What, therefore, is the future of acute medical care in the NHS? How should we best train and supervise our junior medical staff? Should consultant physicians be brought reluctantly out of their subspecialty to deal with acute medical admissions? Are consultant physicians who subspecialise in acute medical care needed? Medicine moves on, Calman's proposals are being implemented, and the systems and work patterns of the past may not be ideal for the future.

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1 Mather HM, Elkeles RS on behalf of the North West Thames Diabetes and Endocrinology Specialist Group. Attitudes of consultant physicians to the Calman proposals: a questionnaire survey. *BMJ* 1995;311:1060-2. (21 October.)

Hunger strikes

Doctors do not have final decision on hunger strikers in prison

EDITOR,—George J Annas¹ believes that in Britain the most definitive ethical statement regarding treatment of hunger strikers in the custody of the state remains "the 1974 statement of the BMA's central ethics committee that prison doctors 'must' have the 'final decision.'"² This is inaccurate.

In 1993 the BMA stated that when a prisoner whom the doctor considers to be capable of forming a rational judgment refuses nourishment in full knowledge of the consequences, he or she should not be fed artificially.³ This endorses the World Medical Association's Declaration of Tokyo.⁴

In 1994 the High Court applied principles of self determination recognised in many recent British cases in the case of a hunger striker in prison. The court stated that a prisoner has a right to have his or her wishes respected except where there is countervailing state interest in protecting third parties or in preserving order and discipline within the prison.⁵ This ruling, which reinforces the medical profession's ethical position, makes clear that in Britain prison doctors do not have the final decision.

Nevertheless, there remains a lack of satisfactory authoritative legal and ethical guidance on the position of incompetent prisoners.

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- 1 Annas GJ. Hunger strikes. *BMJ* 1995;311:1114-5. (28 October.)
- 2 Ethical statement: artificial feeding of prisoners. *BMJ* 1974;iii:52-3.
- 3 BMA. *Medical ethics today, its practice and philosophy*. London: BMA, 1993.
- 4 World Medical Association. *Declaration of Tokyo. Torture and other cruel, inhumane or degrading treatment or punishment*. Geneva: WMA, 1975.
- 5 Robb v Home Secretary [1995] 1 FLR 412.

Hunger strikers should be treated like other patients who refuse consent to treatment

EDITOR,—We see no reason why hunger strikers should not be subject to the same considerations as other patients who refuse to consent to treatment. If this is what George J Annas means by "trying to medicalise the hunger strike" (which he says will not lead to a solution) then we believe that he is

mistaken.¹ Our legal and ethical responsibilities should not depend on patients' political persuasion any more than they depend on their religious beliefs, as in the case of Jehovah's Witnesses.

Annas highlights some of the problems associated with hunger strikers but does not refer to British case law or a recent document published by the Law Commission,² which provides a framework for doctors working in Britain. He asks if the "model of the living will" should apply. The model of the living will applies because forced treatment of hunger strikers must depend on their capacity to refuse consent to treatment. Legal precedent in Britain indicates that it is unlawful to override valid refusal of consent to treatment. Also, in drafting the Mental Incapacity Bill the Law Commission referred to the case of *re T*,³ in which Lord Donaldson stated: "What matters is whether at that time [that is, the time of the decision to refuse treatment] the patient's capacity was reduced below the level needed in the case of a refusal of that importance." In other words, if the decision to refuse treatment was valid at the time it was made then it must be respected if nothing else changes apart from a deterioration in the patient's health (including unconsciousness). Without this, advance directives would be meaningless. We agree with Annas that written documents refusing treatment are not a "solution." Indeed, according to the Law Commission, what matters is the "true scope and basis" of the decision rather than the way it has been recorded.²

Finally, Lord Donaldson has given two pieces of advice for cases in which there is doubt with regard to refusal to consent to treatment, which we would find helpful if we were faced with a hunger striker.³ Firstly, "doubt falls to be resolved in favour of the preservation of life," and, secondly, "doctors and health authorities should not hesitate to apply to the courts for assistance." Within the limits of clinical expediency, doctors should test difficult decisions about treatment in the courts more often.

