



THE PHYSICIAN'S GUIDE TO TREATING THE DETAINEE/PRISONER ON A HUNGER STRIKE

ISRAELI MEDICAL ASSOCIATION

JUNE 2014

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Printed in Israel, 2014

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Everything set forth in this document refers to men and women alike and is written in the masculine form for convenience only.

Opening Statement

Dr. Leonid Eidelman, IMA President

Over the last several years, detainees and prisoners held in Israeli prisons have used the hunger strike as a tool for having their demands met. Over one thousand hunger strikes have occurred to this point. In general, these hunger strikes began and continued in facilities of the Israeli Prison Services (IPS), while several of the hunger strikers were hospitalized in public hospitals throughout the country in the event the hunger strike continued. The hunger strikes lasted anywhere from several days to weeks and months, during which the prisoners drank and agreed periodically to undergo tests, and take vitamins and carbohydrates intravenously. Each time, the duration and extent of cooperation with IPS and/or hospital physicians varied. No detainee or prisoner in Israel has ever died during a hunger strike.

Complex professional, organizational and ethical dilemmas accompany the medical treatment of the hunger striker. The medical literature is of limited help, mostly due to the lack of controlled research in the field and great variation among studies.

According to the IMA position, forced feeding is equivalent to torture and every physician has the right to refuse to force feed a hunger striker against his or her will. In addition, forced feeding is not without its own set of risks and may itself harm the hunger striker.

In June 2014 tens of hunger striking detainees were simultaneously hospitalized in various hospitals in Israel. Against the backdrop of this complicated situation, and in order to bring about professional dialogue and agreement among the different parties entrusted with the medical treatment of hunger strikers, the Israeli Medical Association (IMA) convened a Consensus Conference under the heading of "Treatment of prisoners/detainees on hunger strikes-the medical challenge." Participating in the conference were representatives of the scientific associations, members of the ethics bureau, representatives of the Ministry of Health, the National Council for Bioethics, IPS physicians, representatives of the International Committee of the Red Cross and others.

The following are the agreements reached at the conference:

1. Doctors respect the freewill of the hunger strikers as people and patients.
2. Treatment of hunger strikers is medically complex and is contingent on different underlying conditions of the patient and their various states of hunger.

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3. This treatment is provided against a backdrop of the tension between the principle of the sanctity of life and the duty to respect the autonomy of the patient.
 4. The role of the physician is to do all that s/he can to help the hunger striker to stay alive - whether the hunger strike will continue or cease - all in accordance with the patient's free will.
 5. In accordance with generally accepted ethical principles in Israel and abroad, forced medical treatment, including force-feeding, is forbidden.
 6. Physicians must maintain complete medical confidentiality when treating hunger strikers.
 7. Doctors are not "all-powerful." The continuance of voluntary hunger strikes may cause irreversible health damage and even death of the hunger strikers, regardless of the treatment given to them.
 8. There must be cooperation between the attending physicians, the directors of the different hospitals, doctors from the Israeli Prison Service and the Ministry of Health in order that physicians comply with the accepted rules.
 9. Physicians shall be part of a team that will design the logistical preparations of the public health system for the admission and treatment of the prisoners, out of concern that the current hunger strike may grow and expand to have a substantial impact on the ability of hospitals and medical staff to provide medical care to all hospitalized patients.
 10. The Israeli Medical Association and IMA Ethics Bureau will stand by and support the treating physicians.

These agreements form the basis for this guidebook, which is meant to serve as a tool for navigating the challenge of treatment of a hunger striker.

Medical ethics and detainee/prisoner hunger strikers

Dr. Tami Karni-Surgeon, Chair of the IMA Ethics Bureau

Over the last few decades, changes that began with the adaptation of Israeli medicine to accepted standards in the US, Canada, Britain and many other countries belonging to the WHO, led to the paternalistic model being replaced by patient autonomy, which has become a leading principle in doctor-patient relations.

