After grievances, my next best/worst love/hate relationship as a correctional physician is with hunger strikes (HSs). The hate part: HSs are time-consuming, frustrating, and—worst of all—my patient could die. The “love” part: HSs demand all the specialized skills of correctional medicine, especially working closely with custody staff. And when all that comes together, it’s a reminder of why correctional medicine is such a rewarding profession.
For it all to come together, medical staff must have some understanding of the issues faced by custody staff during a HS, and similarly, custody staff must have some understanding of the medical issues. The purpose of this article is to review those medical issues, not at the level of a medical practitioner, but at a deep enough level that the jail commander can feel comfortable in the partnership. I have organized this article into four parts that follow the chronology of a hunger strike: The Start, Managing the Middle, The End, and Epilogue.

For the purposes of this article, a HS is any reduction in fluid or food intake other than for the purposes of losing weight. Avoidance of certain foods (e.g., anything with tomatoes in it) is a food preference, not a HS. On the other hand, I am including under the HS umbrella the failure to adequately drink and eat due to physical or mental illness. Technically, this might not be what we would consider in retrospect to have been a voluntary “strike.” However, it is much safer to include it in this discussion because in the early stages of a HS both behaviors may look the same.

The Start

The reasons people start a HS are not relevant here (at least not yet). What is relevant is recognizing when a HS has started. The role of the front-line deputy could not be more critical at this stage. It is the deputy who sees the individual day in and day out, and who is in the best position to recognize changes in behavior—and in this case, changes in the inmate’s eating and drinking behavior. As such, deputies need to receive well-designed training on the observation of inmate eating and drinking behavior, both upon hiring and periodically as part of in-service training. Because there is some overlap between these two topics, I recommend incorporating this training with the standard suicide training provided to deputies. Indeed, the isolation unit and the mental health unit are two important venues in the jail where deputies need to be particularly vigilant about suicide and HS.

Jail policy should cast a “wide net” to allow deputies to raise a red flag to healthcare staff when they suspect abnormal drinking or eating behavior in an inmate. In other words, avoid limiting yourself to one very strict threshold for labeling a behavior as a HS, such as the “nine consecutively missed meals” rule. This rule can be part of what deputies look for, but—and this is especially important in restrictive housing and mental health settings—any significant change in eating habits (even if it’s not a set number of consecutive missed meals) should trigger a red flag to healthcare staff. Similar to how we view suicide risk, custody staff don’t need to be confident that someone is entering a HS before moving into action; they just need reasonable suspicion or concern.

The “nine consecutively missed meals” rule is ill-advised for two reasons. The first has to do with the physiology of water deprivation. Nine consecutive meals span three days. While people on a HS can last several weeks without food (more on that later), the rule of thumb is that water deprivation is lethal after 72 hours (sometimes less). Thus, if a person is refusing all intake—food and fluids—by the time the nine-meal rule kicks in, the person is close to death.

The second reason has to do with the physiology of both water and food deprivation. Deprivation can be dangerous even if it’s intermittent. As long as a person is deprived of enough water and food relative to their need, they are in danger. Thus, a person can drink and eat intermittently and still die of dehydration or starvation—it just takes longer. So, while deputies certainly should be alert to an individual who has stopped drinking and eating for several meals in a row, the trigger number of meals needs to be lower than nine (I would advise two or three), and they should also be alert to a pattern of intermittent refusing of fluids or food.

What should deputies do next? It’s simple. As with concern about suicide risk, they should notify healthcare staff. Which healthcare staff? The initial contact can certainly be to a licensed nurse. If that nurse is an LPN (or LVN; licensed practical or vocational nurse), your expectation should be that the nurse will immediately notify an RN (registered nurse) or practitioner (physician, physician assistant, or nurse practitioner). An LPN should not be making an assessment independently about whether the patient is in trouble. It is the RN’s responsibility to find the root of the HS, and to resolve it if the resolution is within his or her scope of practice.

