1. Preface

The Oxford English Dictionary defines Hunger Strike as the act of refusing to eat for a long period of time in order to protest about something. This is in contrast to a patient who is not eating because of food preferences, an eating disorder, a (physical) clinical symptoms (e.g. nausea from chemotherapy or withdrawal from drugs and alcohol) or other serious physical or mental illness. The objective of this policy is to provide the Justice Health and Forensic Mental Health Network (Justice Health NSW) staff with procedure/s for the management of a patient commencing a hunger strike and to minimise the associated health risks of a hunger strike.

Please reference to (Appendix 2), The Australian Medical Association (AMA) Position Statement on Medical Ethics in Custodial Settings and (Appendix 3), the World Medical Association (WMA) Declaration of Malta on Hunger Strikers

Please Note: this policy applies to all Justice Health NSW patients. This policy operates with some modifications for the Forensic Hospital (FH).

Any references to Corrective Services NSW (CSNSW) or Youth Justice NSW (YJNSW) do not apply to the FH.

2. Policy Content

2.1 Mandatory Requirements

Justice Health NSW staff must escalate patients who have commenced a hunger strike through local/Stream escalation/reporting pathways to Managers as soon as the patient is identified to them.

All patients who have commenced a hunger strike must be discussed daily at (local Health/Correctional Centre; Stream; Hospital) Safety Huddles and include Corrective Services NSW (CSNSW) for the custodial setting.

2.2 Implementation - Roles & Responsibilities

Please refer to local escalation/reporting pathway to Manager/s.

3. Procedure Content

3.1 Notification and Ongoing Management

Please Note: All interactions with patients (including [minimum daily review and assessment), must be documented in the patients' Medical Record (JHeHS) utilising the SOAP framework.

The following procedure must be implemented for patient's intent to undertake a hunger strike:

1. Justice Health NSW clinicians must escalate through local escalation/reporting pathways (including the Nursing Unit Manager) of the Health/Correctional/Detention Centre when notified of a patient's intent to undertake a hunger strike.

2. The Nursing Unit Manager (NUM) or delegate of the NUM (Nurse in Charge [NiC]) must escalate through local escalation/reporting pathways to Managers for further escalation through Clinical Operations.
3. For adults in custody, the Nurse Manager (NM) must escalate commencement of a hunger strike to the Clinical Director Primary Care (CDPC) and Clinical Director Custodial Mental Health (CDCMH). For adolescents in custody; the NM must escalate to the Clinical Director Adolescent Health (CDAH) and Clinical Director Adolescent Mental Health (CDAMH). For patients in the FH the NUM/AHNM must inform the Clinical Director Forensic Hospital (CDFH)/Deputy Director of Nursing (DDON).

4. For adults in custody, the (relevant) NUM/NM must provide daily updates to the (relevant) Service Director(s), Operations and Nursing (at daily Safety Huddles) and JHFMHN-OperationsandNursing@health.nsw.gov.au, (relevant) Clinical Directors and comprehensive clinical handover to the After Hours Nurse Manager (AHNMonDuty@health.nsw.gov.au), Hunger Strike Multidisciplinary Team JHFMHN-HungerStrike@health.nsw.gov.au and JHFMHN–HC-*[Health/Correctional Centre.nsw.gov.au]* email utilising the below format (Table 1: Patient of Concern – Hunger Strike). *[Please Note: This procedure does not apply for the FH]*.

   For the FH; the commencement of a hunger strike must be sent to JHFMHN-FH-IncidentNotification@health.nsw.gov.au. For the duration of the hunger strike; the NUM or delegate must provide shift by shift updates via the FH Shift Reports and the patient should be discussed in the Daily Safety Huddle.

   Documentation must include:

   a. Hunger Strike Progress Report form (JUS110.052)
   b. SAGO/SPOC/SMOC Chart
   c. Daily Fluid Balance Chart on Daily Fluid Balance form (SMR120001)
   d. Food and Fluid Summary form (JUS110.051)
   e. Documentation in JHeHS of the patients response as to:
      - Intent to continue the hunger strike
      - Understanding of potential consequences of continuing the hunger strike

Table 1: Patient of Concern – Hunger Strike

Patients of Concern – Hunger Strike		
Xxxx Health/Correctional Centre/Location	Name: Xx XX DOB: xx/xx/xxxx MIN/MRN: xxxx Situation:	Update xx/xx/xxxx:

Assessment

When Justice Health NSW staff are notified of a patient's intent to undertake a hunger strike, the patient must be assessed in the Health Centre/Facility. If this is not possible due to engagement of, or access to the patient, then this must be clearly documented in the patients' medical record and further attempts should be made as soon as practicable.