The meaning of autonomy is that the patient has complete liberty to make decisions, freely and independently, regarding his medical treatment and the granting of permission and informed consent prior to such treatment. Such consent will be granted on the basis of full medical knowledge, given to the patient by the doctor with integrity, transparency, and in a reasonable and balanced manner. Autonomy also means the right of the patient to push off or refuse his doctor's suggestions without their being imposed upon him. Respecting the independence of the patient means respecting him as a human being, and protecting his privacy and medical confidentiality. The physician must respect these rights and work with the patient in accordance with them. Is the situation of prisoners or detainees on hunger strikes similar to that of a patient who refuses treatment? Does a doctor-patient relationship exist?

A hunger striking prisoner is not sick. He is an individual who has chosen to express his protest, his position, in order to achieve individual, political or other gains by embarking on a hunger strike. The hunger striker might risk his life or even cause his death but this is the sole means of protest remaining to the prisoner. A prisoner in such a situation usually does not request that the doctor feed him, and certainly not by force.

This is not a case of treating an illness, it is a basic requirement for life-food and drink-which the prisoner has decided not to allow himself. There is tremendous frustration in watching from the sidelines as a person takes action that could be considered suicidal, without stopping him. The sanctity of life is a supreme value, but does it override the dignity of a person and his rights to his body and life?

Most physicians have a difficult time with such situations. We were trained to save lives, to do good and not do harm. To see a prisoner on hunger strike under your watch amounts to suffering for the doctor and keeps him up at night. What should he do with such a prisoner?

In the IMA ethical code for physicians (2009) it is written:

E. The prohibition against force feeding a hunger striker-

- 1. The physician shall explain to the hunger striking prisoner the significant risk to his life if he continues with the hunger strike.*
- 2. The physician shall not exert undue pressure on a hunger striking prisoner in order to dissuade him from his decision. The doctor should also ascertain on a daily basis how the hunger striker wishes to be treated should he lose consciousness. These findings must be recorded in the medical records and kept confidential.*
- 3. Should a hunger striker lose consciousness, the physician shall decide, based on his best judgment and medical conscience, how to continue treatment, taking into consideration the hunger striker's wishes and desires as he expressed them during the strike.*
- 4. The physician shall not participate in the forced feeding of a hunger striking prisoner.*

The doctor-patient relationship is one of trust. A person in need of medical treatment must know that in the context of this relationship he is protected, the doctor will act in his best interests, without discrimination. The doctor's obligation to adopt this outlook is universal, and was established by the World Medical Association without regard to geography, different belief systems or affiliation with opposing sides, as in war.

Prisoners who fast as protest against the authorities or in order to gain something from them are in a forced situation where they do not have many outlets for protest. Most prisons allow only a small window of opportunity for complaints or opposition, so that a fast is perceived as the sole means of protest available to prisoners. This is especially true in the case of political prisoners. A hunger strike is considered a non-violent form of



The forced feeding of a suffragette
in a British jail, 1911

protest. The threat of violence is directed at the hunger striker himself, and not directly at the authorities. In British history, for example, the suffragettes went on a hunger strike to achieve equal rights for women. Ghandi went on a hunger strike in India and was greatly admired, the Irish in 1980 went on a hunger strike that resulted in their death.

Physicians have an ethical obligation to respect the rights of hunger strikers.

The World Medical Association released two statements dealing with forced feeding and hunger strikes.

The Declaration of Tokyo from 1975 asserts that doctors will never ignore or participate in acts of torture. The Declaration clearly establishes that prisoners on a hunger strike shall not be force fed in order to continue torturing them. This is the meaning of paragraph 5 of the declaration.

The Declaration of Malta from 1991 (attached) deals specifically with hunger strikes and gives a certain leeway to the treating doctor by allowing him the final decision regarding what is best for the patient, after taking into account all considerations. Forced feeding is not an option-the most the doctor can decide, according to the Declaration, is to artificially feed a hunger striker who can no longer think clearly due to the extended fast, in order to give him a second chance.

The ethical obligations of a doctor regarding hunger strikers focus on giving reliable and professional advice to the hunger striker. The medical advice is often the deciding factor in the length of the hunger strike. The treating doctors must warn prisoners suffering from illnesses or medical problems that could deteriorate as a result of extended fasting not to begin a hunger strike-or at least not a complete hunger strike.