In the absence of a resolution, the RN should contact a practitioner. It is then the practitioner’s job to decide whether the patient is at risk, and if so, what the course of action will be. Though it’s not critical that the jail officially label this now as a “HS,” it is critical for the practitioner to clearly communicate the nonconfidential part of the plan to custody staff, and that medical and custody staff follow this plan until the practitioner officially ends it.

Managing the Middle

Take Your Own Pulse

Now that the medical practitioner has notified staff of a problem, the goal is to keep the patient hydrated and nourished and to avoid the very difficult issue of force-feeding a patient who is not mentally incapacitated. There are two helpful concepts to keep in mind at this juncture. The first is captured by a passage from a 1970s satirical medical novel, The House of God, in which doctors in training were exhorted in an emergency to “first take your own pulse.”

As mentioned earlier, failure to drink anything is rapidly fatal. Fortunately, most strikers drink. Harm from not eating happens more slowly. Based on data from previous strikers around the world, we now
generally expect that an otherwise healthy individual who continues to drink water can survive for several weeks without food. (The 10 IRA inmates who protested their treatment in a Dublin prison in the 1980s lived for 72 days just drinking water, hence the very rough 72/72 rule: People can survive approximately 72 hours without water and 72 days without food.)

However, depending on a person’s health, as well as conditions in the jail (e.g., high temperatures), death can come sooner. On the other hand, if someone takes some nourishment in their fluid, for example tea or vitamins, they can live longer—even months, as demonstrated by strikers in the Turkish prison system in the 1990s. The take-home message is that strikers are usually not emergencies (again, as long as the person is drinking). Medical and custody staff usually have time to evaluate, negotiate, and plan.

Look for the Off-Ramps
The second helpful concept is captured by a very descriptive term coined by Dr. Scott Allen, former medical director of the Rhode Island prison/jail system: Look for the “off-ramps” that can avert the “end of the road” force-feeding of a competent person. What are some of those off-ramps?

Off-Ramp 1: Mental (or Physical) Illness. The first off-ramp is diagnosing serious mental illness (or serious physical illness that impairs the patient’s cognitive abilities). Your expectation of your practitioner is that he or she can assess whether or not the patient has sufficient decision-making capacity. This is not quite the same thing as competency. Competency requires a decision from a court, whereas every licensed practitioner should be able to—and is expected to—make decisions on a daily basis regarding their patients’ ability to make healthcare decisions in their own best interest.

Absent that ability, the practitioner has the right—the duty—to treat the patient in a way that he or she knows or reasonably expects the patient would want if thinking clearly. If the least invasive method of providing that treatment and preventing serious and imminent harm requires force—and every effort has been made to get the patient to cooperate—so be it. You should not expect the practitioner to seek a court order (nor would that be safe or defensible if seeking a court order caused a clinical delay in care).

If the underlying problem is a physical illness, treatment of the illness may be enough to restore the patient’s desire to drink and eat. Similarly, if the underlying problem is a primary mental illness, hopefully the medical practitioner, working in collaboration with the mental health practitioner, can treat the mental illness and restore the patient’s desire to drink and eat. (Note that forced antipsychotic administration beyond a few days—usually 72 hours—will likely require other legal steps, which vary from State to State.)

The role of the front-line deputy could not be more critical at this stage. It is the deputy who sees the individual day in and day out…

This is a good place to mention a rare but important type of HS: the individual who is using a HS as a means to die. As I discuss later, it is unusual for individuals to purposely use a HS to end their life, but it does happen. These cases are very challenging because the individual may have, or appear to have, decision-making capacity. The case of McNabb vs. Washington is a good example.

Mr. McNabb was convicted of arson in which his stepdaughter was severely burned. He decided to stop drinking and eating with the intent of ending his life. His reasons were quite rational, and both medical and psychiatric physicians found that he retained decision-making capacity. Reasonable physicians, correctional administrators, and ethicists might disagree about the perfect way to treat people like Mr. McNabb. Some would argue that, having decision-making capacity, a physician cannot force-feed him. Others would argue that suicide—whether attempted quickly with a rope, or slowly with starvation—is still suicide, and if we would cut the rope, we should force-feed. Fortunately, suicide by starvation in a person with apparent decision-making capacity is the exception, not the rule. (If you don’t like a story without an ending, I ordered Mr. McNabb to be force-fed.)

