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REVIEW ARTICLE

Hunger strikes in prisons: a narrative systematic review of ethical considerations from a physician's perspective

G. Gulati[1,2,*], B. D. Kelly[3], D. Meagher[2], H. Kennedy[3,4] and C. P. Dunne[5]

[1] *Department of Psychiatry, University Hospital Limerick, Limerick, Ireland*
[2] *Department of Psychiatry, Graduate Entry Medical School, University of Limerick, Limerick, Ireland*
[3] *Department of Psychiatry, Trinity College Dublin, Dublin, Ireland*
[4] *Central Mental Hospital, Dublin, Ireland*
[5] *Graduate Entry Medical School, University of Limerick, Limerick, Ireland*

Objectives. We sought to identify and review published studies that discuss the ethical considerations, from a physician's perspective, of managing a hunger strike in a prison setting.

Methods. A database search was conducted to identify relevant publications. We included case studies, case series, guidelines and review articles published over a 20-year period. Non-English language publications were translated.

Results. The review found 23 papers from 12 jurisdictions published in five languages suitable for inclusion.

Conclusions. Key themes from included publications are identified and summarised in the context of accepted guidelines from the World Medical Association. Whilst there seems to be an overall consensus favouring autonomy over beneficence, tensions along this fine balance are magnified in jurisdictions where legislation leads to a dual loyalty conflict for the physician.

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Introduction

A 'hunger strike' is by definition food refusal as a form of protest or demand (Crosby *et al*. 2007). This is distinct from food refusal as a consequence of mental illness such as in situations where someone may be severely depressed or harbouring a fixed false belief that their food is poisoned.

Hunger strikes in prison have occurred in several countries including Turkey, South Africa, Ireland and the US Naval base at Guantanamo Bay, Cuba (Crosby *et al*. 2007). In Ireland, these came to the forefront of international attention in 1981, after the death of 10 individuals protesting against the withdrawal of special category status for paramilitary prisoners by the then British Government (Beresford, 1997).

General practitioners, physicians and psychiatrists are commonly involved in the assessment and treatment of those refusing food in prison, and in such a role may be faced with legal and ethical complexities as well as media and governmental pressures. The general practitioner is commonly asked to assess capacity, monitor physical health and may be called upon to provide emergency treatment for the acutely unwell prisoner on hunger strike (Getaz *et al*. 2012). The general practitioner may refer to a psychiatrist to exclude mental illness and assist in capacity assessment (Brockman, 1999). The general practitioner may seek a medical hospital consultant's advice when there is substantial deterioration of physical health including in medical emergencies arising from prolonged fasting or if there is a need for supervised refeeding (Caenazzo *et al*. 2016).

The most widely accepted basis for contemporary decision making remains the Declaration of Malta adopted by the World Medical Association (2006). This cites the need for ethical decision making, respect for autonomy, balancing beneficence (whilst stating that this does not necessarily involve prolonging life at all costs) and non-maleficence (which would include not forcing treatment on competent people). It states unambiguously that forced-feeding contrary to an informed and voluntary refusal is unjustifiable. It states that in the case of dual loyalties (to the patient and the state), the first duty remains to the patient and highlights the need for clinical independence, developing trust and maintaining confidentiality.

Increasing international experience and ethical debate has been published over the last two decades. To date, much of this literature has been published in

* Address for correspondence: G. Gulati, Consultant Psychiatrist, Department of Psychiatry, University Hospital Limerick, Limerick, Ireland and Adjunct Senior Lecturer in Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland.
(Email: gautam.gulati@hse.ie)

jurisdiction-specific contexts, although the key themes appear to converge. Here, we systematically review literature relating to ethical issues for physicians (a term used interchangeably with 'medical doctor' in this paper and includes general practitioners, psychiatrists and hospital medicine consultants) to identify these themes and inform discussion.

Methods

A MEDLINE and CINAHL (1996–2016) search was conducted with the search terms 'Hunger Strike' and 'Ethic*'. We included case studies, case series, guidelines and review articles provided there was a discussion of ethical issues. Publications that did not cite ethical issues (15) were excluded as were publications discussing issues exclusively to do with children/adolescents aged <18 years (1). The timeframe of the database search included 10 years before and 10 years after the landmark consensus position adopted by the World Medical Association in 2006. Grey literature and book chapters were not included in this review.

