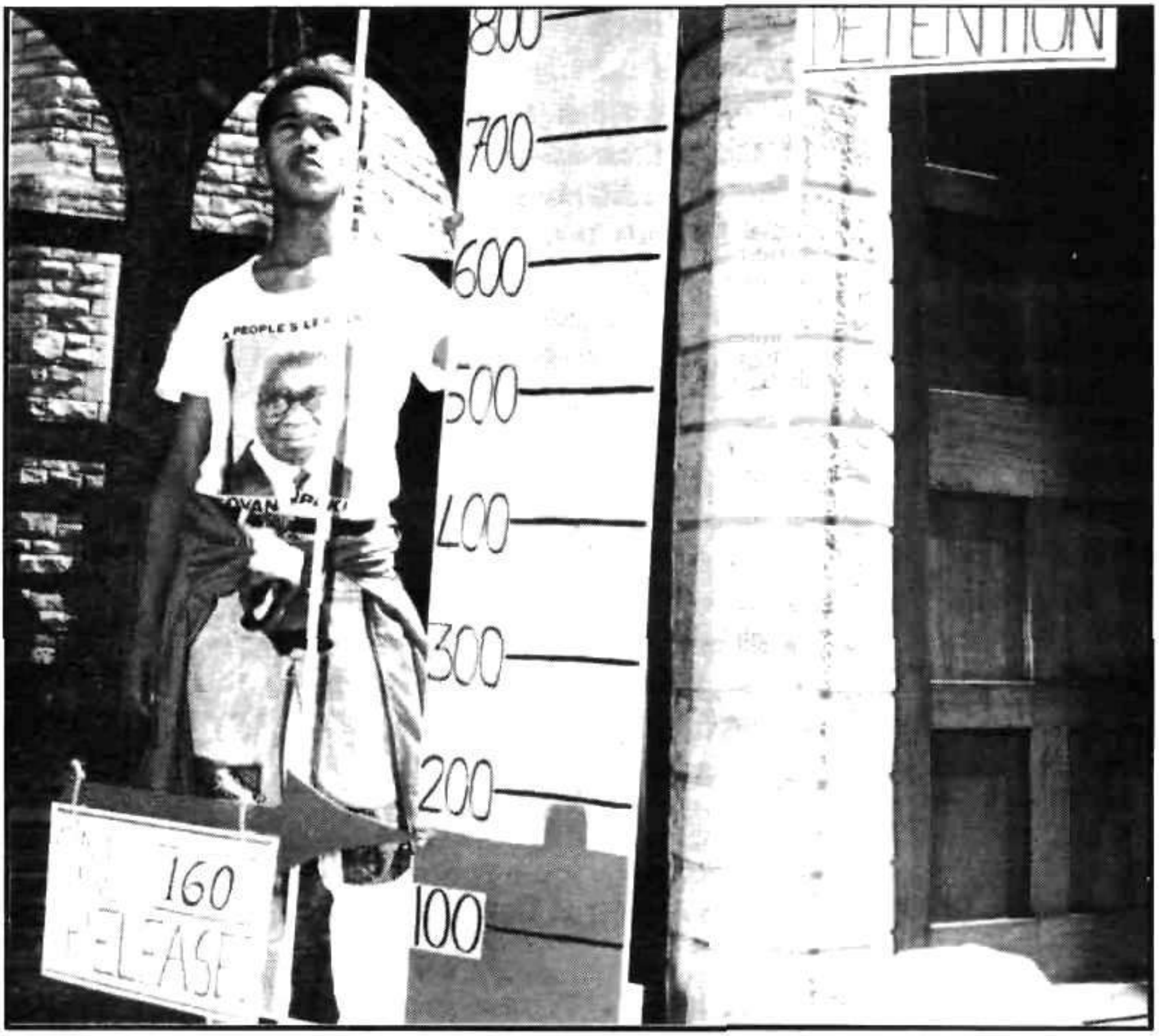
The motivation for fasting

Given all these stresses experienced by detainees, including prolonged detention with no end in sight, and with the possibility of being forgotten altogether by society, it is not surprising that detainees have resorted to fasting to draw attention to their plight. Hunger strikes by political detainees can be viewed as an attempt to reassert some control over their own lives.

