

# **A Case of Self-Imposed Starvation: Effective Use of Multidisciplinary Team Strategies**

Hugo J. Reyes PA

Alonso Pezo Salazar MD

Dileep Sreedharan DO

# Disclosure And Disclaimer Statement

- We do not have any relevant financial relationships with any commercial interests.
- This informational presentation was developed by independent experts. The information provided in this presentation is not the official position or recommendation of NCCHC but rather expert opinion. This information is not intended to be appropriate for every clinical situation nor does it replace clinical judgment.
- NCCHC does not endorse or recommend any products or services mentioned

# Learning Objectives

1. Discuss the important medical complications associated with prolonged starvation in a patient exhibiting psychosis.
2. Review the Washington State Department of Corrections (WA DOC) policy for involuntary hydration and tube feeding.
3. Describe the multidisciplinary team approach to providing effective medical and mental health treatment.

# Case report of Mr. K

- 30 y/o male serving a lengthy sentence.
- **Lost approximately 50lbs** in an unknown number of months due to severely restricting food and water. Baseline weight: 170 lbs
- Patient's progressive weight loss was not recognized due to facility-wide COVID19 limitations.
- Transferred to Washington State Penitentiary's (WSP) medical Inpatient Unit (IPU) from another prison s/p assault.
- Mental Health team was alerted for **possible depression**.

# Initial Medical Exam

- BP: 108/56; T: 97.4; P: 80; R: 16; O2Sat: 97%; **Wt: 122**; Ht: 6'0"; **BMI: 16.5**
- The patient appears **very frail**, thin and overall emaciated. He makes minimal eye contact and is mostly bent over, looking down to the floor when talking to him.
- HEENT: Positive ecchymosis noted to the right periorbital area and the upper cheek.
- Skin: pale but otherwise warm, dry, non-diaphoretic. He has normal skin turgor.
- Abdomen: Thin appearing abdomen with **ribs that are overtly showing**. He has **hypoactive bowel tones** in all 4 quadrants.
- MSK: Able to sit and stand with limited difficulty, **gait and ambulation are slow** and a bit shuffled but otherwise normal.

# Initial Mental Status Exam

- Alert and oriented X 4.
- Long and unkempt greasy looking hair, slightly malodorous.
- Sitting at the edge of the bed facing away from the door with hands interlocked. Occasionally would kneel on the floor to pray.
- Speech is slow, soft and monotone.
- Clear psychomotor retardation.
- **Prominent religious delusions.**
- No suicidal thoughts, intent, or plans.

# Initial Impression

- Medical: Starvation-related malnutrition
- Psychiatric: MDD, severe, with psychotic features

# Potential Immediate Complications

Constitutional: arrested growth, hypothermia, **cachexia**

Nutritional: **vitamin deficiencies** – Wernicke-Korsakoff

Dermatologic: xerosis, lanugo hair, telogen effluvium, carotenoderma



Endocrine: osteoporosis and pathologic fractures, euthyroid sick syndrome, hypoglycemia

Pulmonary: respiratory failure, pneumothorax, pneumomediastinum

GI: gastroparesis, **constipation**, hepatitis, diarrhea

Muscular: **muscle wasting**

Neurologic: cerebral atrophy, enlarged ventricles, cognitive impairment, peripheral neuropathy, seizures

Cardiac: myocardial atrophy, **bradycardia**, arrhythmias, **EKG changes, hypotension**

Renal: **dehydration, AKI**, renal calculi, hypokalemia, hypomagnesemia

Hematologic: anemia, leukopenia, thrombocytopenia





# Immediate Considerations

- When to pursue use of IV fluids (passive or forced)?
- When to pursue involuntary antipsychotic medications?
- Consider 1:1 monitoring.
- Necessity for capacity evaluation vs protocol-driven management.
- Coordination for MDT ASAP.

# Long Term Considerations

- Medical complications once the patient starts eating.
- Long term antipsychotic and antidepressant administration.
- Explore Electroconvulsive therapy (ECT) if the patient did not respond to pharmacological interventions.
- Housing.

# Epidemiology of Hunger Strikes in DOC

- 45 episodes of refusal to eat documented in WSP since 2012.
- Two episodes documented as requiring forced feeding (4%).