People suffering from medical problems such as diabetes, IBS, stomach or duodenum ulcers, or metabolic disorders should refrain from total fasting. The doctor must evaluate each hunger striker and inform him in advance of his risks in undertaking a hunger strike, in order that he might make a decision based on all available data.

Doctors who work in the prison service often find that prisoners do not believe them, even when they try to give objective advice. One can understand prisoners who sometimes do not trust physicians, whom they view as part of the prison service, no matter what their medical advice might be. The doctors are sometimes hard pressed to convince the hunger striking prisoners that they are working in their best interests; therefore, there is sometimes a need to bring in an outside physician, not simply to provide medical advice but also as a neutral mediator vis a vis the authorities. This physician can fill an essential role only if he has the trust of the fasting prisoners, and if this trust, which stems from

the doctor-patient relationship, is not breached.

In certain situations, the hospitalization of a hunger striker in the hospital for additional tests can serve a humanitarian function, by allowing the prisoner to resume eating by order of his doctor. The prisoners, for their part, will trust the doctor only if they are convinced that medical confidentiality will be maintained.

The hunger striker is transferred to the hospital after 24-28 days on a hunger strike.

The doctor treating a hunger striker must confirm that the prisoner is fully aware of the results of extended fasting. The doctor must ask the hunger striker to fully explain what he expects from the doctor at such point that the fast clouds his judgment and communication with him is no longer possible.

The physician must raise with the prisoner important issues such as artificial feeding and resuscitation, before such point as significant conversation with him becomes impossible. The doctor must clearly know which approach to take, and explain it to the hunger striker so that they may make a joint decision. If for personal reasons the doctor cannot abide by the decision taken, he must withdraw from his position as the treating physician in order to allow a different doctor to fulfill the wishes of the prisoner.

Even if the doctor agrees to refrain from treating, in certain situations he may nonetheless decide to resuscitate the dying prisoner, if the external situation changes—for instance, if a political decision is taken after the patient lost consciousness. There may additional circumstances as well that would justify such an approach, and in every case of uncertainty one must act in the best interests of the patient. However, if after resuscitation the prisoner stands by his request to refrain from treatment, the doctor must abide by this request and allow him to die a dignified death, without being subjected to repeated attempts at forced resuscitation. Doctors may take no part in such forced measures, which can turn into cruel, inhumane or humiliating treatment.

In most cases of hunger strike, the prisoners do not wish to die. Those who refuse food by definition do not wish to starve themselves to death, and they count on the medical treatment to keep them from harming themselves. Most hunger strikers prefer to find a way to solve the conflict, and will sometimes stop their strike if they get some sort of concessions from the government.

In the case of the most determined hunger strikers who refuse treatment and unequivocally state that their willingness to bear the most severe consequences of their protest, it would seem that the most logical ethical approach is to abide by international guidelines and abstain from any attempt to convince them.

The job of the doctor during a hunger strike is often ambivalent. On one hand, those who refuse food but have no intention of harming themselves may see the doctor as a savior, in that he provides artificial nutrition before any harm comes to them. On the other hand, political prisoners may view the doctor as a torturer in a white coat, who approves and carries out forced feeding by instruction of the authorities and thus betrays his role as a doctor.

Doctors outside the system and the national medical association must support those doctors who work in situations of dual loyalty (such as the army, prison services, police force etc.). Medical ethics binds the profession as a whole and there is no room in such situations for personal ethics of the physician. These doctors must be able to petition a higher medical authority if instructions they receive from their employer conflict with the basic principles of medical ethics. The World Medical Association and the Red Cross will stand by them in such a situation.

As mentioned, physicians who treat hard line prisoners determined to carry through with their hunger strike till the end can find themselves in an untenable conflict of autonomy versus the sanctity of life.

Autonomy ←————→ Sanctity of life

How can a doctor simultaneously fulfill his obligation to preserve life, preserve human dignity and honor an individual's autonomy over his body?