As part of this initial assessment the clinician should discuss with the patient, and clearly document, why they have commenced, their motivation and their intent on continuing a hunger strike.

If the patient agrees, the following observations should occur on a daily basis (or with greater frequency if clinically indicated). Please refer to Justice Health NSW Policy 1.322: Recognition and Management of Patients who are deteriorating:

- A-G assessment (Including wellbeing check) – (including documentation of) baseline observations:
    - Blood Pressure (BP) (including postural BP)
    - Heart Rate (HR) (including postural HR)
    - Temperature (Temp)
    - Respiratory Rate (RR)
    - Blood Glucose Level (BGL)
    - Weight (Wt).
- Assess the patients for signs of mental illness using a mental state examination (MSE) – Appendix 1
- Every week (7) days – Electrocardiograph (ECG).
- Urinalysis
    - Specific gravity (SPG)
    - (pH)
    - Ketones (KB) - to exclude starvation ketosis.

If the patient is not drinking, and if the patient agrees:

- Regular (frequency to be defined by the multidisciplinary team) - Electrolytes, Urea, Creatinine (UEC) include Magnesium (Mg), Phosphate (PO4) and Calcium (Ca)
- Regular (frequency to be defined by the multidisciplinary team) - Full Blood Count (FBC)

For patients who are refusing the above observations; a physical assessment, including of the signs and symptoms of hydration must be assessed to the best of clinician's ability and documented in the Medical Record (level of consciousness [LOC], thirst, oliguria, weight loss, dry mucous membranes, decreased skin turgour, increased capillary refill, postural hypotension, flattened internal jugular veins – in supine position. An assessment of the patient's capacity to refuse care will be made by the MDT if medical instability is suspected, due to the proven effects of starvation on cognitive impairment.

All abnormal findings must be documented and escalated with the treating or ROAMS Medical Officer (immediately) or for adolescent patients the Clinical Director Adolescent Health (CDAH). For the FH; abnormal findings must be escalated to their treating MO/or on-call Registrar after hours. If the patient does not agree to have vital signs monitored, this must be documented in the patient's Medical Record.

All food and/or fluid intake (including volume, e.g. 150mls of water) during the patient's hunger strike must be documented on the Daily Fluid Balance Chart on Daily Fluid Balance form (SMR120001). Justice Health NSW staff should refer to CSNSW Risk Intervention Team (RIT) Officer monitoring documentation to Justice Health NSW staff outlining food/fluid intake.

Regular medication must continue to be administered if the patient consents (unless contraindicated) and reviewed by the MO/multidisciplinary team. (Any patient refusal for medical evaluation and treatment must be documented in the patient's Medical Record).

Patients requiring insulin or oral hypoglycaemic medication will routinely require review by a Medical Officer as the dosage/regimen may need to be modified. (Any patient refusal for medical evaluation and treatment must be documented in the patient's Medical Record).

All CSNSW/YJNSW patients commencing a hunger strike must be placed on the Health Centre's Mental Health Waiting List - Priority 1 (urgent) for assessment by a Psychiatrist (the assessment must include a capacity assessment). The Service Director/Clinical Director who has been notified of the patient undertaking a hunger strike will ensure the relevant clinician is allocated to complete a mental health assessment within the timeframe. For the FH; patient's commencing a hunger strike be reviewed by a Medical Officer daily.

For Aboriginal and Torres Strait Islander patients; NUMs must contact the Manager, Aboriginal Health, Integrated Care Services.

For culturally and linguistically diverse (CALD) patients; utilise the NSW Health Care Interpreter Service (Policy Directive PD2017_044: Interpreters – Standard Procedures for Working with Health Care Interpreters). For CALD patients. In the FH - FH Procedure Interpreter Services

Please Note: Patients should not be transferred to an external hospital unless there is a deterioration in the patient's physical or mental health status. All decisions regarding transfer to hospital must be made in consultation with the multidisciplinary team (as described below), NUM and NM (in the after-hours setting the AHNM, ROAMS Medical Officer and the relevant Clinical Director/s. For the FH:

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1.249 Leave, Ground Access and SCALE - Forensic Hospital

In the Custodial Setting; the (Regional) Nurse Manager must engage the Governor/Manager of Security (MoS) of the Correctional Centre to ensure that interventions are consistent with CSNSW Hunger Strike Policies. Any challenges must be escalated via the local escalation/reporting pathway to Manager/s.