Results

We reviewed 39 publications of which 23 were included in our review. Studies were mainly in the English language, with others translated from Norwegian (1), French (3), Spanish (1) and Dutch (1) using Google translate software. The publications included papers from 12 separate jurisdictions.

Publications cited ethical arguments along one or more recognised axes in medical ethics: the principles of justice, autonomy, beneficence and non-maleficence (Beauchamp & Childress, 2001). Justice requires that procedures uphold the spirit of existing laws and are fair to all involved. Autonomy requires that the patient have independence of thought, intention, and action when making decisions regarding health care procedures and that a decision-making process must be free of coercion. Beneficence requires that the procedure be provided with the intent of doing good for the patient involved. Non-maleficence requires that a procedure does not harm the patient involved or others in society.

We present our findings in a narrative format, identifying the jurisdiction that the publication relates to, where possible, to aid contextualisation.

Australia

Kenny *et al.* (2004) writing from an Australian perspective and looking at hunger strikes in detained asylum seekers, noted that there may be pressures on the treating physician based on legal directives from an employing authority that may contradict ethical positions adopted worldwide. They report that such hunger strikes have occurred in Australia since the introduction of the policy of mandatory detention for asylum seekers, and that these came to the forefront of public attention when 200 detainees embarked on a hunger strike at the Woomera Immigration Reception and Processing Centre in 2002. They further report that an Australian Government regulation empowering the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) to authorise non-consensual medical treatment for a person in immigration detention if they are at risk of physical harm, could inherently conflict with World Medical Association (2006) guidelines that prohibit force-feeding. However, they also state that authorisation by DIMIA does not compel medical practitioners to enforce treatment if such action is contrary to their 'ethical, moral or religious convictions'.

Austria

Röggla (2005) raised an issue similar to the Australian context with a then recent Austrian legislation 'which demands and legalises medically enforced feeding of detained asylum seekers on hunger strike'. He noted that the doctor's involvement in the process, which included positioning of nasogastric tubes would be contrary to international medical standards and cited the importance for prison medical doctors to act independently of 'governmental interests'. He noted that the doctor's duties in handling a prisoner on hunger strike were well defined: acquiring a detailed medical history; carrying out a thorough examination; advising the prisoner of clinical consequences; and regular reevaluation and ascertainment of wishes. He argued that any treatment administered to the patient must be with the patient's approval.

France

Fayeulle *et al*. (2010) surveyed doctors in France about the management of hunger strikes. In all, 95 responses were received from 174 penal institutions across the country. They concluded that the majority of doctors opted for 'a neutral attitude' (63%), noting that hunger strikes were mostly brief (less than a week in 85% of cases). They went on to state that it was refusal of care that made the medical approach potentially challenging. They further detailed how 'faced with such a situation, 45% of the doctors (surveyed) privileged their duty of care' and 28% 'respected the patient's wishes'. In total, 5.5% of the doctors surveyed provided written information concerning the risks incurred during a fast and 23% of those surveyed had witnessed complications due to fasting. The utility of treatment using vitamins was rarely recognised (32.7%).

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Italy

Caenazzo *et al*. (2016) writing from an Italian perspective regarding prisoners hospitalised at Padua hospital, report instances of court ordered treatment including force-feeding. The authors suggest the use of independent 'ethics consultants' becoming involved in the case of hospitalised hunger strikers to assist the building of trust, information giving and to facilitate informed decision making. Garasic & Foster (2012) raise potential inconsistencies in the application of law so as to favour the weight given to either autonomy or beneficence based on the demographics of an individual case. They describe the case of a Tunisian Muslim prisoner charged with rape and held in an Italian prison. He went on a hunger strike, protesting his innocence and subsequently died with prison authorities reporting that force-feeding was withheld to respect autonomy.

Norway

Dahlberg & Dahl (2015) describe a Norwegian case wherein an asylum seeker in his fifties was on hunger strike for 7 weeks and thereafter brought to an emergency room with impaired consciousness, but deemed to have capacity following assessment by a psychiatrist. They note that the two opposing issues are one of patient autonomy and an ethical duty to provide immediate medical assistance. The latter, in the Norwegian legal context specifically excludes situations relating to hunger strikes, blood products and life-prolonging treatment. However, the authors opine that legislation did not appear to reflect any consistent balance between the considerations of autonomy and the medical professional's duty to provide immediate medical care. They note that exemptions for providing emergency medical care for hunger strikers were unconditionally accepted without weighing the gravity of risk to the person's life. They hypothesise that if their patient instead had expressed their political dissent by igniting himself, the relationship would not have been exempt from the obligation to help, as this is not listed among the exceptions in Norwegian legislation.