What happens to the hunger striker?

The term "Voluntary Total Fasting" (VTF) has been coined as the medical name for hunger strike. The changes in physical condition during VTF have been fairly well described. In the first week there is a rapid loss of weight of about 3-4 kilograms. Thereafter, weight loss is much slower with a steady average loss of about 300 grams per day over the following weeks. Energy during this period is supplied mainly from the breakdown of the body's fat stores. It normally takes about four weeks to use up these stores in the average well-nourished individual. After four weeks, protein breakdown, especially from muscles, increasingly becomes the important source of

Charles Malunga after a 29 day hunger strike - a desperate attempt to secure his release



Detainees' barometer - monitoring the release of detainees during the national hunger strike

energy. This is the stage of potential complications, and at this stage, vitamin deficiencies may develop. Wernecke's encephalopathy - an acute brain disease caused by thiamine (vitamin B) deficiency - has been described in hunger strikers. This problem can be treated by replacing this vitamin.

The symptom of hunger experienced by detainees during a total fast may, paradoxically, disappear in a day or two. But as the fast continues, symptoms of increasing lethargy (loss of energy), weakness, lack of concentration and sleepiness occur. Some patients also complain of headaches, abdominal cramps, dizziness and faintness. Bleeding gums and haematuria (blood in the urine) may also develop. A universal complaint is that of feeling cold. After about 30 days, the hunger striker may no longer feel thirst. He or she may experience episodes of confusion which may lead onto more persistent confusion, followed by coma and death. Blindness also develops in this late stage. Most individuals will die after 40-60 days of the VTF.

The South African experience

Some of the detainees in the recent hunger strikes reached the critical stage of complications rather earlier than expected. Some developed severe medical problems after only 2-3 weeks of fasting. One reason may be that many detainees were physically fit and thin. Thus, they started the fast with relatively small amounts of body fat. Their fat stores would then not last as long as in fatter individuals. They presumably quickly reached the stage of breaking down the body's protein for energy.

Secondly, because of a poor prison diet, the possibility existed that they may have started the hunger strike with reduced vitamin stores.

Thirdly, for whatever reason, many individuals appeared to lose their thirst drive early. As a consequence, they drank less and became dehydrated with hypotension (low blood pressure) and signs of their kidneys starting to fail (pre-renal failure). This was a common reason for admission to hospital.

On average, patients in Johannesburg had lost about 10 kg in weight by the time they were admitted. This amounted to about 10- 15% of their initial body weight over a period of 3 weeks. What little medical literature there is on the topic suggests that better-nourished individuals usually reach this stage after 4-5 weeks of fasting when they have lost 18-20% of their initial body weight.

The role of health workers in a hunger strike

For doctors and other health personnel, VTF creates some complex medical and ethical problems. The doctor specifically is confronted by individuals who are voluntarily harming themselves and who become slowly but progressively weaker and sicker. This must present itself as a contradiction for a doctor, who has been trained to intervene in sickness and to preserve life. The doctor is now constrained to stand back and watch the patients deteriorate instead of providing very simple remedies to reverse the process. Against this contradiction, it must be stressed that the hunger strike is voluntary and that it is motivated by the prevailing conditions of detention. It is an act that requires great courage and determination.

Article 6 of the Declaration of Tokyo provides some useful guidelines to the doctors of such patients. It states: "Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner".

Thus, most doctors reject the option of force feeding mentally competent hunger strikers. But this does not mean that the doctor's role is a passive one and that he or she must stand back and do nothing. The declaration itself places an obligation on the doctor to establish mental competence and explain the medical consequences of the fast. This includes an explanation of the complications which may be anticipated as the fast progresses. When providing these explanations, the doctor must adopt a "neutral attitude" to the patient's responses. Specifically, there should be no pressure to break the fast, and no threat, direct or implied, to withdraw medical attention.

