Legal and ethical implications of medically enforced feeding of detained asylum seekers on hunger strike

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ABSTRACT

- The current practice of non-consensual medical treatment of hunger-striking asylum seekers in detention needs closer inquiry.
- An Australian Government regulation empowers the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) to authorise non-consensual medical treatment for a person in immigration detention if they are at risk of physical harm, but there are doubts about whether the regulation would withstand legal challenge.
- Authorisation by DIMIA does not compel medical practitioners to enforce treatment if such action is contrary to their "ethical, moral or religious convictions".
- The World Medical Association has established guidelines for doctors involved in managing people on hunger strikes. The Declaration of Tokyo (1975) and the Declaration of Malta (1991) both prohibit the use of non-consensual force-feeding of hunger strikers who are mentally competent.
- If called upon to treat hunger strikers, medical practitioners should be aware of their ethical and legal responsibilities, and that they should act independently of government or institutional interests.

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HUNGER STRIKES BY ASYLUM SEEKERS have occurred in Australia since the introduction of the policy of mandatory detention over a decade ago.[1] At times, the number of asylum seekers involved in this form of protest has reached crisis point, with over 200 detainees embarking on a hunger strike at the Woomera Immigration Reception and Processing Centre in 2002. Hunger strikes are a politically charged issue, with the former Australian Minister for Immigration, Multicultural and Indigenous Affairs (Phillip Ruddock) asserting that such actions are manipulative efforts by detainees to gain refugee status.[2-4]

The Australian Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) can authorise physicians, under Migration Regulation 5.35, to provide non-consensual medical treatment. In 2001, DIMIA issued about 40 authorisations for compulsory medical treatment.[4] Such actions risk violating international medical guidelines. It is therefore timely to examine both the legal and ethical implications for doctors if they coercively rehydrate or force-feed detained asylum seekers.

Reasons for food refusal

The World Medical Association (WMA) has defined a hunger striker as a "mentally competent person who has indicated that he [or she] has decided to refuse to take food and/or fluids for a significant interval".[5] The motivations underlying hunger strikes by asylum seekers are complex. A study in the United States indicated that asylum seekers embark on hunger strikes in the early phase of detention to express their distress and opposition to incarceration. In the later stages of detention, especially after refugee claims have been rejected, hunger strikes commonly represent a desire to die rather than to be forcibly repatriated to situations of danger.[6]

The relationship between hunger strikes and mental illness is complex. A study of hunger-striking political prisoners in South Africa found that 77% were clinically depressed.[7] Nevertheless, the presence of mental illness does not mean *ipso facto* that a hunger striker is not competent to make decisions about pursuing the protest. Asylum seekers held in immigration detention centres in Australia may have been exposed to high levels of trauma in their countries of origin and during their journey to Australia.[8] After arrival, they experience ongoing stresses, including separation from family, interviews with immigration officials, and delays in the asylum application process. They also experience social isolation, boredom and frustration. Rates of depression and related disorders in detention appear to be extraordinarily high, particularly among those held for prolonged periods.[9,10] It is imperative that a comprehensive psychiatric assessment is made early in a hunger strike to decide whether depressive or other symptoms are primarily reactive to environmental circumstances, or whether the competence of the person to decide to pursue the strike is impaired by a severe depressive illness or associated morbid mental state.

Legal aspects

The Australian Government introduced a regulation in 1992 which empowers DIMIA to authorise medical treat-

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ment to be given to a person in immigration detention without their consent (Migration Regulations 1994 (Cwlth), Regulation 5.35). The regulation is invoked when a Commonwealth Medical Officer or registered medical practitioner provides written advice to the Secretary of DIMIA that:

- if medical treatment is not given to a particular detainee, there will be a serious risk to his or her life or health; and
- that the detainee refuses to give, or is not reasonably capable of giving, consent for the medical treatment.