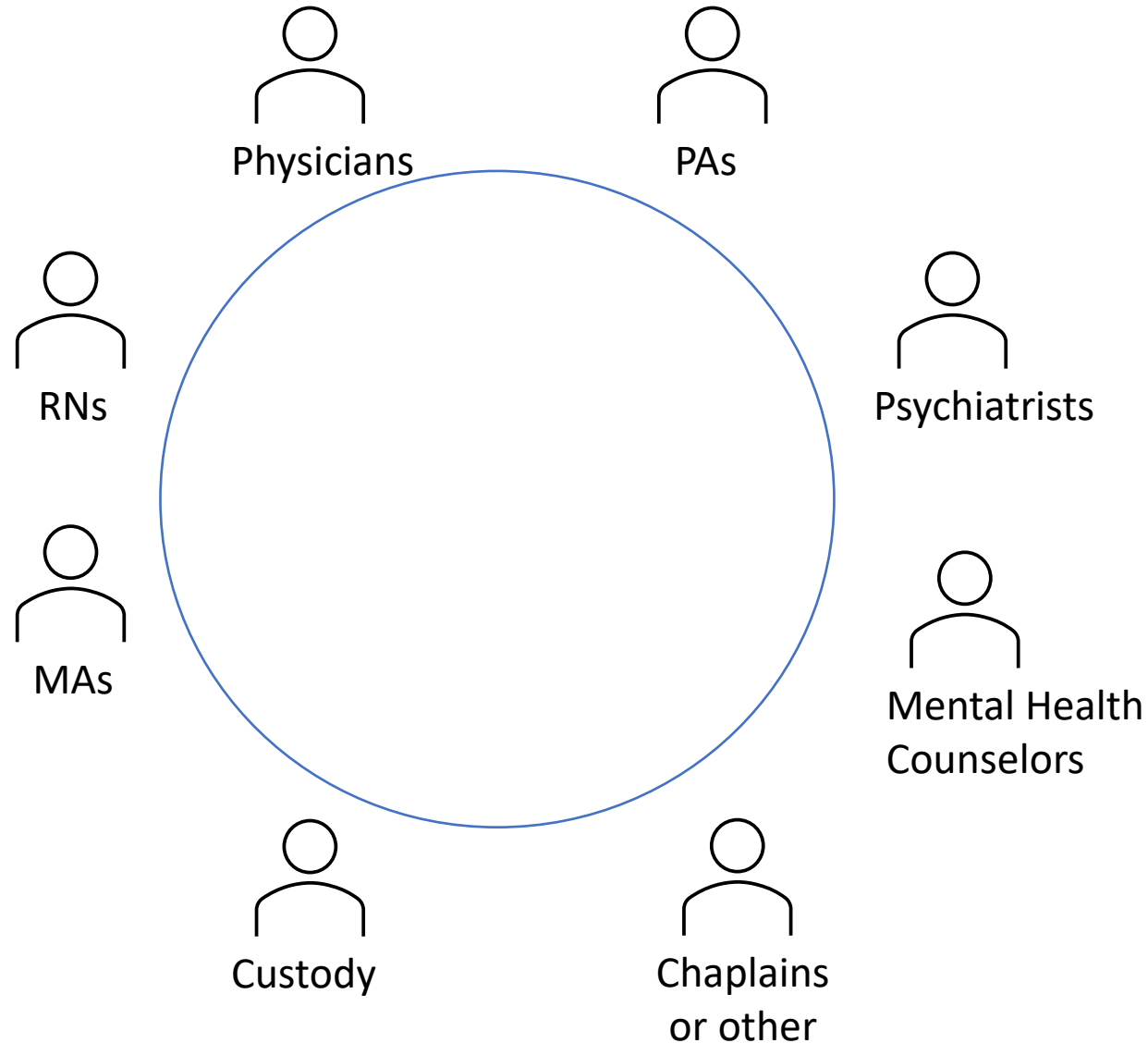
# Ethical Dilemmas in Hunger Strikes

- The World Medical Association Declaration of Malta states that **forced feeding is unethical**.
- The **8th Amendment** to the Constitution in the United States **prohibits cruel and unusual punishment** and has been variably interpreted to permit forced feeding in certain situations, often involving the court system.
- Clinicians in correctional environments may need to **balance** divergent ethical principles such as respecting the **sanctity of life** and respect for **individual autonomy**.
- Generally, states have been successful when they have argued that their **responsibility to preserve life** outweighs the individuals' right to starve themselves.

# Psychological Implications of Starvation

- Starvation induced **loss of competence** has been documented.
- The person on hunger strike should finalize an **advanced directive**, to be followed in the event of their becoming incompetent, and express wishes.

# What are Multidisciplinary Team Meetings?



- Evolved into **standard practice** in cancer, surgery and mental health.

# MDTs: Pros and Cons

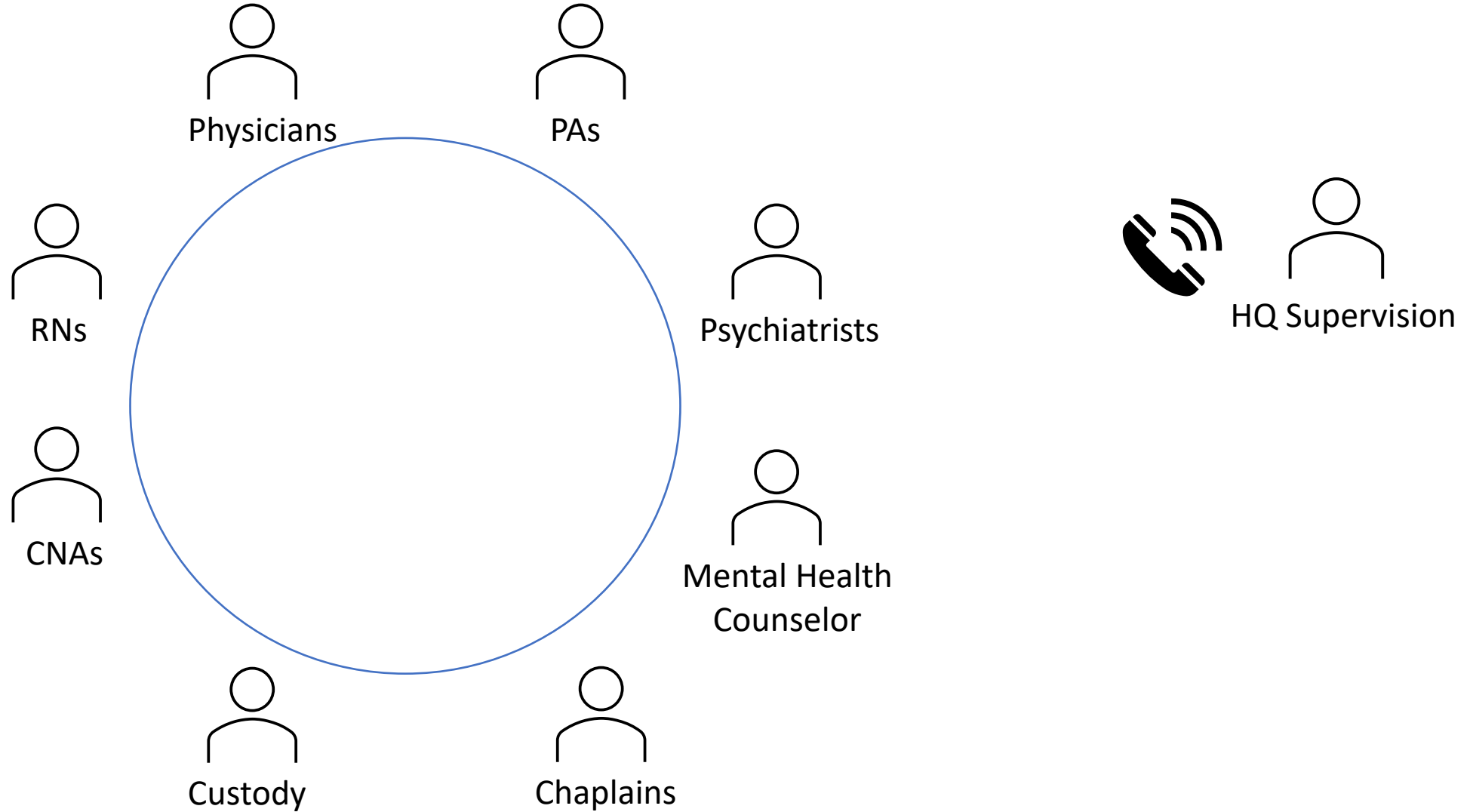
## Pros:

- Counteracts “**silo effect**” and “**halo effect**”
- Breaks down **communication barriers**
- **Promotes cooperation** between stakeholders
- Stage for less “verbal” parties to **speak up**
- **Improves adherence** to clinical guidelines
- **Potentially improves** patient outcomes, safety and satisfaction
- Potentially improves staff’s competence, experience level and job satisfaction

## Cons:

- Can be very **resource-intensive**
- **Might not affect** patient outcome, safety or satisfaction
- Can contribute to **increased bureaucracy**

# Our MDT Members





# Timeline of Weight and Clinical Progression



# 1<sup>st</sup> MDT – week #1

- Goal: To present the case to the team and develop a plan of care.
- Concerns:
  - Medical: Refusing all oral intake and IV fluids. Tachycardic and orthostatic.
  - Psych: Discussed the nature of depression and psychotic features. Refusing antipsychotics and antidepressants. Deemed not to have capacity to refuse IV fluids. Cannot give emergent IM antipsychotics until BP stabilizes.
  - Psych Assoc: Chaplain requested.
  - Nursing: The patient requests to talk to his mother.