Certain prisoners can strongly oppose any medical treatment, and even any dialogue, in their quest to achieve their goal. One must respect the right of every prisoner to decide if he is interested in medical intervention, and the medical decision should be for the good of the patient, and only for his good. This means that there might be a need to allow hunger strikers to die-or to resuscitate them if the doctor sincerely believes that he wishes to live.

The Ethics Bureau wrote a position paper in 2005 which received the support of the IMA and is based on the Declaration of Madrid. This position paper was reaffirmed in two additional discussions of the IMA ethics bureau (the most recent in 2013). The position paper states as follows:

1. A hunger striker is a mentally competent individual who has indicated his desire to refuse to take food and/or fluids for an unlimited period of time, with the knowledge that this could cost him his life.
2. The doctor must receive a comprehensive detailed medical history of the hunger striker and carry out a thorough medical examination at the onset of the hunger strike.

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3. The doctor must inform the hunger striker of the risks involved in such a strike, including the risk that the strike may cost him his life.
 4. The doctor must inform the hunger striker whether he will be willing to accept the latter's request to refuse food and/or liquids, including intravenous feeding, should the hunger striker lose consciousness.
 5. A doctor may not apply any kind of pressure with the aim of dissuading the hunger striker from continuing the strike.
 6. A doctor shall not participate in force-feeding a hunger striker.
 7. A hunger striker is entitled to request a second medical opinion and is entitled to request that the second doctor be responsible for his continued treatment. In the case of an incarcerated hunger striker, the matter will be coordinated with the prison doctor.
 8. The doctor is entitled to offer the hunger striker the option of continuing to receive medication if the striker received medication prior to the hunger strike, as well as the option of receiving fluids during the hunger strike.
 9. A doctor is entitled to demand, in cases of coercive participation, to remove the hunger striker from the presence of fellow strikers.
 10. The doctor should ascertain on a daily basis whether or not the patient wishes to continue with his hunger strike and that this decision was made of his own free will and without external pressure of any kind.
 11. The doctor should also ascertain on a daily basis how the hunger striker wishes to be treated should he lose consciousness and is unable to make an informed decision. These findings must be recorded in the medical records and kept confidential.
 12. Should a hunger striker lose consciousness and no longer be able to express his free will, the doctor shall be free to decide, based on his best judgment, how to continue treatment of the hunger striker, keeping the latter's best interests in mind and taking into consideration the hunger striker's wishes and desires as he expressed them during the strike.
 13. The doctor has a responsibility to inform the hunger striker's family that the individual embarked on a hunger strike, unless this is specifically prohibited by the hunger striker himself.

WMA Declaration of Malta on Hunger Strikers

Adopted by the 43rd World Medical Assembly, St. Julians, Malta, November 1991 and editorially revised by the 44th World Medical Assembly, Marbella, Spain, September 1992 and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006.

PREAMBLE

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 often a form of protest by people who lack other ways of making their demands known. In refusing nutrition for a significant period, they usually hope to obtain certain goals by inflicting negative publicity on the authorities. Short-term or feigned food refusals rarely raise ethical problems. Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians. Hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. Physicians need to ascertain the individual's true intention, especially in collective strikes or situations where peer pressure may be a factor. An ethical dilemma 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. 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. These guidelines and the background paper address such difficult situations.

PRINCIPLES

1. 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.
2. 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 involuntarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

3. '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 values.
4. 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. 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.
5. 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-clinical reasons.
6. Confidentiality. The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously harms others. As with other patients, hunger strikers' confidentiality 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.
7. Gaining 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 where they cannot guarantee confidentiality.

GUIDELINES FOR THE MANAGEMENT OF HUNGER STRIKERS

1. Physicians must assess individuals' mental capacity. This involves verifying that an individual intending to fast does not have a mental impairment that would seriously undermine the person's ability to make health care decisions. Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers. They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health.
2. 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 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 to repeat back what they understand.
3. A thorough examination of the hunger striker should be made at the start of the fast. 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.
4. Sometimes hunger strikers accept an intravenous saline 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.
5. 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.
6. 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 peer group, the authorities 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.