Serbia

Alempijevic *et al*. (2011) discuss the ethical issues arising in a 48-year-old sentenced male Serbian prisoner who died 15 days after commencing a hunger strike. Throughout the fasting period, he refused medical examinations and was found to be mentally competent while doing so. Autopsy results did not suggest starvation and the cause of death was one of heroin intoxication. The authors opine that despite potential conflicting opinions, one of the attending doctor's duties is to recognise the right to refuse treatment, with complexity arising when a competent hunger striker becomes incompetent. They note that the conflict between the need for treatment and respecting refusal is pressured given that the hunger striker will die or sustain permanent damage without food. The authors report that the Law on Enforcement of Penal Sanctions in The Republic of Serbia determines that prisoners must not be medically treated without having their explicit consent and that forced-feeding of prisoners is prohibited. However, if refusal of medical treatment or voluntary deprivation of food seriously impairs the prisoner's health and endangers his or her life, medical treatment shall be carried out as determined by a medical doctor who must subsequently examine the patient daily. The ethical standard set by the Serbian Medical Chamber advises that no medical examination or treatment should be initiated without the patient's consent. The Serbian Act on Health Protection also permits a medical doctor 'conscious objection' except in providing emergency medical care.

Spain

García-Guerrero (2013) summarises that the ethical issues to consider are those of autonomy, beneficence and non-maleficence. He goes on to say that autonomous actions have three fundamental components: knowledge, intention and the absence of external pressures that may influence the act. Respect for personal autonomy is twofold: adequate information to inform sound decision making by those who take them, and the absence of control. Beneficence comes into play if help is voluntarily asked for. The author suggests that force-feeding of a prisoner on hunger strike is against the principle of autonomy of the people, and could not be considered beneficence but could be considered ethically maleficent. He reports that the legal position in Spain is complex with interplays of penitentiary regulations and constitutional doctrines.

García-Guerrero & Vera-Remartínez (2015) in a descriptive analysis of episodes of 'voluntary total fasting' amongst Spanish prison inmates over a 14-month period reviewed biochemistry and weight changes. They found that only one-third of those who go on hunger strike in prison actually fast. They conclude that episodes of voluntary total fasting were common in Spanish prisons, but 'rarely were they carried out rigorously and entail a risk for those who fast'.

Switzerland

Getaz *et al*. (2012) from a Swiss perspective, propose guidelines for managing hunger strikes. In the ethical discussion, they highlight the role of autonomy stating that 'As any citizen, detainees have the right to refuse food and fluid, as well as any medical

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treatment …. The physician should not override voluntary, informed and competent decisions of the patient'. They highlight the need for a competency assessment and encourage the use of advance directives. They outline that the conventional dual physician–patient relationship shifts to a triadic physician–patient–authority relationship in case of a hunger strike and that additional partners claim a role and may try to pressure the physician, such as family, public, media or politics. By refusing to force-feed a detainee, doctors may be exposed to judicial pressure or sanctions and to negative opinions from media. They assert that the physician should be impartial, empathic and should not become involved in the conflict between the hunger striker and partners as it is critical that the physician obtains the confidence of the hunger striker but also the respect of the authority which the patient conflicts with. They indicate that the physician is also expected to play a role as neutral mediator in the conflict between the person who fasts and the partner he pressures. They narrate, in relation to conscientious refusal that 'If, for conscience reasons, a physician is unable 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'. Their opinion is that the duty of care is to the patient alone and recommend that the stewardship of health care in custody should be passed from Ministry of Justice to the Ministry of Health to minimise the dual loyalty conflict for the doctor involved.

Martin (2010), also writing with the Swiss context highlights the tensions between beneficence in the medical profession and the individual's right to autonomy. He cites the case of a cannabis farmer, who carried out a hunger strike against his sentence. An ethical conflict existed for the state, whereby it must on one hand keep those in custody safe and, on the other, be seen to treat everyone equally under the law. This could be undermined if the state was seen to be 'blackmailed' to alter a sentence through food refusal.