# 1<sup>st</sup> MDT – week #1

- Duration: 75 min
- Plan:
  - MDT agreed forced IVF if the patient refuses.
  - Plan for forced feeding next week if clinically indicated.
  - Plan to contact family and chaplain visit to assess belief system and psychiatric history.
  - MDT scheduled in 1 week.

# WA DOC Force Feeding Policy – 620.100

- Identify offenders at risk
  - 9 missed meals (“food and/or fluid”) – Not always easy to do
- Notify
  - Chain of command – Health Authority, Superintendent
  - Documentation – Unit log
  - Offender movement (as needed)
- Exemption
  - Terminally ill
  - Advance directive

**Washington State Penitentiary**  
**REFUSING FOOD SERVICE PROGRAM**

Name of incarcerated individual \_\_\_\_\_ DOC number \_\_\_\_\_ Housing Assignment \_\_\_\_\_

The above named individual is refusing to participate in the Food Service Program per DOC 620.100 Force Feeding of Offenders and DOC 320.255 Restrictive Housing. During breakfast, lunch, and dinner, the individual did not consume any portion of the meal.

| Meal # | MEAL:<br>Breakfast / Lunch / Dinner | DATE | EMPLOYEE NAME (please print) |
|--------|-------------------------------------|------|------------------------------|
| 1      |                                     |      |                              |
| 2      |                                     |      |                              |
| 3      |                                     |      |                              |
| 4      |                                     |      |                              |
| 5      |                                     |      |                              |
| 6      |                                     |      |                              |
| 7      |                                     |      |                              |
| 8      |                                     |      |                              |
| 9      |                                     |      |                              |

**Health Services notified:**

☐ Yes ☐ No Date: \_\_\_\_\_ To whom: \_\_\_\_\_

Incident Management Reporting System (IMRS) number: \_\_\_\_\_

Name of reporting employee/contract staff \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Distribution: **ORIGINAL** - Central File **COPY** - Unit File **SCAN COPY TO:** Superintendent, Health Services Manager 3, Correctional Unit Supervisor (CUS), Captain, Shift Lieutenant, Counselor

**DAILY MEAL MONITORING -**

| DATE | % EATEN | SPECIFIC FOODS EATEN/ NOT EATEN |
|------|---------|---------------------------------|
|      | B       |                                 |
|      | L       |                                 |
|      | D       |                                 |

| DATE | % EATEN | SPECIFIC FOODS EATEN |
|------|---------|----------------------|
|      | B       |                      |
|      | L       |                      |
|      | D       |                      |

| DATE | % EATEN | SPECIFIC FOODS EATEN |
|------|---------|----------------------|
|      | B       |                      |
|      | L       |                      |
|      | D       |                      |

| DATE | % EATEN | SPECIFIC FOODS EATEN |
|------|---------|----------------------|
|      | B       |                      |
|      | L       |                      |
|      | D       |                      |

| DATE | % EATEN | SPECIFIC FOODS EATEN |
|------|---------|----------------------|
|      | B       |                      |
|      | L       |                      |
|      | D       |                      |

| DATE | % EATEN | SPECIFIC FOODS EATEN |
|------|---------|----------------------|
|      | B       |                      |
|      | L       |                      |
|      | D       |                      |

| DATE | % EATEN | SPECIFIC FOODS EATEN |
|------|---------|----------------------|
|      | B       |                      |
|      | L       |                      |
|      | D       |                      |

# WA DOC Force Feeding Policy – 620.100

- Health Services
  - Designation of care
    - Medical
    - Mental Health
  - Diagnostic tests
    - Height and weight
    - Vitals
    - Labs (Non-Consensual Blood Draws – Policy 620.020)
    - Imaging



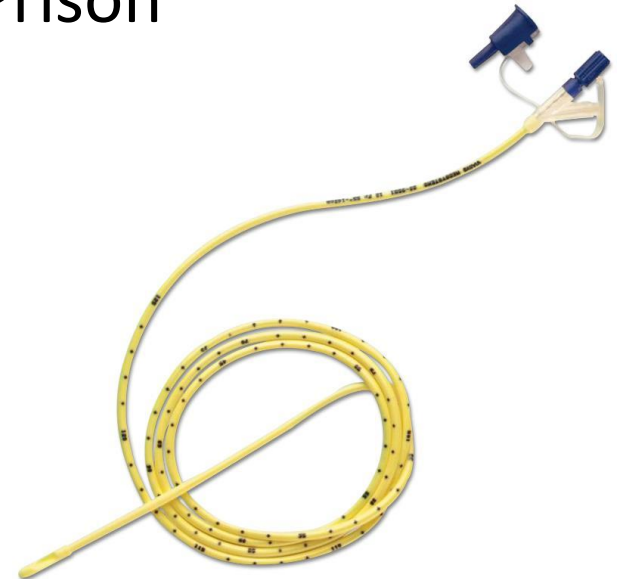
# WA DOC Force Feeding Policy – 620.100

- Health Services
  - Frequency of visits, Q24 hrs. minimum
    - Education and documentation
- Access to Food
  - Meals made available or brought to offender
  - Beware of manipulation



# WA DOC Force Feeding Policy – 620.100

- Forced Feeding
  - Practitioner written documentation – Risk of health/death
  - Notification and final approval
    - Health Authority (CMO, Assistant Secretary of Prison)
    - Superintendent
  - Plan
    - Potential Transfer – Higher level of care?
    - Type of feeding
      - Enteral vs parenteral
      - IV fluids





