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Angaben zur Veröffentlichung / Publication details:

Haselwarter, Dominik, Katja Kuehlmeyer, and Verina Wild. 2024. "Ethical challenges in health care during collective hunger strikes in public or occupied spaces." *Bioethics* 38 (6): 549–57. https://doi.org/10.1111/bioe.13306.

Received: 25 April 2023 | Revised: 21 April 2024 | Accepted: 7 May 2024

DOI: 10.1111/bioe.13306

ORIGINAL ARTICLE

bioethics WILEY

Ethical challenges in health care during collective hunger strikes in public or occupied spaces

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Abstract

Public collective hunger strikes take place in complex social and political contexts, require medical attention and present ethical challenges to physicians. Empirical research, the ethical debate to date and existing guidelines by the *World Medical Association* focus almost exclusively on hunger strikes in detention. However, the public space differs substantially with regard to the conditions for the provision of health care and the diverse groups of healthcare providers or stakeholders involved. By reviewing empirical research on the experience of health professionals with public collective hunger strikes, we identified the following ethical challenges: (1) establishment of a trustful physician–striker relationship, (2) balancing of medico-ethical principles in medical decision-making, (3) handling of loyalty conflicts and (4) preservation of professional independence and the risk of political instrumentalization. Some of these challenges have already been described and discussed, yet not contextualized for public collective strikes, while others are novel. The presence of voluntary physicians may offer opportunities for a trustful relationship and, hence, for ethical treatment decisions. According to our findings, it requires more attention to how to realise autonomous medical decisions in the complex context of a dynamic, often unstructured and politically charged setting, which ethical norms should shape the professional role of voluntary physicians, and what is the influence of the hunger strikers' collective on individual healthcare decisions. Our article can serve as a starting point for further ethical discussion. It can also provide the basis for the development of potential guidelines to support health professionals involved in public collective hunger strikes.

KEYWORDS

decision making [MeSH], fasting [MeSH], loyalty conflicts, professional autonomy [MeSH], protest, refugees [MeSH]

1 | INTRODUCTION

Public collective hunger strikes have occurred in various European countries over the past decade. These political protest actions were mainly initiated by asylum seekers or undocumented migrants in order to fight for social and political rights such as legal residency, better housing conditions and protection against deportation. Prominent examples of public collective hunger strikes were those of groups of asylum seekers on public squares in Germany,[1] undocumented migrants in squatted buildings in Brussels,[2] in the *Calais Jungle* refugee camp in France[3] or the mass hunger strikes of migrants in the Greek cities of Athens and Thessaloniki.[4] In the recent past, the phenomenon of public collective hunger strikes also emerged in the context of climate activists' protests.[5]

Hunger strikes are political acts taking place within complex social, political and societal contexts.[6] They are defined by the World Medical Association (WMA) as 'food refusal as a form of protest or demand' which is particularly undertaken by people 'who lack alternative means to gain attention'.[7] There are three different forms of hunger strikes: *partial fasting* (ingestion of fluids, sugar and vitamins but no solid food), *total fasting* (ingestion of fluids but no solid food) and *dry fasting* (ingestion of neither fluids nor solid food).[8] All three forms of hunger striking can lead to serious health damage, both acute and long-term. While total fasting on average can be kept up for 2–3 months,[9] dry fasting will lead to death by dehydration within 1 week.[10] Cases of dry hunger strikes—also in the public setting—have been described in which circulatory insufficiency due to hypovolemic shock requiring cardiopulmonary resuscitation occurred after a few days.[11] Fasting can induce severe neurological and psychological changes, such as alteration of consciousness and memory, or mental illnesses, such as psychotic episodes or delusions.[12] Possible long-term health effects of hunger striking are renal failure, starvation colitis, Wernicke–Korsakoff syndrome[13] and the refeeding syndrome, a life-threatening metabolic disorder.[14]

Due to their significant health effects, hunger strikes demand medical monitoring and an offer of health care. While pursuing a certain political or personal goal to improve their lives, hunger strikers are risking the precondition necessary for living their lives—their health—in doing that. Thus, health professionals are faced with a paradoxical situation. They might deal with a person who is simultaneously claiming to be willing to die for a certain goal, wanting to achieve an improvement for their life (and/or the lives of others) and/or presenting individual health-related needs to a professional. Such motivations and needs can collide, resulting in individual or group-related moral dilemmas for the strikers and the healthcare professionals.

The existing ethical[15] debate focuses almost exclusively on hunger strikes in custodial settings, such as prisons and detention centres.[16] Practical and ethical guidance is provided by the Declaration of Malta published by the World Medical Association,[17] which also explicitly addresses hunger strikes in detention. However, ethical challenges from the perspective of health professionals in the specific context of a non-custodial collective hunger strike in public or occupied spaces (in the following: public hunger strikes) have not been systematically described so far. Furthermore, there is scarce empirical research on health care in public hunger strikes. Yet it is urgently needed to account for the specific context(s) and challenges, as public hunger strikes are likely to remain a mode of protest, for example, regarding the climate crisis. A systematic examination of ethical issues can lead to the development of guidelines—or a revision of existing ones—that can support physicians who care for hunger strikers and are in need of such guidance.[18]

[1]Glöde, H., & Böhlo, B. (2015). Der Marsch der protestierenden Flüchtlinge von Würzburg nach Berlin und ihr Protest bis heute. *Forschungsjournal Soziale Bewegungen, 28*(4), 75–86. https://doi.org/10.1515/fjsb-2015-0410; Haselwarter, D., Wild, V., & Kuehlmeyer, K. (2022). Providing health care in politically charged contexts: A qualitative study about experiences during a public collective hunger strike of asylum seekers in Germany. *International Journal of Qualitative Studies on Health and Well-being, 17*(1), 2018770; Odugbesan, A., & Schwiertz, H. (2018). "We are here to stay"—Refugee Struggles in Germany Between Unity and Division. In S. Rosenberger (Ed.), *Protest movements in asylum and deportation* (pp. 185–203). Springer.