7. 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 refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal.
8. Continuing communication between physician and hunger strikers is critical. 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. These findings must be appropriately recorded.
9. 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 needs to be given to any advance instructions made by the hunger striker. Advance refusals of treatment demand respect 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.
10. If no discussion with the individual is possible and no advance instructions exist, physicians have to act in what they judge to be 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.
11. Physicians may 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 in dignity rather than submit that person to repeated interventions against his or her will.

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12. Artificial feeding can be ethically appropriate if competent hunger strikers agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.
 13. Forcible 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.

Treatment of hunger strikers: a proposed model

Dr. Nimrod Adi-Intensive Care, Kaplan Medical Center

(Co-authors: Dr. Dekel Stavi and Dr. Galia Karp)

Principles of the document preparation

1. Existence of the four principles of medical ethics
2. Definition of the goals of joint treatment
3. Creation of a personal contract at the start of treatment
4. Ensuring the principles of treatment by:
 - Defining the type of treatment
 - Defining the severity of the stress
 - Recognizing the disease trajectory

Paragraph one: Four principles of medical ethics

(Basis for the IMA position paper and the Declaration of Malta)

- **Patient autonomy**-the patient/prisoner decides what is right for him after receiving a detailed explanation of his condition, the inherent risks and the treatment options.
- **Beneficence**-every medical procedure shall be for the benefit of the patient, according to his world view.
- **Non maleficence**-No medical procedures that could cause harm to the patient (by his perspective) shall be performed, i.e., there shall be no forced feeding.
- **Resource allocation (justice)**-equitable division of resources, i.e., not overloading hospitals, which is liable to negatively affect or even paralyze the functioning of the departments.

Paragraph two: Shared decision making

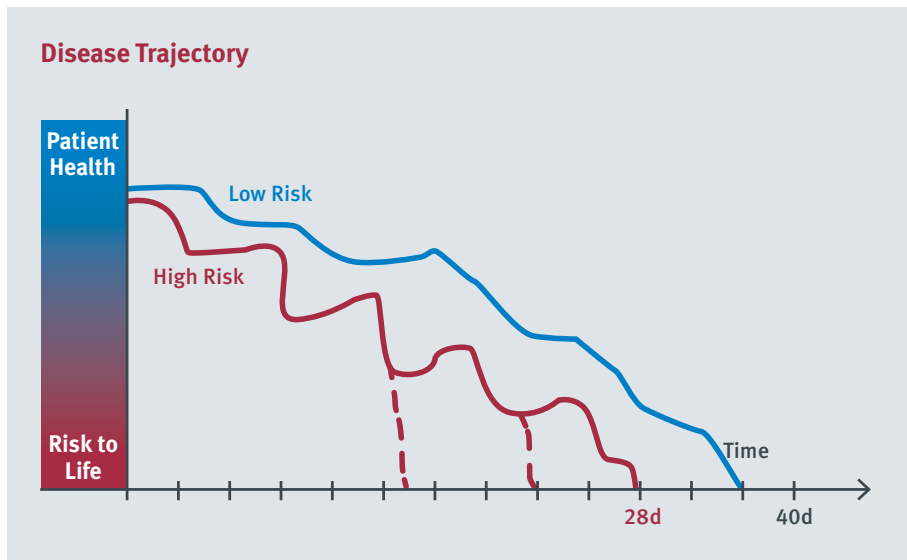
1. Allowing prisoners to go on a hunger strike.
2. Preventing irreversible damage (systemic or organ) or death among the hunger strikers (mutual interest).
3. In order to achieve the shared goals of treatment, medical follow-up should be periodically performed, including examination by a doctor or laboratory tests at critical junctures.

