

Ethics briefings

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Management of prisoners on hunger strike

Management of prisoners on hunger strike has always been a contentious ethical issue. Two arguments are advanced. One is that the authorities and prison doctors have duties to save prisoners' lives. This can entail forcible feeding. The counterargument is that prisoners retain certain rights, including that of deciding when to refuse medical treatment and artificial nutrition. In some countries, practice involves respecting prisoners' refusal of food until they lose consciousness and then forcibly feeding the then incompetent person, on the grounds of "best interests". In the UK, the arguments came to a head in the 1970s when two Irish prisoners, the Price sisters, legally challenged the Home Office's right to force-feed in any case other than where refusal of food arose from a medical or psychiatric condition. It caused a furore and the earlier prison policy of involuntary feeding was overturned. In 1981, the wishes of hunger strikers, including IRA prisoner Bobby Sands, were respected and doctors supervised death-fasts in Northern Ireland. During the 1980s and 90s, the same arguments were used in response to mass hunger strikes in Spain, Morocco and South Africa. In Spain, where 60 political prisoners fasted, some regional judges ordered forcible feeding, while others allowed prisoners to fast. The debate about conflicting moral duties became highly political and in 1990 a Spanish doctor who began involuntary nutrition of hospitalised prisoners was assassinated. Nevertheless force-feeding continued until 1991 when the strike ended. In the same year, in South Africa, sophisticated protocols evolved which applied the concept of advance directives (binding advance refusals) to force-feeding.

Since 1980, hunger strikes by political prisoners have been endemic in

Turkey where well documented allegations of torture are common. In 1996, for example, 12 hunger-strike deaths occurred in prison. In December 2000, two types of hunger strike began: over 2000 protesters only accepted a very restricted diet (not intending to die); but 90 pursued death-fasts. The protest was against "F-type" prisons consisting of small cells. Prisoners believe that, by isolating them, these cells facilitate torture. The Turkish Medical Association (TMA), supported the prisoners, refusing to force-feed them. The TMA itself was threatened by the authorities who said that "judicial consequences" would be incurred by doctors who refused to force-feed. On 19 December 2000, security forces tried forcibly to break up the protests, resulting in the death of 27 prisoners and injuries to 426. Despite this, the hunger strikes continued unabated into the Spring of 2001 when the World Medical Association (WMA) was urged to clarify its guidance to doctors.

The WMA had previously issued two guidelines. The 1975 Declaration of Tokyo addresses medical involvement in torture, which it prohibits. It also prohibits forcible feeding of prisoners who have made an informed refusal. Many doctors concluded that this was because forcible feeding was seen as a form of torture, which some extreme forms clearly are. The intention, however, was to cover situations in which prisoners have been repeatedly tortured and attempt to kill themselves by fasting to avoid the continuation of torture. Just as doctors are advised not to revive prisoners simply to allow torture to continue, they are advised not to force-feed prisoners so that they can be maltreated and interrogated.

The WMA's Malta Declaration of 1991 also covers force-feeding. It says that, once prisoners are unconscious, doctors should act on an assessment of prisoners' "best interests". This seemed to many to undermine the absolutist advice of the Tokyo declaration and to support the argument that it may well be in prisoners' interests to

be forcibly kept alive. The Malta statement, as the more recent document, seemed to supersede the Tokyo guideline. To clarify this, in May 2001, the WMA considered extensively revising the Malta declaration to bring it up to date and to incorporate reference to the increasingly widely accepted concept of the binding nature of a voluntary, informed advance refusal.

Female genital mutilation

The number of girls and women who have suffered female genital mutilation (FGM) is thought to be as high as 140 million; almost 6000 new mutilations each day. There is encouraging evidence from communities that have traditionally practised FGM, however, of a recognition of its harmful effects. In Egypt today girls are 10% less likely to be mutilated than their mothers, with incidence dropping to around 84%.¹ In Kenya in January 2001, two girls won a court order to restrain their father from having them circumcised, and there is growing support for an alternative ceremony of "circumcision by words", which has been proposed by the Kenyan Family Planning Association.

It is rare to hear support for communities' rights to practise female genital mutilation from outsiders. Feminist writer Germaine Greer's comments that attempts to outlaw the practice were "an attack on cultural identity" have been strongly criticised as ignoring the purposes of mutilation and the lack of choice for those upon whom it is inflicted. There are situations where, arguably, women do have a choice and it is these that present the most difficult dilemmas for doctors. Should a doctor comply with a woman's request to be reinfibulated after childbirth? Some might argue that if a competent adult woman makes an informed choice, that should be respected. Patients are, of course, not able to require doctors to act illegally

or use medical skills inappropriately. There is real debate, however, about whether, having failed to persuade her otherwise, there are ever circumstances in which a doctor would be ethically justified in agreeing to her request on the grounds that if she were not reinfibulated the disruption to her life would be immense and she would become an outcast.