The Netherlands

Gevers (2000) noted that the Dutch legal position was less problematic than some other European jurisdictions and more in keeping with ethical positions adopted internationally that supported the principle of autonomy and a presumption of capacity. He noted the importance of neutrality of the doctor and raised the issue of a professional independent of the institution. The difficulty in establishing autonomy in the presence of peer pressure in a group hunger strike was recognised. Gevers noted that the Council of Europe recommendation on health care in prisons in 1998 included rules on medical examination of hunger strikers. His opinion is that the Council of Europe, however, defers to national legislation of member states in the case of intervention in hunger strikes.

Turkey

Arda (2002) commenting on the role of physicians in Turkish hunger strikes argues the need to maintain autonomy and respect consent, whilst noting that 'the boundary and validity of autonomy and its position in suppressed groups is a controversial and questionable issue'. Oguz & Miles (2005) cite their reflections from Turkey's experience with hunger strikes in 1996 and 2000–2003, where over a hundred lives were lost. Tensions between the positions that were taken by government authorities and the Turkish Medical Association are described. Their belief is that the neutrality of the treating physician is key and that the duties of the physician extend to assessing competence, checking the person's freedom to go on a hunger strike (the absence of coercion), providing information on the risks of fasting and supervise refeeding in hospital if there is informed consent for this.

United States of America

Dougherty *et al*. (2013), when evaluating the ethical complexities involved in the force-feeding of detainees at the US detention centre at Guantanamo Bay, Cuba stated that such force-feeding violates medical ethics and constitutes medical complicity in torture. They note that this practice was contrary to the Declaration of Malta (2006) and that personal morals, national security imperatives or 'the norm of military detention' were not in themselves sufficient to justify departure from the general principles of medical ethics and that issues arose from 'dual loyalty' of health care professionals. They noted that the Guantanamo force-feeding policy was a departure in two ways; favouring beneficence over autonomy and reducing informed consent to a procedural issue. They further note that the Declaration of Malta is unambiguous in stating that autonomy trumps beneficence in cases of hunger strike and go on to emphasise that beneficence does not necessarily involve prolonging life at all costs irrespective of other values. The issue of 'dual loyalties' in hunger strike cases was also raised by a Military Medical Ethics workshop (Weisfield *et al*. 2009) in the United States; such that there were two issues related to ethical decision making including the individual circumstances of each case (including cultural issues), and organisational resources to help physicians manage ethical quandaries without resorting to 'heroic tactics'. An Anonymous (2014) case report in the *American Journal of Bioethics* describes a case wherein a prisoner refusing food, deemed to have capacity, is returned to prison from a

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hospital setting with a decision that there was 'no case to treat in the absence of consent'. An application to have a guardian was not accepted given the presence of capacity. Therefore, in the United States, there would appear to be different approaches taken towards detainees in military and civil settings.

United Kingdom

Brockman (1999) summarises the ethical consideration for the psychiatrist: autonomy, competence and mental disorder. He states that psychiatrists visiting prisons may be faced with a variety of other practical and ethical dilemmas, including conflicting obligations, personal distress, countertransference and institutional illness (wherein imprisonment is causing the illness). The author states that both 'society and the law acknowledge that a competent prisoner may choose to commit suicide by starvation'. He notes that the United Kingdom's policy in relation to force-feeding altered in 1974 when the home secretary advised that a prison medical officer would not be neglecting his duty if he did not force-feed a prisoner against his will. Safeguards included a second opinion from a psychiatrist in relation to capacity, and with confirmation from the same, advice to the prisoner that whilst he would receive supervision in a hospital wing and be offered food, the authorities do not require doctors to force-feed and that medical intervention would not occur unless the prisoner himself requests this.

Non-Jurisdiction-specific publications

Fessler (2003) reviewing literature on psychological changes following starvation comments that decision-making capacity can be impaired through psychological changes following a period of starvation, and the need to work with advance directives in such cases. He notes that whilst clouding of consciousness and psychotic breakdown can affect competence, increases in 'aggressivity and anger' as the fast continues do not in themselves preclude competent decision making.

Sakelliadis *et al.* (2009) reviewed European and international guidelines relating to health care in prisons. Their recommendations on managing hunger strikes focus on the principle of informed consent and are consistent with the Declaration of Malta (World Medical Association, 2006) in that autonomy is favoured in the competent hunger striker and advance directives respected unless they are thought to be made under duress. They recommend daily re-evaluations by a physician.