3.2 Multidisciplinary Review and Planning (including CSNSW/YJNSW in the Custodial Setting)

If the patient has not ceased the Hunger Strike by Day 3 – A multidisciplinary Meeting must be organised by the Regional Nurse Manager/Service Director (RNM/SD) that includes:

For the FH – The equivalent position/s outlined below.

Justice Health NSW Staff

Co-Director Services and Programs (CoDS&P) (Clinical)

Clinical Director Primary Care (CDPC) / Clinical Director Adolescent Health

Clinical Director Custodial Mental Health (CDCMH) / Clinical Director Adolescent Mental Health

RNM and CNM/

(relevant) SD (if indicated)

NUM (or delegate) at the Health/Correctional/Detention Centre

Nurse Manager Operations Access and Demand Management (ONMADM) – Adults

Nurse Manager, Custodial Mental Health (NMCMH) (if indicated)

Operational Nurse Manager Long Bay Hospital (ONMLBH) - Adults

NUM/s, Long Bay Hospital – Area 2 (LBH2) and/or Medical Unit at Long Bay Hospital (MU-LBH) / (NUM/s – Centre dependant - Adolescent Health

Manager, Aboriginal Health, Integrated Care Service (if indicated)

Senior Dietitian *(For advice on management e.g. refeeding syndrome)*

Plus – Any additional Justice Health NSW staff requested/required by the multidisciplinary team (e.g. Executive Director Clinical Operations (EDCO), Legal Manager).

[For older patients]

Clinical Director Aged Care (CDAC)

Specialist Mental Health Service for Older People (SMHSOP) Staff Specialist

Clinical Nurse Consultant, (CNC SMHSOP)

Nurse Practitioner, Aged Care]

External Resources

Specialty Staff Specialist/s - External (Local tertiary referral hospital) - Nominated by General Manager / Director of Medical Services (DMS)

Corrective Services NSW (CSNSW) Staff

Governor and/or Manager of Security (or delegate) of Correctional Centre

Services and Programs Staff

Youth Justice NSW (YJNSW) Staff

Centre Manager

The Multidisciplinary Meeting should include discussion in relation to:

- Background information (including Earliest Release Date [ERD])
- Health assessment (Including Capacity)
- Current interventions
- CSNSW/YJNSW patients - Camera Cell recommendation (documented on Health Problem Notification for [HPNF])
- Input from each of the MDT members
- CSNSW/YJNSW - Security Assessment

- Plan

The NUM (or delegate) must document the discussion and agreed multidisciplinary team plan in the patients' Medical Record (JHeHS).

If the Hunger Strike continues beyond Day 5 – *[The multidisciplinary team should reconvene to discuss the requirement for transfer]*. Where the multidisciplinary team agree that the patient requires to be transferred, the patient should be transferred to the Long Bay Hospital – Area 2 (ambulatory), the Medical Unit at Long Bay Hospital (MU-LBH) or Mental Health Unit at Long Bay Hospital (MHU-LBH) (inpatient) for greater intensity of onsite Multidisciplinary health care services. Metropolitan Detention Centres (Cobham, Reiby or Frank Baxter) for Adolescent Health.

Where a patient remains on a hunger strike beyond Day 3 – these multidisciplinary meetings must occur at a minimum of weekly (with extraordinary meetings as required to manage patient complexity or imminent risks have been identified).

Food and fluids must continue to be made available and accessible to patients on a hunger strike. This must be communicated to CSNSW or YJNSW or FH - Medirest. It may be contraindicated to encourage intake. The multidisciplinary Team will provide a plan regarding risk of refeeding syndrome including ongoing management and feeding. Please reference - National Institute for Health and Care Excellence (NICE) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition pp: 13–16.

With the patient's consent, the outcome of the multidisciplinary meeting should be discussed with the patient's family or carer (person of contact)/designated carer including documentation of this discussion in the Medical Record. (The multidisciplinary team will determine the most appropriate person to make this contact).

There must be consensus agreement from the multidisciplinary team to cease the Hunger Strike procedures. This must be documented by the CDPC/CDFH in the Medical Record.

Please Note: As per CSNSW/YJNSW - No negotiations with the patient regarding Correctional/Detention Centre placement or regime will be undertaken whilst the patients' hunger strike continues.