Off-Ramp 2: Voluntary Resumption. A second off-ramp is the voluntary resumption of drinking and eating. Because this may involve negotiating conditions of confinement, it falls in your bailiwick as the jail administrator rather than that of the healthcare team. However, there is still an important role for the healthcare team if they have gained the reputation of being fair, objective, and caring among the jail population. Therefore, you should expect, encourage, and support two or three members of the healthcare team (e.g., nurse, mental health counselor, medical practitioner) to develop a regular and meaningful dialogue with the
patient (i.e., once or more often per day; the same person each time). If the healthcare team members are unable to convince the patient to fully resume drinking and eating, they should recommend measures that can provide partial nutrition, such as vitamins, as a way of prolonging the striker’s life (in the eyes of the striker, long enough to achieve the goal of the HS).

Off-Ramp 3: Tincture of Time.
A third off-ramp—one that flows from taking your own pulse—is time. Though there are not a lot of sources of good information on the frequency with which people on HS die, there are some indications. The International Committee of the Red Cross has identified very few individuals across multiple countries and multiple years who have died.

The California Department of Corrections and Rehabilitation has arguably experienced the largest series of HSs in recorded world history—almost 40,000 individuals in three HSs spanning three years. With a few exceptions, the hallmark of the striker who has decision-making capacity is that they want something: an improvement or change in their conditions of confinement or a political/social change. Even the most headstrong of these individuals does not want to die—though he or she may be willing to die. Therefore, it is generally in their own interests to remain alive as long as possible.

Indeed, it is believed that the Turkish prison strikers (having learned from the experience of the IRA inmates who only drank water) ingested nutrients such as sugar and vitamins to stretch out their survival as long as possible. Therefore, do not feel compelled to rush, unless the individual has stopped drinking. As a very rough rule of thumb, closer physiologic monitoring is generally not necessary until someone has lost 10% of their body weight. They are in greater danger when they reach 20%, and death is a high risk at a 30% body weight loss.

Off-Ramp 4: Removing the Pressure. A fourth off-ramp—really a number of off-ramps—becomes possible if we identify coercion as contributing to the individual’s motivation to go on a HS. Earlier, I mentioned the great importance of the jail administrator to encourage and support a small team from among the jail’s healthcare professionals to visit the striker often, establishing a strong health professional-patient relationship and engendering communication. These visits might lead to convincing the patient to resume drinking and eating (second off-ramp). But, if done well, they may also eventually lead to the patient disclosing if he or she is under pressure to not eat or drink.

Pressure may come from jail peers, gang leaders, clergy, family, or other social leaders in the community. Whether learned through conversations during these frequent visits, or from other jail intelligence, if these kinds of pressure are operant, we can sometimes get the patient to resume drinking and eating by simply changing their venue. If possible, we could move the patient to the infirmary, another building of the jail, or a sister jail. Another venue change that is sometimes effective is a transfer to the community hospital (even absent any medical intervention).

Another variant of this off-ramp is to use an approach that is face-saving for the individual. If the healthcare team has been effective in establishing trust and rapport, the striker may share the coercive position he or she is in, and might agree (i.e., provide informed consent) to intravenous or tube feeding, as long as it appears to everyone that he or she was “forced” to receive these treatments.

The last part of this off-ramp is negotiating to provide some or all of the individual’s wishes. This is clearly a custody matter (unless the wishes are of a medical nature), for which the readers have much more expertise than the writer.

A Road Hazard to Avoid
Whether it is driven by a need to control, a fear of being “scammed,” or perhaps a belief that it’s the right thing to do, some jails actually restrict access to water and food if an inmate is declared to be on a HS. They will place the individual in a dry cell and stop delivering meals until the individual verbalizes that he or she agrees to resume drinking and eating.