Rieder *et al*. (2010) summarise historical considerations across various jurisdictions reporting that legal and ethical conflicts arise when the self-determination and intrinsic rights of the striker are ignored by authorities and cite examples of adverse outcomes where force-feeding was undertaken. They note that the European Court of Human Rights ruled in 2007 that 'forced and repeated nutrition without medical indication, with the aim of compelling the detainee to cease his protesting attitude and applied in a way that the latter causes unnecessary pain and humiliation of the detainee, is considered an act of torture'. The authors assert that medical care in these situations should impartial and independent from the judicial and penal system to avoid conflicts of interest.

Irmak (2015) outlines the potential conflict between the obligations of beneficence and autonomy. He states that international medical guidelines require physicians to accede to unpressured advance directives and in the absence of such, to make a decision on the basis of the patient's values, previously expressed wishes, and best interests. He argues that in the absence of an advance directive and if competence is already lost, the physician has a responsibility to resuscitate and review when decision-making capacity is regained. Thereafter, the physician has a 'moral obligation' to respect any decisions and follow advance directives, even if this were to mean continued fasting.

Druml *et al*. (2016) published guidelines on artificial nutrition and hydration using a consensus-based methodology (Delphi). Their guidelines include a discussion of ethics. In the case of Hunger strikes, the guidelines report a strong consensus for the statement that 'providing nutrition against the will of the patient who is able to give his/her consent or make judgments (enforced feeding) is generally prohibited'. They indicate that although the legal situation might differ in some countries, the World Medical Association has established clear guidelines for physicians involved in managing people on hunger strike. The forced-feeding of hunger strikers who are mentally competent is not allowed.

Summary and discussion

We summarise key ethical issues relating to hunger strikes in prisons as highlighted by authors from 12 jurisdictions worldwide. Our review suggests that there are several key themes emerging which remain consistent with the widely accepted consensus position of the World Medical Association (2006):

a. There seems to be agreement from a medical view point that the right to autonomous self-determination should be respected in an individual who is competent and acting without duress.
b. That treatment proceeds only when voluntary consent to treatment is obtained, or in an emergency when treatment is provided to an incompetent individual in the absence of a valid unpressured advance refusal.
c. That the balance between the principles of autonomy and beneficence could be at odds in a person who is on a hunger strike, but that beneficence does not necessarily mean prolonging life at all costs.

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d. That force-feeding a competent individual against his will is an act against the principle of non-maleficence.
e. That in the case where there is conflict between loyalty to the patient and the state, the first duty of the medical professional is to his patient.

This to our knowledge, is the largest review of this topic to date. One significant limitation of this study is the lack of publications from the Middle East, China, Russia and Korea, which may bias the findings, given differing human rights perspectives across the world. Human rights intrinsically affect the weightage given to the fine balance between autonomy and beneficence considerations, especially in relation to detained individuals. The source of this bias may be linguistic, a Tower of Babel bias (Grégoire *et al*. 1995) wherein linguistic exclusions to review studies lead to exclusions, however, non-English language studies were included in this review and there were no exclusions based on articles published in dialects from the said countries. There may be a potential bias arising from a lack of studies from these regions being indexed in the electronic databases used in this review. Future research would benefit from a review of grey literature and a more comprehensive world view of the debate extending to a review including searches of legal and human rights databases. Similar ethical issues exist in jurisdictions such as Israel, where concerns have been expressed around legislation that permits force-feeding of Palestinian hunger strikers (Bob, 2016) and China, where hunger strikes in relation to political prisoners are sometimes reported in local media as monitored by human rights organisations (Fung, 2016).

Capacity assessment is a key consideration for practitioners attending a prisoner on hunger strike. Capacity may be affected by mental illness or as a result of physiological changes arising from prolonged fasting, although, as Fessler (2003) points out, this evaluation is complex. The clinical boundaries of mental incapacity may be critically tested in hunger strikes. For example, in some jurisdictions, the elements of mental capacity to give or withhold consent may be defined in statutes that do not fully accord with international rights, conventions or clinical science. In jurisdictions with legal provisions for making advance directives, such may be used to respect autonomy for those who subsequently lose decision-making capacity (Getaz *et al*. 2012; Irmak, 2015).

Ethical conflicts for physicians may be highlighted by jurisdictional law. In relation to the position in Australia (Kenny *et al.* 2004), a useful distinction could be made from a position taken by a Government Department which 'authorises' non-consensual medical treatment. The key argument arising would be that 'authorising' is not the same as 'ordering'. In comparison, legislation which 'demands' (Röggla, 2005) in the Austrian context is more strongly worded and likely to be a more potent source of ethical conflict for attending physicians.