# WA DOC Force Feeding Policy – 620.100

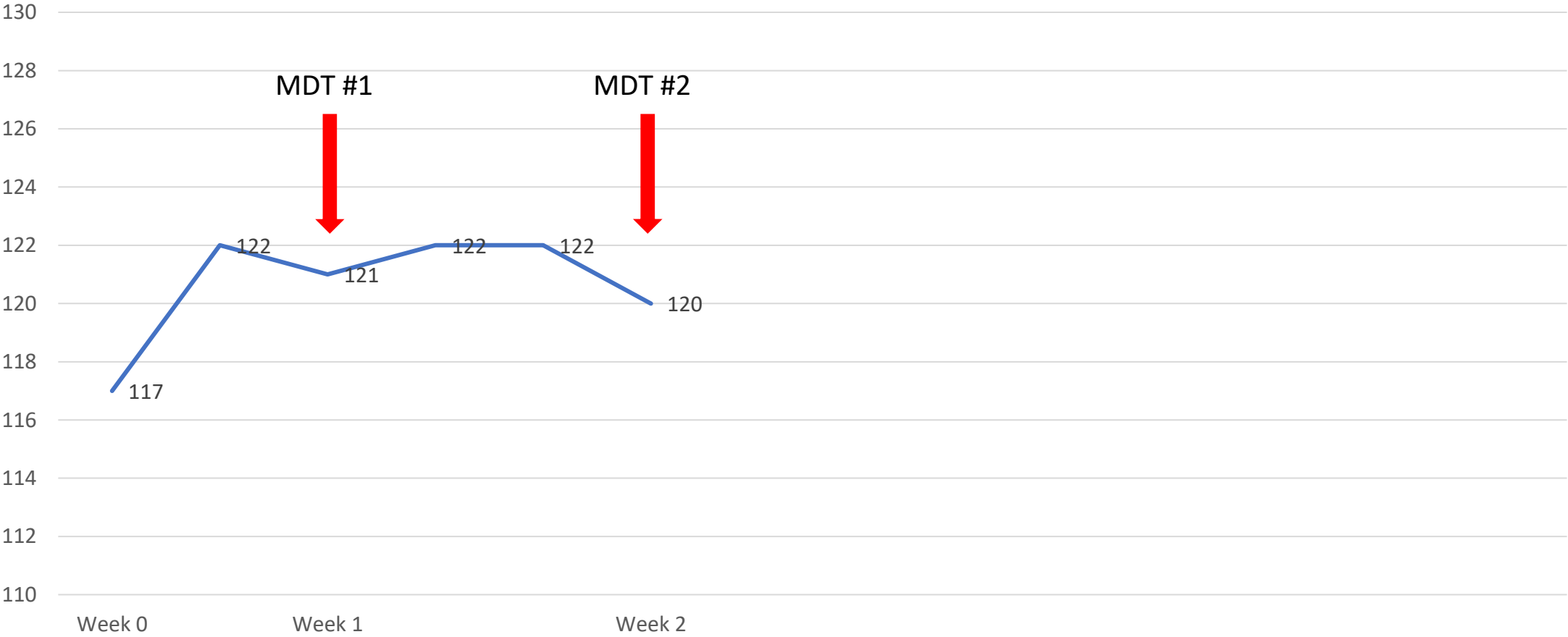
- Use of Force
  - Written approval – Assistant Secretary of Prisons
  - Restraints
    - Chair vs Table
    - Special circumstances and approval
  - Videotaping
  - Barriers with staff
- Completion of Forced Feeding
  - Clinical, laboratory, diagnostic testing



# Mental Health Challenges and Considerations

- The patient refused oral antipsychotics and antidepressants
- Choosing the appropriate antipsychotic medication
- Initial limitations to administering Zyprexa
  - Treatment naive
  - Side effects

# Timeline of Weight and Clinical Progression



## 2<sup>nd</sup> MDT – week #2

- Goal: Update on the status and discuss force feeding
- Updates:
  - Medical: Received IVF x3 since the last MDT. Passively refuses. Plan for force feeding. Discussed NGT strategies. Setting threshold for hospital admission.
  - Psych: Barriers for ECT. Patient refusing PO meds. Receiving lower olanzapine dose due to hypotension. Planning RTU placement. Psych plans to assign a primary therapist.
  - Nursing: RNs and CNAs attempted to create rapport through humor, care, kindness, and encouraged to eat/drink, shower.

## 2<sup>nd</sup> MDT – week #2

- Duration: 60 min
- Plan:
  - Medical will coordinate the approval for force feeding. Anticipate refeeding complications.
  - 14-day involuntary antipsychotic medication hearing.
  - MDT scheduled in 1 week.

# Refeeding Syndrome

- Refeeding syndrome is defined as the **clinical complications** that can occur as a result of **fluid and electrolyte shifts** during aggressive nutritional rehabilitation of malnourished patients.
- Characterized by:
  - **Hypophosphatemia**
  - Hypokalemia
  - Congestive heart failure
  - Peripheral edema
  - Rhabdomyolysis
  - Seizures
  - Hemolysis
  - Respiratory insufficiency

# Refeeding Syndrome

- Risk Factors
  - Directly related to the **amount of weight loss** and the speed of the weight gain
  - Weigh less than 70% of their ideal body weight
  - BMI <14 kg/m<sup>2</sup>
  - **Low baseline levels** of phosphate, potassium, or magnesium prior to refeeding the patient
  - Little or no nutritional intake for the previous **5 to 10 days**.

# Refeeding Syndrome - Complications

- **Cardiovascular**: impaired myocardial contractility, heart failure, arrhythmias.
- **Pulmonary**: dyspnea, impaired respiratory function, respiratory failure.
- **Muscular**: myalgias, tetany, rhabdomyolysis.
- **Gastrointestinal**: enzyme elevations, diarrhea.
- **Neurologic**: tremors, paresthesias, delirium, and seizures



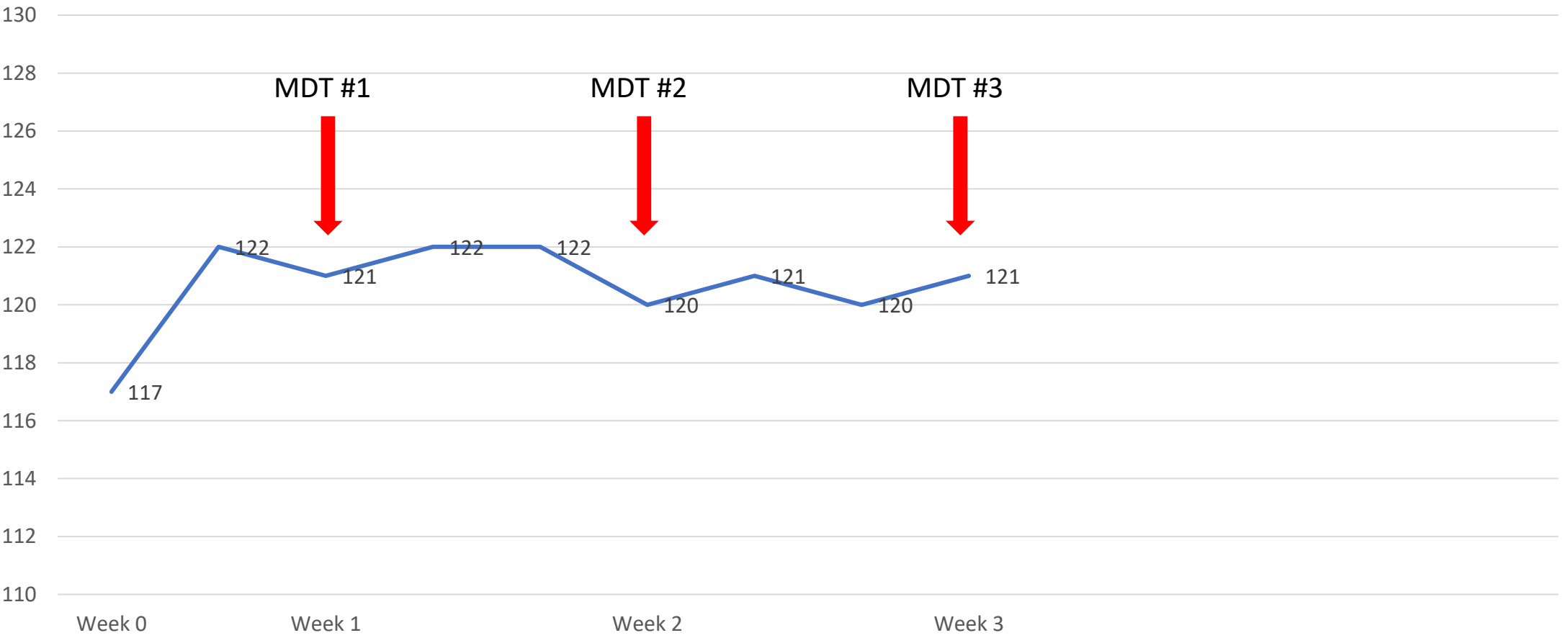
# Refeeding Syndrome – Prevention and Management