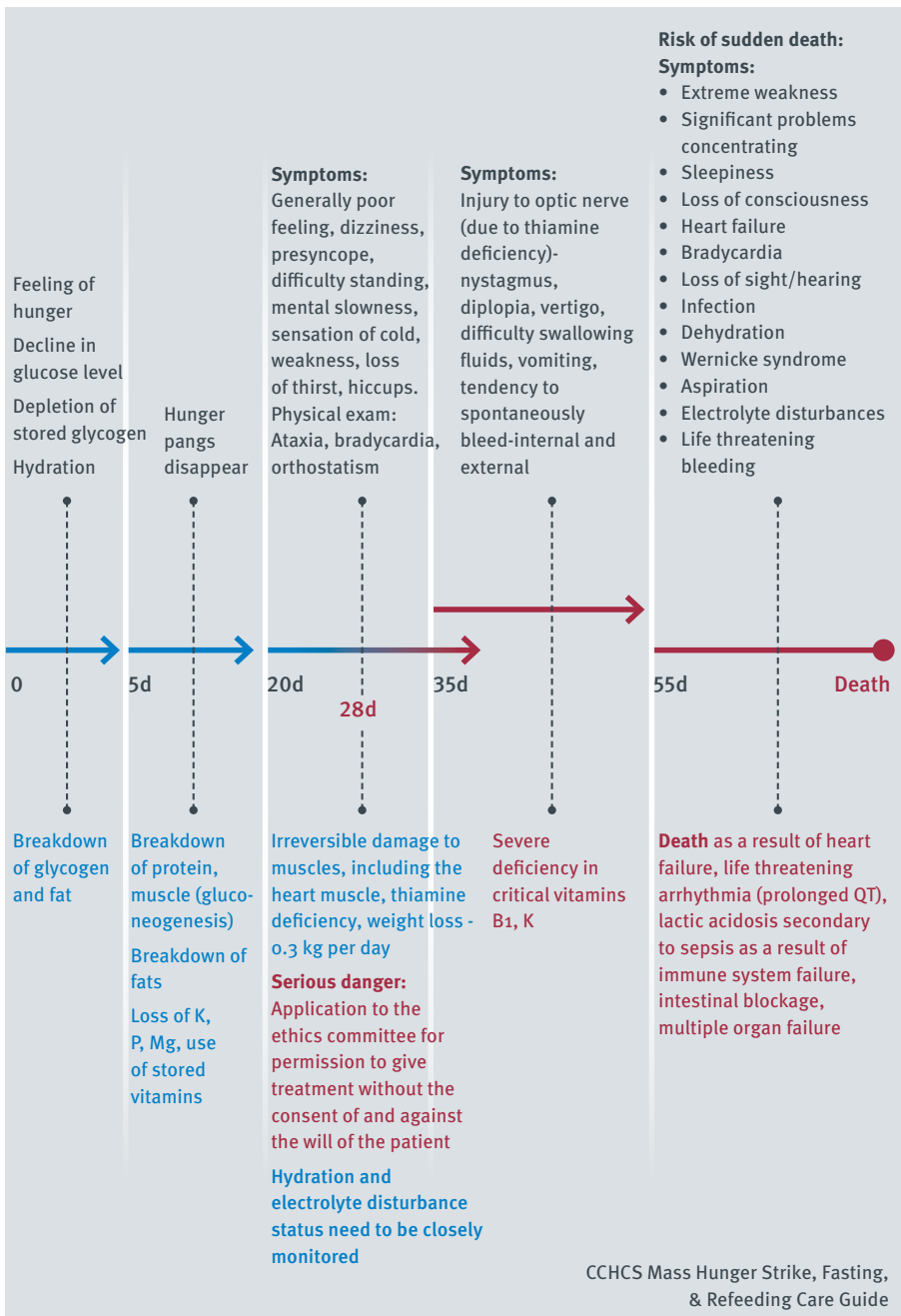
Paragraph three: Creation of a joint contract at the outset of the hunger strike

1. It is the right of hunger strikers to fast without forced feeding. It is preferable to reach a mutual understanding and agreement upon a partial hunger strike.
2. The moment there is risk of irreversible damage or death, focused medical intervention shall be performed, with the purpose of preventing and treating danger.

Paragraph four: Execution and maintenance of the treatment principles

1. Defining the risk to the patient-according to the system/organ (cardiovascular, pulmonary, renal, liver, immune) and metabolic reserve. Classification of the patient's degree of risk of injury or death accordingly: Low, Moderate or High Risk.
2. Defining the level of stress, according to:
 - Complete hunger strike
 - Partial hunger strike
3. Recognition of the disease trajectory-identifying during the course of the illness (hunger strike) points of time at which the hunger strikers are in danger, in addition to routine tests, signs and symptoms.