Remember the jail’s goal in a HS is to avoid a death. The last thing we want to create are any barriers preventing someone who wants to surreptitiously take water or food, from helping us meet our goal. Therefore, if there’s a mechanism by which you suspect the striker will sneak anything orally, then do what you can to make it happen. For example, if she or he might be getting food from a roommate or a nearby resident—barring a compelling penological need—don’t move the individual away from their “source.”

The End
If your custody and healthcare team has not managed to find an off-ramp by now, you are arriving at the end of the road. It is at this point that the discussion turns from penology and physiology to medical ethics. Medical ethics are built on five pillars, three of which are relevant to this discussion. The first of those pillars—arguably the primary one—is patient autonomy; that is, a patient’s right to choose what medical therapies he or she will and will not accept. The second and third pillars are beneficence (“do good”) and non-maleficence (“do no harm”). These three principles are key in understanding the medical professional’s ethical approach to the striker.

Force-feeding therapies—at last initially—make use of one or two (or both) interventions. One is intravenous feeding. The patient can be given all of his or her daily water requirement and some of the daily nutritional requirement via an intravenous catheter placed in his or
her arm (also known as a peripheral intravenous catheter). However, there is a limit to how much nutrition can be supplied through such a catheter and eventually, to supply all of a patient’s nutritional needs, a much longer catheter must be inserted at the hospital (central venous catheter). While these interventions are common and relatively safe, they are not without potential complications, such as infection and blood clots.

The other intervention is nasogastric feeding. In this method, a flexible tube is inserted via the nose into the stomach, and water and liquid food (e.g., Ensure) are administered over the course of the day. This method can provide a person’s entire nutritional need. However, although a common and safe intervention, it is not without potential complications. Insertion of the tube through the nose can be uncomfortable and cause some bleeding, especially if the patient is not cooperative. If the tip of the tube doesn’t end up in the correct location—and sometimes even when it does—the fluid administered through the tube can go down the windpipe and cause pneumonia. So from an ethical standpoint, force-feeding satisfies the physician’s ethical duty to do good (save a life), but violates his or her ethical duty to do no harm (cause discomfort, infection, blood clots, pneumonia).

How does a medical professional balance these different ethical principles? The medical profession has been very clear in guiding its members. For a patient who retains decision-making capacity (and who is not attempting suicide), in the case of a HS, a patient’s right to autonomy is the dominating ethical principle. The most authoritative guidance comes from the World Medical Association (WMA), of which the American Medical Association is a member. The WMA’s Declaration of Malta on Hunger Strikers states that for physicians “Forced feeding is never ethically acceptable.” Their instruction assumes that the patient has decision-making capacity and has made their decision free from coercion. Thus, the Declaration allows that force-feeding might be ethically acceptable, for example, if an individual were being coerced to HS by a gang under threat of violence: “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.”

Finally, to understand the jail physician’s role in HSs, jail administrators need to recognize the difference between what is legal and what is ethical for a medical professional. Force-feeding may be legal in your jurisdiction. A court might even issue an order to force-feed the individual. However, this would not eclipse the medical professional’s ethical duty described earlier.

**Epilogue**

The coordinated efforts of your custody and healthcare team have finally paid off. The individual is voluntarily drinking and eating again. Yeah! Have your deputies bring on the trays? No!

Depending on the degree of starvation, resuming normal eating right away can be fatal. The danger is from something called the Refeeding Syndrome. The body’s sudden restart of the metabolic factory can cause dangerous shifts in electrolytes, which can cause serious harm, including fatal heart rhythms. So from an ethical standpoint, force-feeding satisfies the physician’s ethical duty to do good (save a life) but violates his or her ethical duty to do no harm (cause discomfort, infection, blood clots, pneumonia).

Dr. Marc F. Stern is a correctional physician at the University of Washington, School of Public Health in Seattle, Washington. He has served as medical director of the Albany County Jail and the Washington State DOC, and he advises and trains correctional health-care and custody professionals on systems for safe patient care. He can be reached at mfstern@uw.edu.