- Main prevention: limit initial amount of calories **(1400 to 1600 kcals/day)**
- Avoiding very **rapid increases** in the daily caloric intake and **monitor the patient daily** during the early stages of the refeeding process.
- **Frequent monitoring** of electrolytes, especially **phosphorous** levels.
- Monitoring for and treating **cardiovascular and pulmonary complications**.

# Refeeding Syndrome - Treatment

- **Reduce nutritional support** and aggressively **correct electrolyte derangements**.
- Moderately to severely ill patients with seizures, marked edema, or a serum phosphorous  $<2$  mg/dL should be **hospitalized** for close monitoring.
- **Continuous telemetry** may be needed.

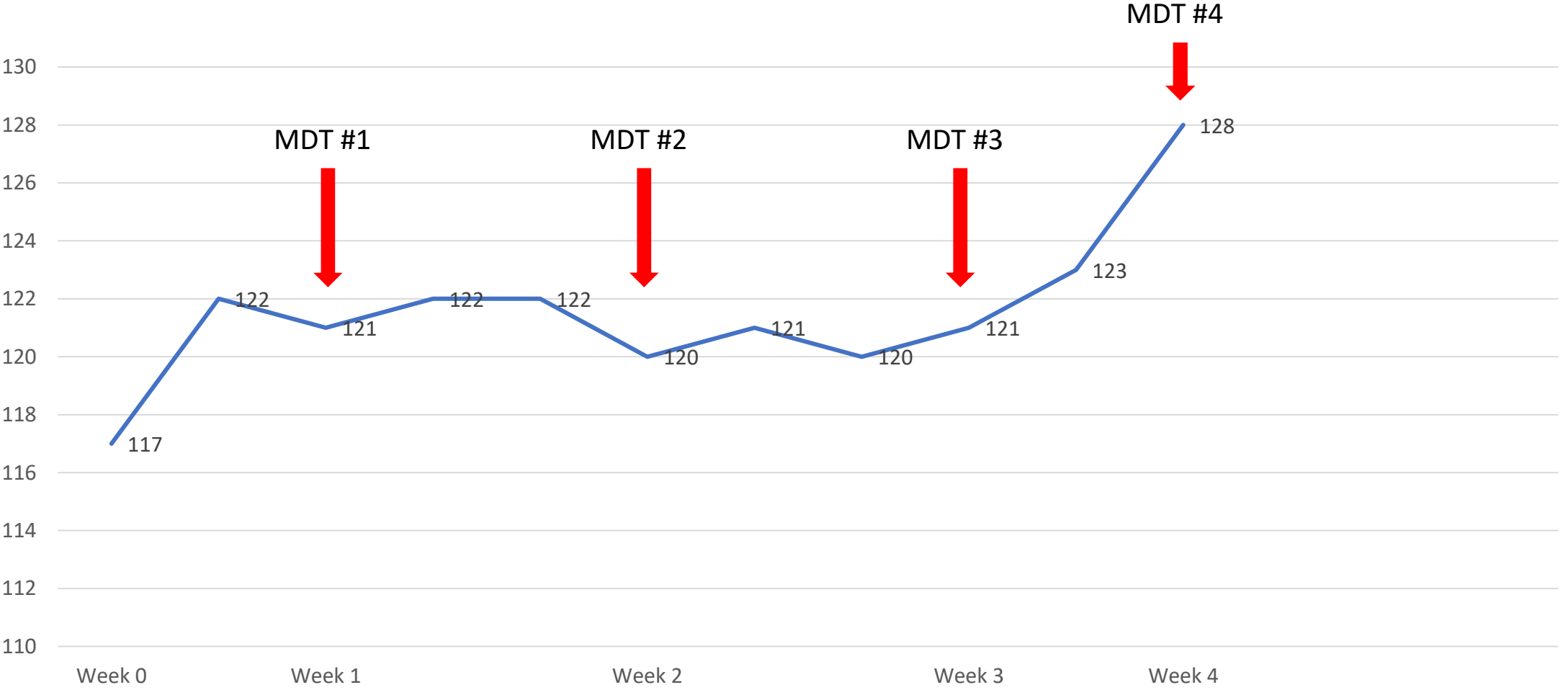
# Timeline of weight and clinical progression:



# 3<sup>rd</sup> MDT – week #3

- Goal: To provide updates, review and discuss clinical course and plan
- Updates:
  - Medical: forced feeding x1, removed NGT. Has been eating approx. 600cal/day. Developed moderate pedal edema. Continues w/ hypotension. More talkative/responsive, agreed to ambulate, sleeping better.
  - Psych: Accepted to the RTU. Sleeping better, stopped VS check at night so he can sleep. Continues to explore ECT as an option. Slowly going up on Zyprexa dose
  - Custody: Plans to walk him every shift, weigh him and provide yard time. Staff is gently encouraging him to ambulate.
- Duration: 60 min
- Plan:
  - Continue current course and weekly MDTs.