Our review highlights several potential conflicts of interest for physicians working in prisons. The majority of publications included highlight the fact that despite these conflicts of interest, the 'duty of care' is primarily to the patient. Röggla (2005) cites the importance of acting independently from 'governmental pressures' and Getaz *et al*. (2012) surmises that physicians could be subject to judicial pressure or sanction as well as adverse media coverage in the course of their work in these circumstances. The primary conflict of interest comes from 'dual loyalty' (Weisfield *et al*. 2009) in that the physician has a 'loyalty' to the patient as also a loyalty to the employing organisation. As the latter are likely to be governmental organisations, the latter 'loyalty' extends to that of the state. There are areas of clinical practice in prisons where there is clear guidance wherein to breach patient confidentiality such as when disclosure is made of information that could potentially affect the security of the institution or the immediate well-being of another (Blightman *et al*. 2013); this would be one example of when duty to the state overrides the duty of confidentiality to the patient.

The state has penal interest in those found to have criminal culpability following principles of justice, whether restorative or retributive. Ethical conflicts exist for the state in the case of prisoners on hunger strike where the state must, on one hand, keep those in custody safe, and, on the other, be seen to treat everyone equally under the law (Martin, 2010). Such ethical conflicts may cause the state to pressure a physician to share more information about a prisoner than he usually would or indeed coerce the prisoner to end the hunger strike. The latter would arguably, fundamentally conflict the principle of autonomy. A number of publications reviewed (Oguz & Miles, 2005; Getaz *et al*. 2012; Caenazzo *et al*. 2016) cited the importance of the 'neutrality' of physicians involved as key to their involvement. Caenazzo *et al*. (2016) argue that such conflicts of interest may be avoided by the use of independent 'ethics consultants'. Dougherty *et al*. (2013) argued that personal morals, national security imperatives or military detention were not in themselves sufficient to justify departure from the general principles of medical ethics despite the 'dual loyalty conflict'. No publication in this review suggested a departure from this position, which is in keeping with the Declaration of Malta (World Medical Association, 2006), which notes that 'Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is

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to the individual patient … 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'. Brockman (1999) writing from a psychiatrist's perspective notes that the prisoner may see the doctor as an 'agent of the state' which in itself is not conducive to a therapeutic relationship and that the doctor, who may already be subject to conflicting obligations in having to weigh up the duty to the patient *versus* a duty to the institution, may experience personal distress precipitating feelings of therapeutic impotence or anger.

Establishing autonomy and the absence of coercion within a prison setting can be challenging. The goal of prison officers is to maintain order while operating within the limits of the law. Privacy and confidentiality of medical consultation may be threatened where prison officers escort a patient for review. Staff suspicion and animosity towards prisoners have the potential to colour a medical encounter (McKinney, 2008). Such potential infringements on autonomy need to be factored into medical assessment.

Dougherty *et al*. (2013), in keeping with the position of the World Medical Association (2006), note that force-feeding competent hunger strikers may be complicit to torture. It may be worth considering the ethical complexities which may arise for a physician called to conduct the feeding procedure itself. Boyd (2015) says that any form of force-feeding of the competent hunger striker whether it be through nasogastric tube or intravenous total parenteral nutrition would be 'wrong' and a violation of basic human rights. The physician bound by the accepted worldwide position may refuse to be involved (Tait, 2015). In such circumstances, non-medical personnel might potentially be employed such as in the case of state ordered executions in the United States (Boehnlein, 2013) which albeit a separate, more complex ethical issue, raises some shared ethical conflicts for the physician involved. The issue is that whilst a procedure may be incompatible with medical ethics, the consequences of lack of medical expertise may have significant adverse effects on patient well-being through procedural complications, improper pain control and such considerations may themselves violate human rights through increased suffering.

It is evident from our review and considerations discussed that the care of prisoners on a hunger strike will remain an ethically complex issue for medical practitioners who are asked to advise in this circumstance or if their patient is subjected to a medical procedure by non-medical staff. Ethical issues arise for psychiatrists who play a key role in assessing for the presence or absence of mental disorder, motives for hunger strike and, most importantly, help assess capacity. The central premise remains the need to act in the interests of the patient in the face of institutional and societal pressures.

Conflicts of Interest

None.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this review was not required by their local Ethics Committee.

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