3.4 Informed Consent and Capacity

Please refer to Justice Health NSW Policy: 1.085 - Consent to Medical Treatment - Patient Information (Implementation Guide to NSW Health PD2005_406 Consent to Medical Treatment – Patient Information)

Informed consent to treatment, or refusal to treatment, requires the following:

- the patient must have capacity to consent to/refuse treatment;
- the decision must be fully informed; and
- the decision must be made voluntarily and free of coercion

In NSW there is no legislated definition of capacity. However, the Attorney General's Department of New South Wales has published the Capacity Toolkit which provides health professionals with useful guidance on assessing capacity.

The Capacity Toolkit states a person is generally deemed to have decision-making capacity when they are able to:

- *Understand the facts involved in the decision*
- *Know the main choices that exist*
- *Weigh up the consequences of the choices*
- *Understand how the consequences affect them*
- *Communicate their decision.*

The Toolkit identifies six key principles to be applied whenever assessing capacity:

1. *Adults are presumed to have capacity until established otherwise*
2. *Capacity is decision-specific and may fluctuate over time*
3. *Do not assume a person lacks capacity because of their age, appearance, disability, behaviour or any other condition or characteristic*
4. *Assess the person's decision-making ability – not the decision they make*
5. *Respect privacy*
6. *Substitute decision making is a last resort*

When assessing capacity; the Toolkit advises that assessors:

- *Tell the person about the process – communicate about the purpose of the assessment and what is involved*
- *Consider cultural and linguistic diversity and capacity. This may require the following:*
    - *Use of an interpreter*
    - *Seeking information about the cultural, ethnic and/or religious background of the patient, and taking this into account when conducting the assessment*
    - *Consideration of the effect of a proposed decision on the patient's relationships within their cultural and religious community*
- *Avoid making value judgments*
- *Avoid undue influence. Decisions should be made voluntarily and in the absence of coercion.*

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Principle 10. Physicians must assess the mental capacity of individuals seeking to engage in a hunger strike. This involves verifying that an individual intending to fast is free of any mental conditions that would undermine the person's ability to make informed health care decisions. Individuals with seriously impaired mental capacity may not be able to appreciate the consequences of their actions should they engage in a hunger strike. Those with treatable mental health problems should be directed towards appropriate care for their mental conditions and receive appropriate treatment. Those with untreatable conditions, including severe learning disability or advanced dementia should receive treatment and support to enable them to make such decisions as lie within their competence.

As such, capacity assessment for patients in the custodial setting must be by two clinicians (Medical Officer); at least one clinician, being a Psychiatrist.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

5. Legislation and Related Documents

Legislation	*Crimes (Administration of Sentences) Act 1999* *Mental Health Act 2007*
NSW Ministry of Health Polices and Forms	*Recognition and Management of Patients who are Clinically Deteriorating* *Capacity Toolkit* *Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW* *SMR110010 Standard Adult General Observation (SAGO) Chart* *SMR110019 Standard Paediatric Observation Chart (SPOC)* *SMR110.013 Standard Maternity Observation Chart (SMOC)* *Daily Fluid Balance Chart on Daily Fluid Balance form (SMR120001)* *Food and Fluid Summary form (JUS110.051)*
Custodial Operations Policy and Procedures, CSNSW	Sec 6.10 Hunger Strikes *V1.0 November 2017*
External Resources	*The Australian Medical Association (AMA) Position Statement on Medical Ethics in Custodial Settings* *World Medical Association (WMA) Declaration of Malta on Hunger Strikers* *National Institute for Health and Care Excellence (NICE) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition*
Justice Health NSW Policies and Procedures	1.322 *Recognition and Management of Patients who are Clinically Deteriorating* 1.319 *Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit*

1.085 *Consent to Medical Treatment - Patient Information. Implementation Guide to NSW Health PD2005_406 Consent to Medical Treatment – Patient Information.*

1.037 *Long Bay Hospital Admission Policy (Referral, Admission and Assessment)*

1.252 *Access to Local Public Hospitals*

1.249 *Leave, Ground Access and SCALE - Forensic Hospital*

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Appendix 1

MENTAL STATE EXAMINATION (MSE) [Framework adapted from UC San Diego's Practical Guide to Clinical Medicine (ucsd.edu)]

Appearance: How does the patient look? Neatly dressed with clear attention to detail? Well groomed?

Level of alertness: Is the patient conscious? If not, can they be aroused? Can they remain focused on your questions and conversation? What is their attention span?

Speech: Is it normal in tone, rate, volume and quantity?

Behaviour: Pleasant? Cooperative? Agitated? Appropriate for the particular situation? Awareness of environment, also referred to as orientation: Do they know where they are and what they are doing here? Do they know who you are? Can they tell you the day, date and year?