# Timeline of Weight and Clinical Progression



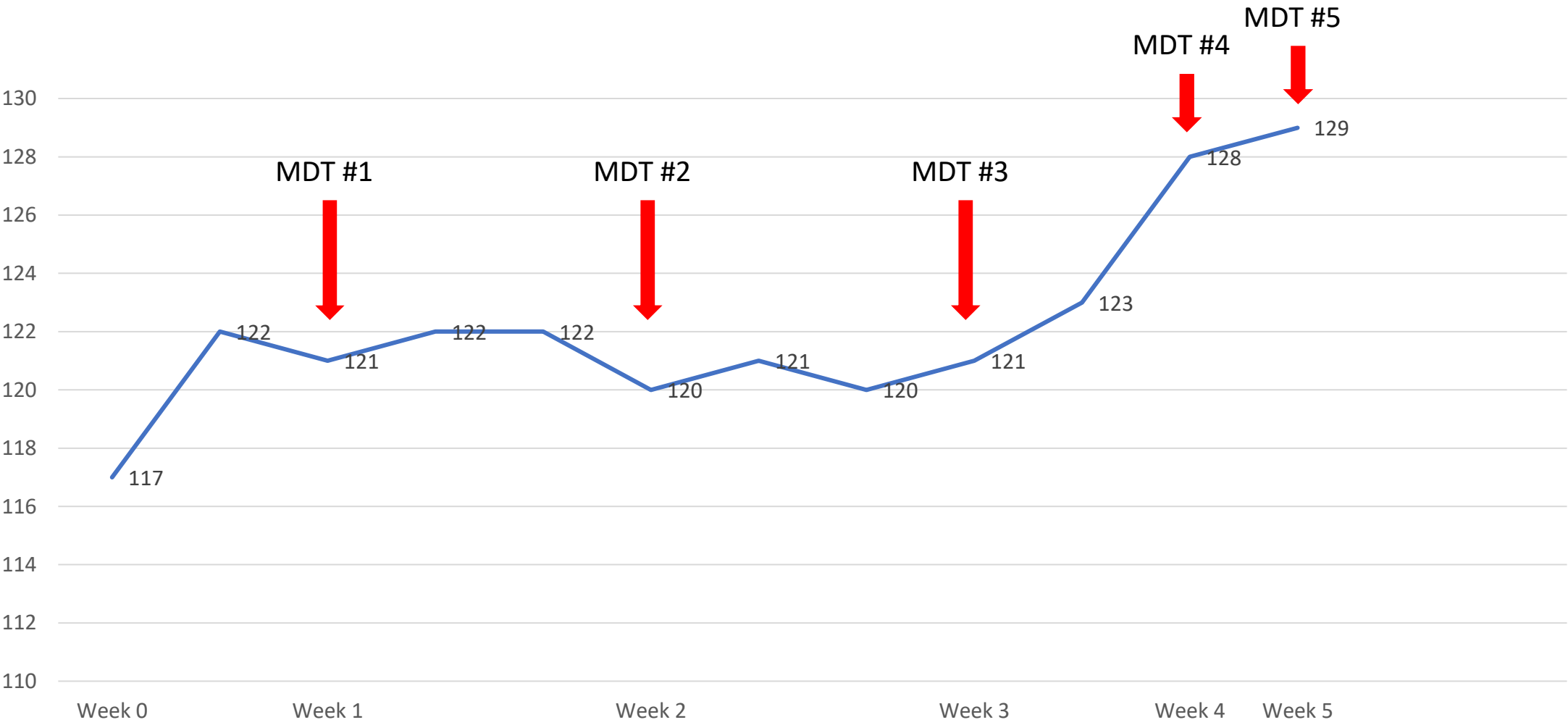
## 4<sup>th</sup> MDT – week #4

- Goal: To provide updates, review and discuss clinical course and plan
- Updates
  - Medical: Eating 50-70% of the meals, no forced fluids or feeding the past week. Walking three times a day. Pedal edema is slightly decreasing.
  - Psych: The patient continues with Zyprexa IM. ECT unlikely. Discussed the continued need for 1:1 observation
  - Custody: Reports seeing overall progress and agrees to provide continued staffing for 1:1.

## 4<sup>th</sup> MDT – week #4

- Duration: 45 mins
- Plan:
  - Contact the chaplain to meet with the patient weekly and invite him to the MDT.
  - Will re-evaluate 1:1 watch in one week.
  - 180 days involuntary antipsychotic medication hearing.
  - MDT scheduled for next week.