Risk to life

Serious risk-a situation in which:

- There is risk to the life of the patient if he does not receive medical treatment.
- There is risk that the patient will suffer serious and irreversible disability if he does not receive medical treatment.
- After 4 weeks on a hunger strike, there is a presumption that the hunger striker meets the criteria for "serious risk" and one may assume that his condition is likely to quickly deteriorate without prior indications.

(From the IMA position paper on hunger strikes, 2005
CCHS Mass Hunger Strike, Fasting & Refeeding Care Guide)

Physician consultation with the prisoner in the prison facility

The examination of a prisoner within the prison facility shall take place as soon as possible following the commencement of a hunger strike.

Stage I - confirming that the prisoner meets the criteria of a hunger strike

1. Intentional abstention from more than 9 meals
2. A mentally competent prisoner who understands the consequences of his actions-the prisoner should understand that the hunger strike is liable to cause irreparable bodily harm and even death.
3. No undue physical or emotional pressure on the prisoner to undertake the hunger strike.

Stage II -

- Case history.
- Physical examination.
- Identification of medical conditions that place the patient at risk for serious complications (high risk group).
- Explanation of the risks and complications expected in a hunger strike, including the risk of death. Clarification of the alternative of essential supplements.
- Determination of the type of hunger strike in which the patient is included: complete strike, partial strike that includes fluids with glucose, salts and vitamins (including thiamine).

Stage III - Creation of a contract

- Underlying presumption is that the prisoner wants to live.
- Joint goal-prevention of irreversible harm to a vital organ. Avoidance of life threatening situations.
- An attempt should be made to reach an agreement whereby in a life threatening

situation, life saving interventions will be performed, according to the discretion of the medical staff. After the emergency situation has passed, the hunger striker can return to his strike.

Treatment in the prison facility

- As we are interested in preventing situations of irreversible harm to organs or of risk to life, it is incumbent upon the system to allow prisoners choosing a partial hunger strike to ingest fluids with sugar. Minimum daily intake: 100-200 grams
- Patients with no background illnesses, who ingest fluids and essential supplements (glucose, salts, vitamins, including thiamine) are classified as low risk.

High Risk Group-medical situations that place the patient at risk for serious complications

- Heart-ischemic heart disease, congestive heart failure
- Lungs-Advanced chronic lung disease
- Kidneys-renal failure requiring dialysis or pre-dialysis (creatinine over 2.5)
- Liver-acute liver failure
- Metabolic-diabetes, malnutrition (BMI <20 at the beginning of the fast)
- Neurology-Nerve muscle disease
- Poor functioning
- Tumors
- Age > 60
- Patient who refuses to take supplementary fluids, salts, glucose or vitamins
- Acute infectious disease

Evaluation of the asymptomatic prisoner until day 28

- Low Risk-The prisoner shall undergo a weekly medical exam until the 14th day, after which he shall be examined every 3 days until day 28.
- High Risk-The prisoner shall undergo a medical exam every 3 days until the 14th day, after which he shall be examined every other day.

Evaluation of the symptomatic prisoner

Any symptom that indicates danger to an organ or to life, requires transfer to and treatment in the hospital.

From this moment on, the patient is classified as high risk.

Patients in a high risk group

- After day 28, the patients shall be evaluated in the hospital including case history and physical exam
- Blood tests-creatinine, glucose, Na, K, Mg, P, albumin (if possible, pre-albumin), liver and clotting functions
- EKG
- Assessment of the patient's ability to make decisions (need for psychiatric evaluation)
- The patient shall remain in the hospital for monitoring until day 28.
- For patients without background diseases who have chosen not to take supplements, if the emergency room physician's assessment is normal, the patient shall return for examination once every three days.
- It is preferable to establish uniform system-wide treatment guidelines for monitoring and treatment in the hospital.