Mood: How do they feel? You may ask this directly (e.g. "Are you happy, sad, depressed, angry?"). Is it appropriate for their current situation?

Affect: How do they appear to you? This interpretation is based on your observation of their interactions during the interview. Do they make eye contact? Are they excitable? Does the tone of their voice change? Common assessments include: flat (unchanging throughout), excitable, appropriate.

Thought Process: This is a description of the way in which they think. Are their comments logical and presented in an organized fashion? If not, how off base are they? Do they tend to stray quickly to related topics? Are their thoughts appropriately linked or simply all over the map?

Thought Content: A description of what the patient is thinking about. Are they paranoid? Delusional (i.e. hold beliefs that are untrue)? If so, about what? Phobic? Hallucinating (you need to ask if they see or hear things that others do not)? Fixated on a single idea? If so, about what. Is the thought content consistent with their affect? If there is any concern regarding possible interest in committing suicide or homicide, the patient should be asked this directly, including a search for details (e.g. specific plan, time etc.).

Perception: This is a description of any observed or disclosed perceptual disturbances. Altered bodily experiences (e.g. depersonalization, derealisation), passivity phenomenon, illusion, hallucination (e.g. auditory, visual, olfactory and tactile).

Insight: Intact, partial or poor insight. The ability to identify potentially pathological events (e.g. hallucinations, suicidal impulses); acknowledgement of a possible mental health problem; locus of control (internal versus external).

Appendix 2

The Australian Medical Association (AMA) Position Statement on Medical Ethics in Custodial Settings endorses the Malta Declaration, and provides the following guidance with regards to hunger strikes:

6.1 Doctors should respect a competent individual's decision to enter into a hunger strike. Doctors should continue to provide care to the individual while respecting their voluntary refusal of nourishment.

6.2 Where a prisoner or detainee refuses nourishment and is considered by the doctor to be capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, the doctor should refuse to co-operate in artificial feeding. Forced feeding contrary to an informed and voluntary refusal is not justifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

6.3 The decision as to the capacity of the prisoner or detainee to form such a judgment should be confirmed by at least one other independent doctor. The doctors must explain to the person the consequences of the refusal of nourishment, ensuring the person fully understands the information. The doctors should be confident the person is entering into a hunger strike voluntarily.

6.4 Doctors should not apply any undue pressure on the person to suspend their hunger strike. Treatment or care of the individual must not be contingent on them suspending their hunger strike.

6.5 Doctors should communicate with a hunger striker on a daily basis to clarify whether the individual wishes to continue with the strike and what they would like to be done if he/she loses decision-making capacity. Advance refusals of treatment should be respected if they reflect the voluntary decision of the person when competent.

6.6 Where a doctor conscientiously objects to a hunger striker's refusal of treatment, the doctor should make this clear to the person at the outset and refer the hunger striker to another doctor who is willing to abide by the refusal. Assessing capacity to make a fully informed decision to refuse feeding and/or treatment is a key aspect of both the Malta Declaration and AMA guidance on hunger strikes.

Appendix 3

WORLD MEDICAL ASSOCIATION (WMA) DECLARATION OF MALTA ON HUNGER STRIKERS

Preface

1. Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres). They are usually a form of protest by people who lack other ways of making their demands known. In refusing nutrition for a significant period, prisoners and detainees may hope to obtain certain goals by inflicting negative publicity on the authorities. Short-term food refusals rarely raise ethical problems. Prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians. Hunger strikers rarely wish to die but some may be prepared to do so to achieve their aims.

2. Physicians need to ascertain the individual's true intention, especially in collective strikes or situations where peer pressure may be a factor. An emotional challenge arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment. The principle of beneficence urges physicians to resuscitate them but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made. This has been well worked through in many other clinical situations including refusal of life saving treatment. An added difficulty arises in custodial settings because it is not always clear whether the hunger striker's advance instructions were made voluntarily and with appropriate information about the consequences.

Principles

3. Duty to act ethically. All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy. Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.

4. Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made by use of threats, peer pressure or coercion. Hunger strikers should not forcibly be given treatment they refuse. Applying, instructing or assisting forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or necessarily implied consent is ethically acceptable.

5. 'Benefit' and 'harm'. Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or primum non nocere. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other determinants.

Physicians must respect the autonomy of competent individuals, even where this will predictably lead to harm. The loss of competence does not mean that a previous competent refusal of treatment, including artificial feeding should be ignored.

6. Balancing dual loyalties. Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients. In this situation,

physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient. They remain independent from their employer in regard to medical decisions.