# Timeline of Weight and Clinical Progression





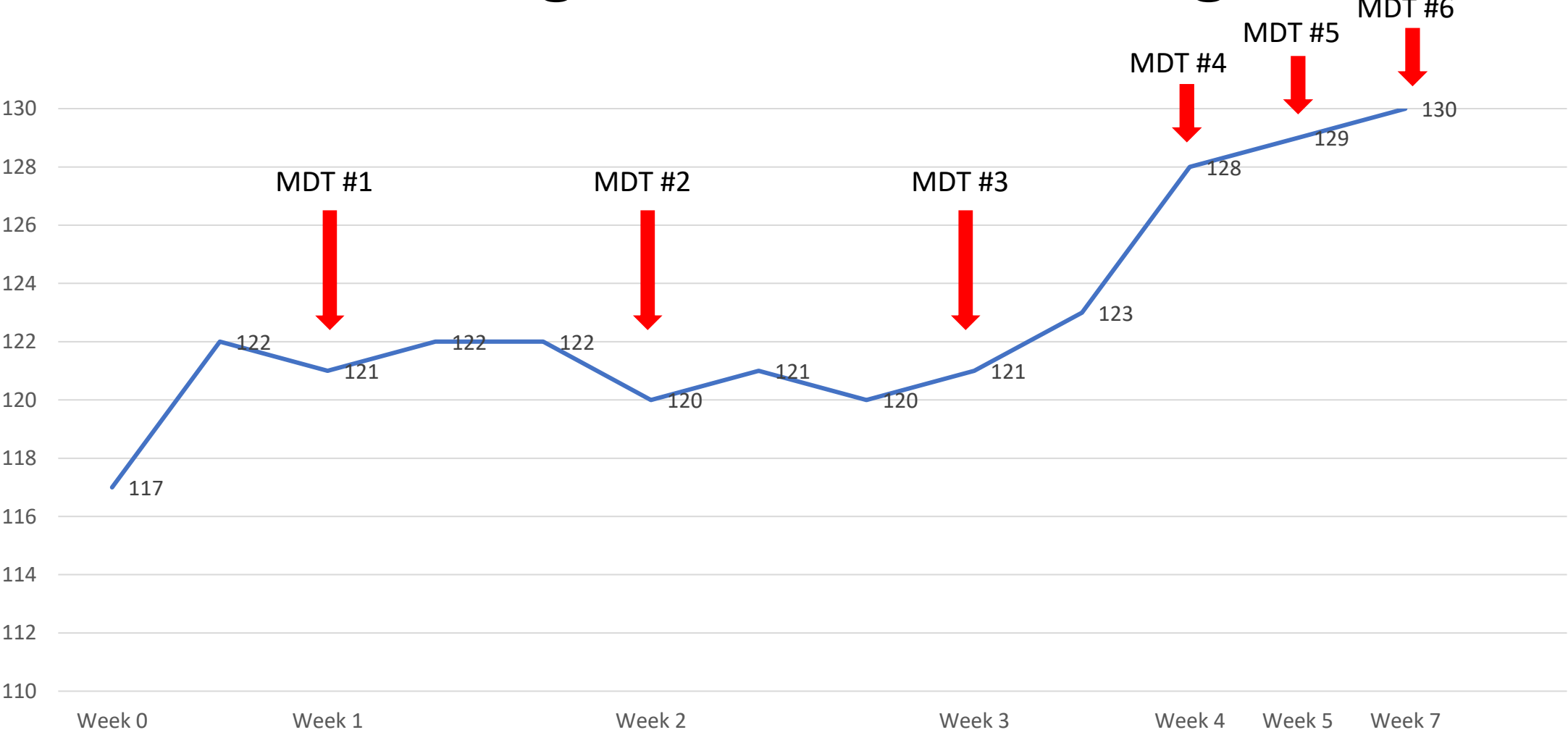
## 5<sup>th</sup> MDT – week #5

- Goal: To provide updates, review and discuss clinical course and plan
- Updates:
  - Medical : No IV hydration or forced feeding. The patient is now walking to the wicket to get his meals. Starting to eat meals within less than 30 minutes compared to over an hour previously. Minimal pedal edema.
  - Psych: Involuntary antipsychotic medications approved for 180 days. Zyprexa dose increase did not result in hypotension. Discontinued 1:1. Softening of delusions noted and more interactive. Weekly meeting with the therapist.
  - Chaplain: talked with the patient regarding biblical nature of fasting and plans to visit weekly.

## 5<sup>th</sup> MDT – week #5

- Duration: 45 mins
- Plan
  - Continue with the current medical and psychiatric plans
  - Continue to work on obtaining ECT in case there are setbacks.
  - MDT in two weeks

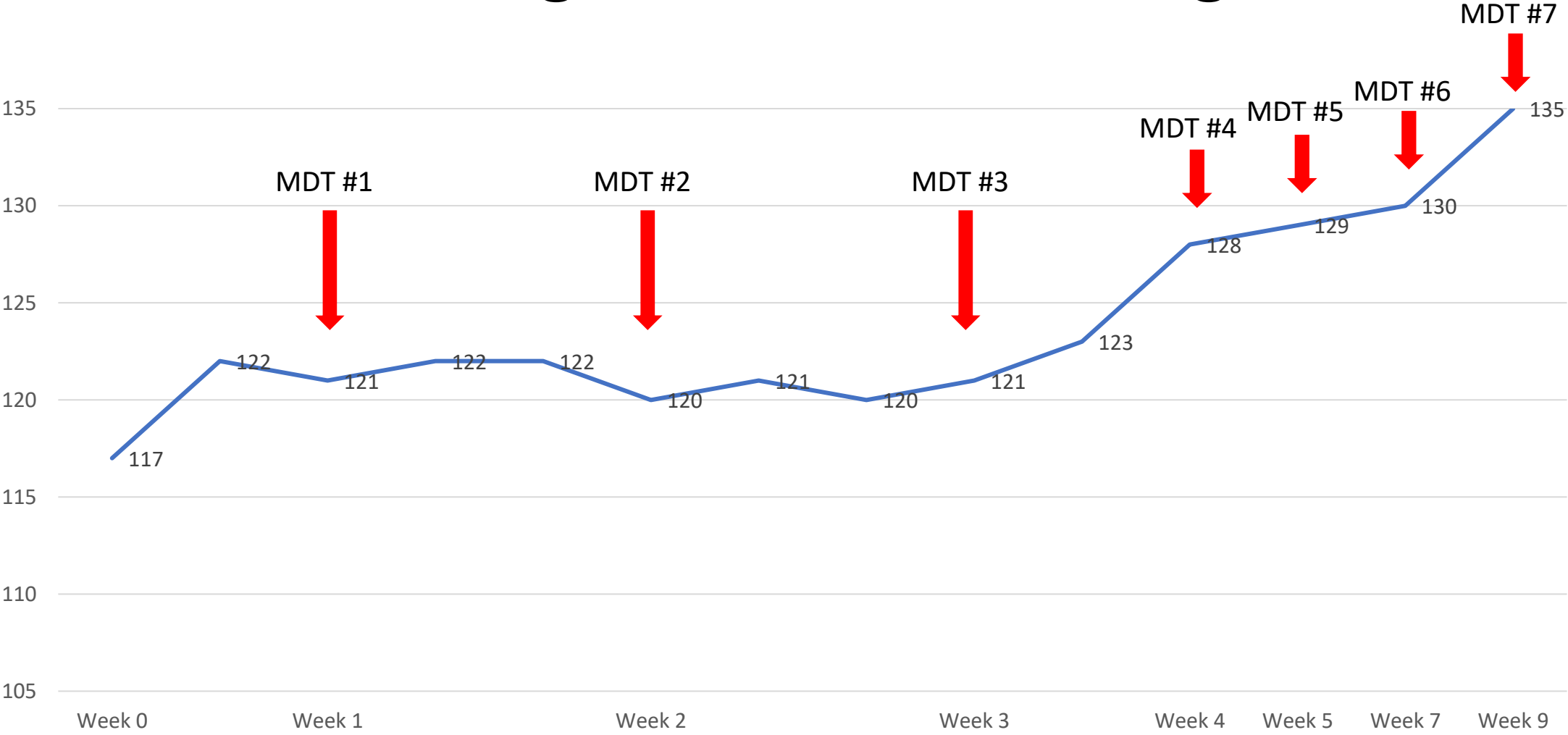
# Timeline of Weight and Clinical Progression



# 6<sup>th</sup> MDT – week #7

- Goal: To provide updates and further planning
- Updates:
  - Medical: Eating 50-75% of the meals. No forced fluids or feeding needed. Plateau in weight gain noted, but overall improvement.
  - Psych: Mother notes the patient is a lot closer to his baseline. Still taking the medication by injection. Less time spent praying. Does not take initiative to get up or walk but will do so promptly when encouraged by staff. Will continue with the current antipsychotic dose.
- Duration: 45 mins
- Plan:
  - Medical to talk with the kitchen for extra portions of the patient's food preference.
  - MDT scheduled for one week.