The Secretary of DIMIA can then authorise non-consensual treatment, including the use of reasonable force (eg, the use of restraints and sedatives). Authorisation by DIMIA does not compel medical practitioners to enforce treatment if such action is contrary to their "ethical, moral or religious convictions".[11]

According to *Hansard*, the regulation received no parliamentary attention or debate at the time of its introduction. Nor has it been the subject of any challenge in Australian courts. Yet legal opinion suggests that, if challenged in court, the regulation would most likely be struck out.[12] It is noteworthy, too, that the Human Rights and Equal Opportunity Commission has recommended that Parliament repeal the regulation.[1]

A long-established common law principle upholds the right to individual self-determination, including the choice to refuse treatment. Persons deemed to be of full mental capacity can refuse treatment, even if that act is tantamount to suicide. A medical practitioner who performs medical treatment without the patient's consent can be held to have committed an assault.[13] This could give rise to a claim of damages.

Arguments have been put that there are exceptions to this common law principle, particularly when it is in the state's interest to intervene. It has been argued that force-feeding of hunger-striking prisoners represents the state's duty to preserve the life of detainees, an imperative that overrides issues of autonomy.[14] Yet, in the United Kingdom, a series of court decisions has endorsed the principle of autonomy and self-determination in relation to hunger strikes, reaffirming the prisoner's rights to refuse treatment.[15]

In summary, there are serious questions about whether the existing Australian regulation would be upheld if challenged in court, as the instrument is not consistent with common law principles and may be in breach of international human rights law.

Clinical complexities

The medical literature indicates that death from hunger strikes can occur between 42 and 79 days of a complete fast. After about a week, the hunger striker experiences dramatic weight loss. In the following weeks, the liver and intestines atrophy, followed by the heart and kidneys. The pulse slows and blood pressure falls. Patients complain of fatigue, headache, faintness and dizziness. By about the 40th day, the striker becomes seriously ill, is bedridden and suffers concentration problems and apathy.[16,17]

The course of physical and cognitive deterioration means that assessment of a hunger striker's mental state and intentions needs to be undertaken early, while they remain mentally competent.[18] As mentioned, in such an assessment, the evidence needs to be weighed up as to whether manifestations of despair and demoralisation are a realistic response or reflect a form of mental illness that in itself impairs competency. If symptoms of despair and hopelessness are reality-based, then standard antidepressant treatments may not necessarily be effective, especially if the environmental conditions generating the despondency (prolonged incarceration and threat of forced repatriation) are not alleviated. The case study in the Box illustrates this dilemma.

Ethical issues

From an ethical perspective, the practitioner caring for hunger strikers confronts the tension between, on the one hand, the imperative to preserve life and, on the other, respect for the autonomy of the individual. Australian practitioners face the added complexity of reconciling ethical and medical issues with the priorities of government policy, particularly the state's interest in maintaining order

Case study — realistic despair or mental illness?

A young male detainee commenced a hunger strike in a remote detention centre after his claim for refugee status had been rejected. The initial strike was a protest about his treatment in detention, which he alleged had involved a period of solitary confinement and physical restraint. During the first strike, he was rehydrated intravenously under Regulation 5.35. Some months later he again refused food and was rehydrated and fed through a nasogastric tube on several occasions under Regulation 5.35. He developed symptoms of severe depression with associated weight loss of over 10 kg. After 2 months of failed treatment with an antidepressant, he was transferred to a metropolitan hospital. Attending clinicians judged that he was no longer on active hunger strike and that his symptoms of anorexia, hopelessness, loss of interest, and vague suicidal thoughts amounted to clinical depression. Electroconvulsive therapy, intravenous hydration and nasogastric feeding were recommended by the treating staff. The patient refused consent, leading to Regulation 5.35 being invoked.

There was some initial improvement in the patient's condition with this regimen of enforced treatment, but his depression then worsened while treatment was ongoing and he again refused food. Nasogastric feeding was recommended. The patient instructed his lawyers that he did not wish this procedure to be administered, as it caused him pain and discomfort. The hospital staff asserted that they were acting under the authority of the Secretary of the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA). Although the patient was despondent, his concerns about his plight appeared to be reality-based, and his lawyers judged that the patient was acting competently in choosing not to have further treatment. The lawyers advised the hospital that they would challenge the authority of Regulation 5.35, and indicated that they would seek an injunction to prevent the administration of further enforced treatment. It was pointed out that the Regulation did not require a medical practitioner to act contrary to standing ethical guidelines.