7. Clinical independence. Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-medical reasons.

8. Confidentiality. The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously and imminently harms others. As with other patients, hunger strikers' confidentiality and privacy should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm. If individuals agree, their relatives and legal advisers should be kept informed of the situation.

9. Establishing trust. Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimises harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including situations in which the physician may not be able to maintain confidentiality.

10. Physicians must assess the mental capacity of individuals seeking to engage in a hunger strike. This involves verifying that an individual intending to fast is free of any mental conditions that would undermine the person's ability to make informed health care decisions. Individuals with seriously impaired mental capacity may not be able to appreciate the consequences of their actions should they engage in a hunger strike. Those with treatable mental health problems should be directed towards appropriate care for their mental conditions and receive appropriate treatment. Those with untreatable conditions, including severe learning disability or advanced dementia should receive treatment and support to enable them to make such decisions as lie within their competence.

11. As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast. The medical implications of any existing conditions should be explained to the individual. Physicians should verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages. Physicians should also explain how damage to health can be minimised or delayed by, for example, increasing fluid and thiamine intake. Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical. Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient what he or she understands.

12. A thorough examination of the hunger striker should be made at the start of the fast including measuring body weight. Management of future symptoms, including those unconnected to the fast, should be discussed with hunger strikers. Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted. If the hunger striker consents, medical examinations should be carried out regularly in order to determine necessary treatments. The physical environment should be evaluated in order to develop recommendations for preventing negative effects.

13. Continuing communication between the physician and hunger strikers is essential. Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want to be done when they are no longer able to communicate meaningfully. The clinician should identify whether the individual is willing, in the absence of their demands being met, to continue the fast even until death. These findings must be appropriately recorded.

14. Sometimes hunger strikers accept an intravenous solution transfusion or other forms of medical treatment. A refusal to accept certain interventions must not prejudice any other aspect of the medical care, such as treatment of infections or of pain.

15. Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees. Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.

16. Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice. Hunger strikers should be protected from coercion. Physicians can often help to achieve this and should be aware that coercion may come from the authorities, the peer group, or others, such as family members. Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike. Any restraint or pressure including but not limited to hand-cuffing, isolation, tying the hunger striker to a bed or any kind of physical restraint due to the hunger strike is not acceptable.

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

18. When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. Consideration and respect must be given to any advance instructions made by the hunger striker. Advance refusals of treatment must be followed if they reflect the voluntary wish of the individual when competent. In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered. Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution. If well informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because the situation in which the decision was made has changed radically since the individual lost competence.

19. If no discussion with the individual is possible and no advance instructions or any other evidence or note in the clinical records of a discussion exist, physicians have to act in what they judge to be in the person's best interests. This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.

20. Physicians may rarely and exceptionally consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress. If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die with dignity rather than submit that person to repeated interventions against his or her will. Physicians acting against an advanced refusal of treatment must be prepared to justify that action to relevant authorities including professional regulators.

21. Artificial feeding, when used in the patient's clinical interest, can be ethically appropriate if competent hunger strikers agree to it. However, in accordance with the WMA Declaration of Tokyo, where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a decision, he or she shall not be fed artificially. Artificial feeding can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it, in order to preserve the life of the hunger striker or to prevent severe irreversible disability. Rectal

hydration is not and must never be used as a form of therapy for rehydratation or nutritional support in fasting patients.

22. When a patient is physically able to begin oral feeding, every caution must be taken to ensure implementation of the most up to date guidelines of refeeding.

23. All kinds of interventions for enteral or parenteral feeding against the will of the mentally competent hunger striker are "to be considered as "forced feeding". Forced feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

THE ROLE OF NATIONAL MEDICAL ASSOCIATIONS (NMAS) AND THE WMA

24. NMAs should organize and provide educational programmes highlighting the ethical dimensions of hunger strikes, appropriate medical approaches, treatments, and interventions. They shall make efforts to update physicians' professional knowledge and skills.

NMAs should work to provide mechanisms for supporting physicians working in prisons/jails/immigration detention centers, who may often find themselves in conflict situations and, as stated in the WMA Declaration of Hamburg, shall support any physicians experiencing pressure to compromise their ethical principles.

NMAs have a responsibility to make efforts to prevent unethical practices, to take a position and speak out against ethical violations, and to investigate them properly.

25. The World Medical Association will support physicians and NMAs confronted with political pressures as a result of defending an ethically justifiable position, as stated in the WMA Declaration of Hamburg.