It is also the doctor's medical responsibility to actively monitor the hunger striker's medical and mental condition. Doctors should explain and alleviate symptoms as they develop. They should also ensure that proper nursing and supportive care are available at all times. When complications develop, appropriate therapy must be offered. For example, supplementation of fluids, either taken by mouth or even given intravenously, may be acceptable after appropriate explanations. Antibiotics for infections may also be accepted. It must be understood, however, that acceptance of such treatment does not necessarily indicate an end to the fast. Nor should the patient's refusal to accept intervention prejudice any other aspect of medical care.

The doctor should explain the medical consequences of fasting but no attempt should be made to force the hunger striker to eat

The problem of whether or not to resuscitate an unconscious hunger striker must also be addressed while the patient is still mentally competent. The doctor must obtain, in writing, instructions as to the wishes of the patient regarding emergency assistance in the event of the patient becoming confused or unconscious at some later stage. These instructions must be regarded with the utmost confidentiality. Moreover, this statement from a conscious subject should generally be respected into the period of unconsciousness. If, however, no such declaration has been obtained from a patient who is seen for the first time in a stuporose, confused condition, attempts to revive the patient should be undertaken.

The advocacy role of the doctor

The active advocacy-role of the doctor on behalf of his/her patient extends beyond illness and health issues, into psychological and social areas. It applies especially to those situations where the patients cannot help themselves. Detainees are extreme examples of those powerless to control their own personal circumstances. So it is part of a physician's role to intervene on behalf of the patient if the conditions under which the detainee-patient is held are medically or ethically unacceptable. Although it may be difficult, the medical staff must not allow themselves to become, or to be perceived as an extension of the prison services. They are there to serve the best interests of their individual patient.

The doctor should ensure that the patient in "hospitalised detention" has access to family, friends, media and study material

Thus, all patients should have ready access to family and friends, priests and social workers, reading, writing, study materials, media, and to exercise and to participate in occupational and leisure pursuits. Some or even all of these may be expressly prohibited by the conditions of detention, which, in practice, the police do sometimes try to extend into the hospital. If conditions of "hospitalised detention" preclude any of these patient rights, it is the doctor's duty to try to alleviate them through the district surgeon.

This applies also in cases when the detainee recovers from the fast but has not been released from detention. Ethical doctors may be faced with a dilemma of refusing to discharge a patient from hospital back into detention. They will be aware of the psychological problems caused by prolonged detention and that return to prison will be likely to cause the recurrence or intensification of the problems which precipitated the hunger strike in the first place. Very strong arguments, therefore, can be put forward that doctors should not willingly send their patients back to prison.

Introducing food after a hunger strike

After a prolonged fast, eg after 3 or more weeks, there may be atrophy (wasting away) of the lining of the intestine which may result in malabsorption of food. Thus refeeding should not start with normal food but with easily digestible food.

Day 1

About 1 litre of half strength skim milk should be consumed in divided helpings. An additional litre of water should also be taken.

Day 2

If half strength skim milk is tolerated, one litre of full strength milk should be given for the next 24 hours, also with additional water.

Day 3

If all is well after 48 hours, refeeding with soft, easily digestible foods can be started. If this food is tolerated the individual can gradually eat more and more normal foods over the next few days expecting to get onto a normal full diet within one week. It will take several weeks to regain the lost weight.

Should diarrhoea develop at any stage, it should be taken seriously. Oral food should be stopped although fluids should continue. If diarrhoea persists, a doctor must be consulted - intravenous treatment may be indicated.

Vitamins

Vitamin supplements should be started immediately refeeding starts. For example, simple and cheap "vitamin B Complex" or multivitamin tablets, and vitamin C tablets - one of each twice a day for a few weeks.

Exercise

Exercise should be discouraged until the individual is on a full diet. Thereafter gradually increase the amount of exercise as desired.

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