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- 1 Annas G. Hunger strikes. *BMJ* 1995;311:1114-5. (28 October.)
- 2 Law Commission. *Mental incapacity. Item 9 of the fourth programme of law reform: mentally incapacitated adults*. London: LC, 1995.
- 3 *re T* (adult refusal of treatment) [1992] 3 WLR 782-805.

Practical guidelines are important

EDITOR,—We welcome debate on the role of health workers with regard to hunger strikers,¹ but we believe that George J Annas's reaction to our publication on this issue² is disappointing.

Firstly, Annas's comment that "individual doctors will be forced to muddle through, until there is a credible international body capable of articulating standards for medical ethics," is not helpful. It ignores existing guidelines on the relation between doctors and hunger strikers, such as the World Medical Association's Declarations of Tokyo (1975) and of Marbella (1992),³ both of which are based on the autonomy of the patient. It also ignores the reality that doctors in many countries, increasingly confronted with hunger strikes, need practical guidelines. Our publication has apparently satisfied the needs of medical and human rights organisations in the Netherlands and elsewhere, including the United States. At the request of these organisations translations are currently being made.

Secondly, Annas's comments on our suggestion for a "statement of non-intervention" are irrational and biased by his obsession with the "political tactic of a hunger strike." This also does not reflect much confidence in doctors' ability to maintain their clinical objectivity. The difficult situation

that arises when a hunger striker becomes unconscious and therefore cannot express his or her wishes is helped by the use of a living will, especially if a doctor meets the unconscious striker for the first time, has not heard his or her wishes, and has to make a decision. We acknowledge that a living will does not solve all the problems, but we regret that Annas does not comment on the difficult ethical dilemmas that we mention in our publication, such as transcultural psychiatric assessment of the hunger striker's accountability and the problem of group coercion versus individual choice in mass hunger strikes.

Finally, Annas intertwines his comments on our publication with a snipe at Dutch society and its doctors. His subtitle—"Can the Dutch teach us anything?"—and his reference to "the only society to approve of euthanasia by doctors" (which is not the subject at issue) do not strengthen his argument. Doctors and nurses working in difficult circumstances throughout the world are not served by the issue being obscured.

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- 1 Annas GJ. Hunger strikes. *BMJ* 1995;311:1114-5. (28 October.)
- 2 Johannes Wier Foundation for Health and Human Rights. *Assistance in hunger strikes: a manual for physicians and other health personnel dealing with hunger strikes*. Amersfoort: JWFHHR, 1995.

Trends in referral patterns

Main reductions in referrals occurred after study ended

EDITOR,—The study by Rebecca Surender and colleagues suggests that no evidence exists that fundholding encourages a shift away from specialist care.¹ This may be more a case of absence of evidence than evidence of absence. Indeed, two fundholding practices in their study showed a reduction in referral rates, but this was lost in the group average. It would have been interesting if the authors had highlighted how these two practices had reduced referral rates.

The study finished in January 1994, before the main movement towards reduced referrals by fundholders occurred. These changes occurred because fundholders had gained experience from each other, were more knowledgeable about effective care, had established management guidelines for a number of common referrals, and had set up in house clinics. The Oxford study makes no mention of in house clinics or any of these other factors.

The type of contract held by the fundholding practices is not mentioned. In the early days of fundholding many practices had block or cost and volume contracts; these do not provide an incentive for reducing referrals, in contrast to cost per case or cost per attendance contracts, which are commoner now.

Studying the performance of fundholding practices by grouping results into an average obscures the results of the best. The performance of the pathfinders is important, for they set the trends which others follow. Many fundholding practices, including ours, have reduced referrals substantially through improved training of general practitioners, delegating outpatient follow up to practice nurses, instituting management guidelines, working with consultants through in house clinics, and extending the primary health care team to include clinical pharmacists, occupational