In the UK, the law prohibits female genital mutilation, including reinfibulation after childbirth.² There have never been any prosecutions of doctors, although some have been removed from the UK's medical register for performing or offering to perform mutilations on young girls. In December 2000, for example, a family doctor was struck off for offering to mutilate three young Somali girls for £50 each.

In November 2000, an international day against female genital mutilation held at the Council of Europe brought activists from around the world together to discuss how to eradicate female genital mutilation. A majority of members of the European Parliament are calling for European and national governments to recognise the problem, to work to ensure the protection of their citizens and to support organisations working for the elimination of female genital mutilation.

Resuscitation

In February 2001, new guidelines on decisions about whether to attempt to resuscitate patients following cardiopulmonary arrest were published by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.³ The guidelines emphasise the importance of involving patients, people close to them and the health care team in advance decisions about resuscitation attempts. The guidelines will be reproduced in a future edition of this journal.

Genetics and insurance

The use of genetic information by insurance companies has proved to be one of the most controversial issues covered in a recently completed exercise by the the Human Genetics Commission (HGC) in the UK.⁴ Calls have been made by various organisations for either a complete ban on the use of genetic information by insurance companies, a short term moratorium, or strict controls on the use of such information.

With the threat of restrictive legislation never far away, the insurance industry itself took the initiative in 1997 by appointing a clinical geneticist as an adviser and developing a system of self regulation. In 1997 the Association of British Insurers (ABI) issued a policy statement saying that its member companies would not take account of genetic test results to determine premiums for life assurance policies associated with a mortgage of up to £100,000; this policy was reaffirmed in 1999 and is subject to further review in December 2001. The ABI also issued a genetics code of practice,⁵ which gave assurances on many areas of concern.

In 1998, the government set up a genetics and insurance committee (GAIC) to evaluate the scientific and actuarial evidence for the use of specific genetic tests by insurance companies. The genetics and insurance committee advises on the use of individual tests for particular types of insurance (such as life, critical illness, income protection and long term care). The ABI's code of practice now states that only those tests approved by GAIC may be used. In October 2000 GAIC approved the use of genetic tests for Huntington's disease in assessing premiums for life insurance policies. The use of tests for early-onset Alzheimer's disease and hereditary breast and ovarian cancer have also been under discussion.⁶

Other countries have addressed the issue in different ways.⁷ Both the

Netherlands and various states in the USA have enacted legislation restricting the use of genetic information by insurance companies. The Swedish state has reached an agreement with the Swedish Insurance Federation and the German government has set up a Commission of Inquiry into Law and Ethics in Modern Medicine which will consider the issue.

Despite these different approaches, there are some similarities. There is general agreement, for example, that insurers should not require applicants to undergo genetic testing in order to obtain insurance. Both the Dutch legislation⁸ and the Swedish voluntary agreement with the industry set a limit on the size of policy below which genetic test results may not be taken into account. The Swedish agreement also states that the insurance industry will not take account of family history in assessing policies below the stated limit. In Australia, a different approach has been taken and applicants are obliged to provide insurers with existing genetic test results. What the UK position will finally be on this issue remains to be seen since the HGC's decision to reconsider the fundamental principles at this stages means the issue cannot be considered settled.

References

- 1 Population Council. *Post-ICPD: the decline of female circumcision in Egypt*. New York: Population Council, 1999 Feb 22. *Prohibition of Female Circumcision Act 1985*.
- 2 British Medical Association, Resuscitation Council (UK), Royal College of Nursing. *Decisions relating to cardiopulmonary resuscitation*. London: BMA, 2001.
- 3 Human Genetics Commission. *Whose hands on your genes? A discussion document on the storage, protection and use of personal genetic information*. London: HGC, 2000.
- 4 Association of British Insurers. *Genetic testing. ABI code of practice* [revised August 1999]. London: ABI, 1999.
- 5 Up-to-date information can be obtained from the Genetics and Insurance Committee's website: www.doh.gov.uk/genetics/gaic.htm
- 6 More details about international comparisons on this issue can be found on the HGC's website: www.hgc.gov.uk/business_publications.htm
- 7 *Medical Checks Act 1997*.