# Timeline of Weight and Clinical Progression



# 7<sup>th</sup> MDT – week #9

- Goal: To provide updates, discharge plan and ensure continuity of care.
- Updates:
  - Medical: Stable vitals. Eating almost 100% of meals. Discussed the medical transition plan from the IPU to the RTU. Stable for discharge.
  - Psych: The patient is more interactive, less dysphoric, improved self-care, improved relationship with the family, taking more initiative to eat meals, walk etc. Started to take Zyprexa orally instead of injections.
- Duration: 20 mins
- Plan:
  - IPU medical provider to send discharge note, plan and MDT notes to the medical provider in the RTU
  - Establish parameters for re-admission
  - Meet with the therapist twice a week and monthly psychiatric appointment
  - No further MDT scheduled

# Final Medical Assessment

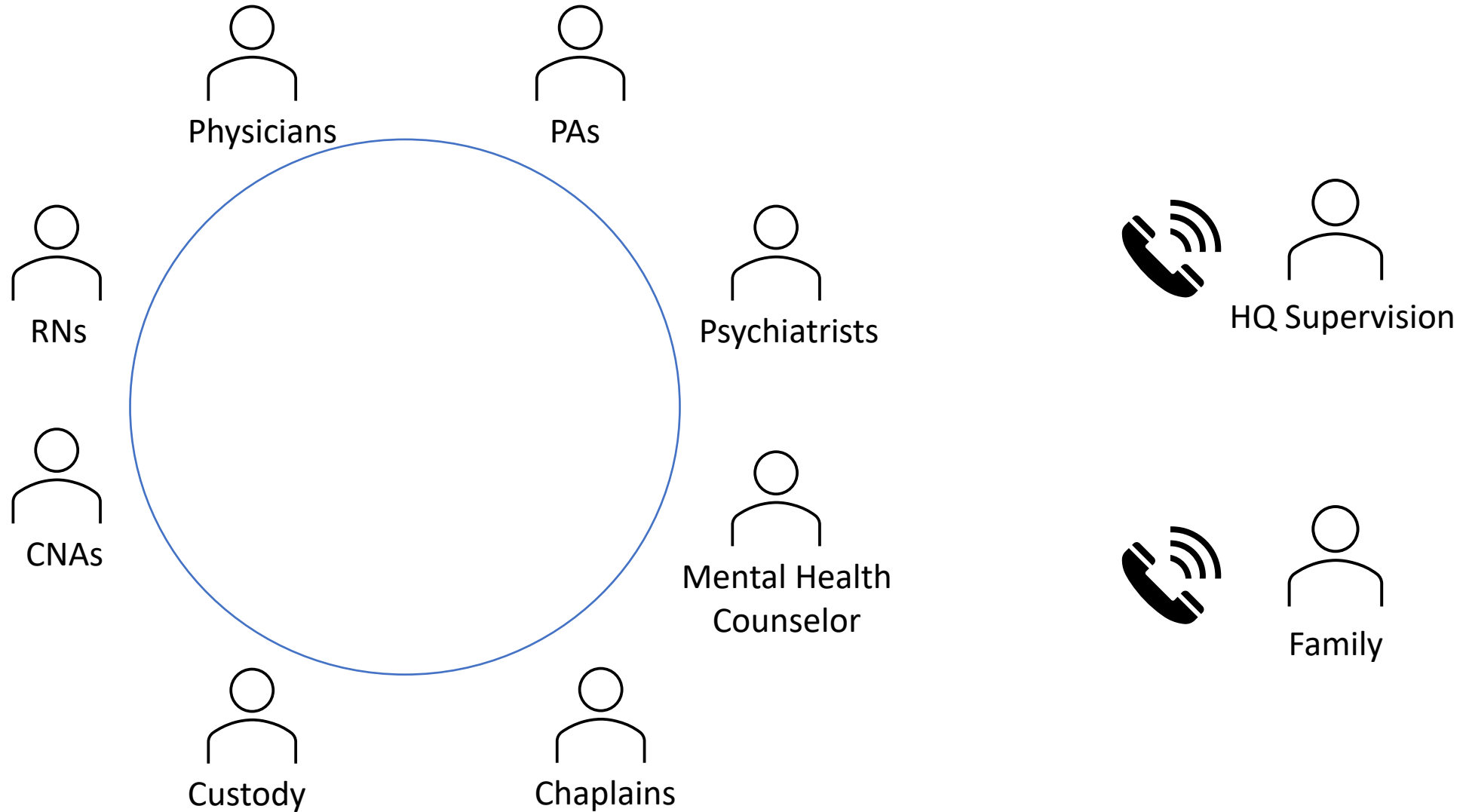
- Total of **2 months** in the medical IPU.
- Admit weight: 122 (low 117)      Discharge Weight: 136.6
- Admit oral intake: 0%      Discharge oral intake: 75-100%
- **Discharge physical exam:** Still thin but with decreased bony prominences (ribs, spine, hips). Able to ambulate with ease. 5/5 strength. No hypotension/orthostasis. NL HR. Labs normalized.
- **Discharge mental status:** looking healthier, appropriate grooming and hygiene. Better eye contact. Speech is soft, normal rate and rhythm. Mood is “good,” with increased range of affect. Significantly improved delusions with improved insight.

# Mental Health Assessment 6 Months Later

- Continues to be on involuntary antipsychotic medication
- Euthymic with no psychomotor retardation
- Currently **no delusions present**
- Engages in weekly psychotherapy
- Currently weighs around **180 lbs**



# MDT Members' Contributions



# Our Successful Outcome Depended On...

- Excellent collaboration between the Medical and Psychiatry team.
- Anticipating complications and barriers to care.
- Contributions from Nursing, Custody and Family.
- Support from the facility and HQ leadership.
- Having clear institutional policies.
- Addressing biases through education.

Questions?

# References

- Annas, Hunger Strikes at Guantanamo – Medical Ethics and Human Rights in a “Legal Black Hole”, NEJM 355;13, September 28, 2006.
- Crosby et al, Hunger Strikes, Force-feeding and Physicians’ Responsibilities, JAMA, August 1, 2007—Vol 298, No. 5.
- N Y Oguz, S H Miles, The physician and prison hunger strikes: reflecting on the experience in Turkey, J Med Ethics 2005;31:169–172. doi: 10.1136/jme.2004.006973
- WMA DECLARATION OF MALTA ON HUNGER STRIKERS, revised by the 68th WMA General Assembly, Chicago, United States, October 2017, <https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/>
- Onur Durmaz, Sena Aktaş & Neslihan Akkişi Kumsar (2020) From psychosis to Wernicke encephalopathy: a case of hunger strike in prison, Neurocase, 26:4, 248-251, DOI: 10.1080/13554794.2020.1786587.
- Mehanna et al, Refeeding syndrome: what it is, and how to prevent and treat it, BMJ 2008;336:1495-8 doi:10.1136/bmj.a301.
- Pacilio et al, Food Refusal Secondary to Psychosis A Case Series and Literature Review, J Nerv Ment Dis 2020;208: 654–657.
- Mehler et al, Nutritional Rehabilitation: Practical Guidelines for Refeeding the Anorectic Patient, Journal of Nutrition and Metabolism Volume 2010, Article ID 625782, 7 pages doi:10.1155/2010/625782