Patients in a low risk group

- After 35 days, the patients shall be evaluated in the hospital including case history and physical exam
- Blood tests-creatinine, glucose, Na, K, Mg, P, albumin (if possible, pre-albumin), liver and clotting functions
- EKG
- Assessment of the patient's ability to make decisions (need for psychiatric evaluation)
- If the medical exam and supplementary tests are normal and the patient is asymptomatic, he shall be reevaluated (in the same manner) every 5 days.
- If the patient is symptomatic, he shall be immediately hospitalized.

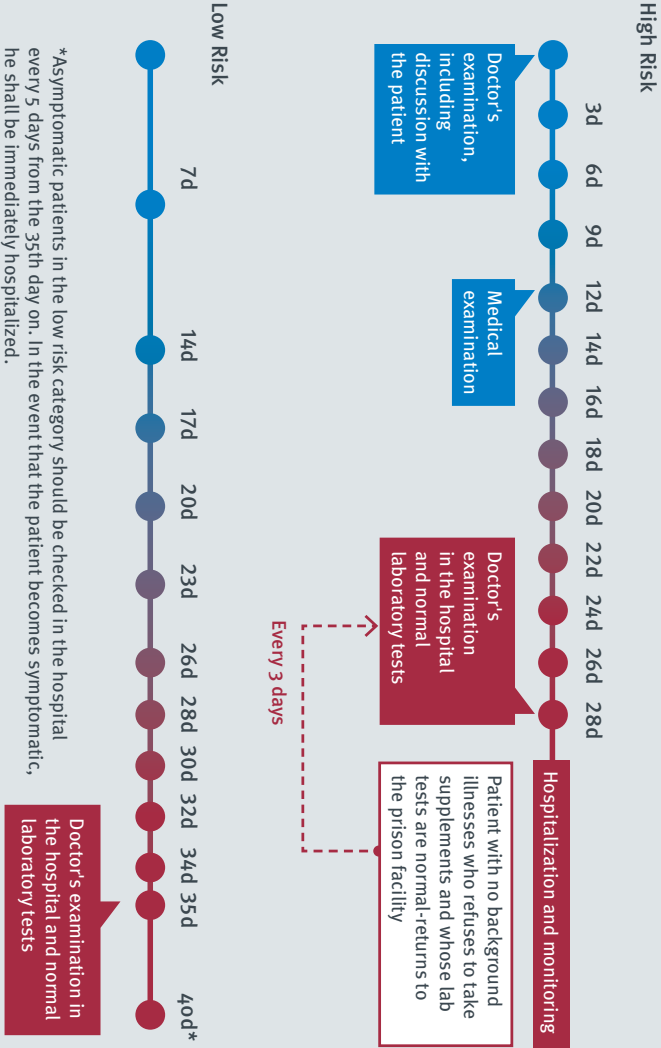
Resuscitation Bundle

In the event of organ damage or risk of life, the patient shall be treated according to the ABCD model upon his arrival at the hospital:

- A. Air Way
- B. Breathing
- C. Circulation
- D. Disability

A patient undergoing an extended fast should be viewed as liable to develop re-feeding syndrome. Re-feeding should be introduced accordingly, accompanied by supplements and vitamins.

Evaluation of the Asymptomatic Prisoner



Conclusion

The picture that emerges is of a complex reality and medical challenge for the treating physicians.

The proposed law that passed in its first reading in June 2014, and which would give legal sanction to provide treatment and/or forced feeding against the will of the hunger striker, essentially places responsibility on the physician to perform an activity despite the active objection of the prisoner. This proposed change is in conflict with accepted medical ethics in Israel and around the world, and turns the reality into one even more complicated than it currently is.

In addition to this guidebook, the IMA has set up a 24 hour emergency hotline to provide support and assistance to physicians. The hotline is manned by Dr. Tami Karni, Chair of the ethics bureau and Dr. Leonid Eidelman, IMA President, in addition to other professional figures within the IMA.



The number of the hotline is 077-8994339

We will continue to periodically update you on this matter on the IMA website.



24 hour emergency hotline 077-8994339

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