As it transpired, no further treatment was necessary, as the patient voluntarily recommenced fluid and food intake. He was eventually released into the community on a bridging visa pending determination of his claim.

and security in detention centres during a period of political controversy about detention. DIMIA itself discharges complex and potentially conflicting roles: this single government authority is responsible for apprehending and detaining asylum seekers, for determining their refugee status, for discharging an ongoing duty of care, and for enforcing repatriation of those whose claims for asylum fail.

Yet international ethical guidelines are unequivocal in their directives to practitioners managing hunger strikers. According to the WMA's Declaration of Tokyo (1975):

> Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.[19]

The principles of the Tokyo Declaration were endorsed by a position statement of the Royal Australasian College of Physicians in July 1993.[20]

The preamble to the Declaration of Malta (1991) (revised in 1992) underlines the ethical risks facing doctors working with government agencies:

> The ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare.[5]

At the same time, this provision does not allow a physician acting alone to compel treatment, as the Declaration makes it clear that if a physician tends towards compulsory intervention the "patient would then be entitled to be attended by another doctor". However, the Declaration of Malta does provide that a doctor may make his or her own decision regarding treatment if hunger strikers are in a state in which they "become confused and [are] therefore unable to make an unimpaired decision or [have] lapsed into a coma".

The difficulty with adhering to universal principles is that hunger strikes almost always occur in a context of competing interests and conflicting administrative and clinical priorities. Clinicians often are at the centre of such institutional pressures, particularly when their employment contract makes them directly responsible to detention or government authorities who have an interest in ensuring the quick termination of actions perceived as undermining the peaceful and effective management of detention centres.[21] Such ethical dilemmas confronting the practitioner in the detention centre environment are not dissimilar to those facing clinicians in other custodial settings. Detailed ethical guidelines have already been developed for these settings.[22,23]

A decision not to intervene and to allow a person to die is extremely difficult for a physician to make. Fortunately, most hunger strikes end without fatalities. It is imperative, however, that hunger strikers be fully assessed early in their strike to assess both their mental state and their genuine intentions, ideally in the form of a confidential advance directive. For such a medical assessment to be legitimate, the hunger striker must feel convinced that the doctor is acting independently and impartially, and not only in his or her capacity as an employee of the detention centre or hospital. The striker also must be advised in detail about the medical consequences of refusing food and about the value of supplementing the fast with essential minerals and vitamins to prevent irreversible neurological damage.

In the case study outlined, the health professionals involved were dealing with a distressing situation of a young man who was deteriorating physically and mentally. The health professionals undoubtedly believed they were acting in what they perceived to be his best medical interests, but their reliance on (or compliance with) the immigration regulation inevitably raises concerns about the truly independent nature of such judgements.

Conclusions and recommendations

Reports of force-feeding of detainees by doctors are a cause for great concern. Whether the physicians involved are acting in ignorance of international guidelines or under duress, it is important to reiterate that, in most cases, such actions contravene the basic human rights of asylum seekers. Doctors coming into contact with a detainee on hunger strike should be aware of their professional, legal and ethical obligations. Despite serious doubts about the legitimacy of Regulation 5.35, until it is challenged in the courts it will provide authority to administer treatment against the consent of a detainee. However, medical practitioners may be acting unethically by relying on this provision.

If contemporary international and local ethical guidelines on the medical management of hunger strikers are inadequate or inappropriate, then representations need to be made to the WMA and the relevant specialist colleges to consider a review. At present, however, doctors who violate the ethical guidelines promulgated by these bodies risk facing the charge of unethical conduct. A wider campaign of medical education is needed to ensure that all practitioners are aware of their medical, ethical and legal responsibilities if ever called upon to manage hunger strikers. Consideration could be given to developing independent ethics panels to guide individual doctors, given the highly complex and politicised context in which hunger strikes occur, whether among asylum seekers or other detainees.[21]

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