[2]Vanobberghen, R., Lafaut, D., Louckx, F., Devroey, D., & Vandevoorde, J. (2022). Between sympathy, fascination, and powerlessness. the experiences of health professionals during the medical monitoring of a hunger strike among undocumented migrants. *Frontiers of Public health*, 10, 756964.

[3]Bargu, B. (2017). The silent exception: Hunger striking and lip-sewing. *Law, Culture and the Humanities, 18*(2), 1743872117709684.

[4]Mantanika, R., & Kouki, H. (2011). The spatiality of a social struggle in Greece at the time of the IMF: Reflections on the 2011 mass migrant hunger strike in Athens. *City, 15*(3–4), 482–490.

[5]Heidtmann, J. (2021, September 15). Hungerstreik fürs Klima. "Was muss man noch tun, damit einen die Politik ernst nimmt?". *Süddeutsche Zeitung*. https://www.sueddeutsche.de/politik/berlin-klima-hungerstreik-1.5411618?reduced=true; Torjesen, I. (2022). Health leaders urge PM to meet hunger striker's demand that MPs be briefed on climate change. *BMJ, 377*. https://doi.org/10.1136/bmj.o999

[6]Filc, D., Ziv, H., Nassar, M., & Davidovitch, N. (2014). Palestinian prisoners' hunger-strikes in Israeli prisons: Beyond the dual-loyalty dilemma in medical practice and patient care. *Public Health Ethics, 7*(3), 229–238. https://doi.org/10.1093/phe/phu021; Haselwarter, D., et al., op. cit. note 1.

[7]World Medical Association. (2006). WMA Declaration of Malta: A background paper on the ethical management of hunger strikes. *World Medical Journal, 52*(2), 36–43, p. 36.

[8]Vanobberghen, R., Louckx, F., Depoorter, A.-M., Devroey, D., & Vandevoorde, J. (2019). The role of physicians during hunger strikes of undocumented migrant workers in a non-custodial setting. *Perspectives in Biology and Medicine, 62*(1), 111–130. https://doi.org/10.1353/pbm.2019.0006

[9]Chalela, J. A., & Lopez, J. I. (2013). Medical Management of Hunger Strikers. *Nutrition in Clinical Practice, 28*(1), 128–135. https://doi.org/10.1177/0884533612462896

[10]World Medical Association, op. cit. note 7.

[11]Guyton, P. (2013, June 06). Flüchtlingsstreik in München: Das Protestcamp ist geräumt. *Tagesspiegel*. https://www.tagesspiegel.de/politik/das-protestcamp-ist-geraumt-5538781.html

[12]Gétaz, L., Rieder, J., Nyffenegger, L., Eytan, A., Gaspoz, J., & Wolff, H. (2012). Hunger strike among detainees: Guidance for good medical practice. *Swiss Medical Weekly, 142*, w13675. https://doi.org/10.4414/smw.2012.13675; Fessler, D. M. T. (2003). The implications of starvation induced psychological changes for the ethical treatment of hunger strikers. *Journal of Medical Ethics, 29*(4), 243–247. https://doi.org/10.1136/jme.29.4.243

[13]Gétaz, L., Rieder, J., Nyffenegger, L., Eytan, A., Gaspoz, J., & Wolff, H. (2012). Hunger strike among detainees: guidance for good medical practice. *Swiss Medical Weekly, 142*, w13675. https://doi.org/10.4414/smw.2012.13675; Fessler, D. M. T., op. cit. note 12.

[14]Eichelberger, M., Joray, M. L., Perrig, M., Bodmer, M., & Stanga, Z. (2014). Management of patients during hunger strike and refeeding phase. *Nutrition, 30*(11–12), 1372–1378. https://doi.org/10.1016/j.nut.2014.04.007

[15]The terms ethical and moral are used interchangeably in this article.

[16]Gulati, G., Kelly, B. D., Meagher, D., Kennedy, H., & Dunne, C. P. (2018). Hunger strikes in prisons: A narrative systematic review of ethical considerations from a physician's perspective. *Irish Journal of Psychological Medicine, 35*(2), 135–142. https://doi.org/10.1017/ipm.2017.33

[17]World Medical Association. (2017). *WMA Declaration of Malta on hunger strikers*. https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/

[18]Haselwarter, D., et al., op. cit. note 1.

In view of the recent socioempirical findings, we aim to provide an overview of ethical challenges[19] in health care during collective hunger strikes in public or occupied spaces.[20] First, we will provide background information on two paradigmatic cases of public hunger strike that have been the subject of empirical research. They illustrate the distinctiveness of public hunger strikes compared to the custodial setting. Then we will describe the ethical challenges. Finally, we will discuss to what extent the current ethical guidance is appropriate and sufficient.

2 | CHARACTERISTICS OF PUBLIC COLLECTIVE HUNGER STRIKES

2.1 | Two paradigmatic cases of public collective hunger strikes

Two of the public hunger strikes in Europe mentioned above have become the subject of empirical studies focusing primarily on professional role expectations and ethical and practical challenges. In both cases, many of the healthcare professionals described their experience as extremely stressful or even traumatic due to the arising moral conflicts and dilemmas.[21]

The first case under research was a hunger strike of undocumented migrants in an occupied building in Belgium.[22] A group of 45 migrants initiated a hunger strike demanding a more humane treatment and a residence permit. The hunger strikers went on *partial fasting* with the intake of sweetened beverages lasting 64 days. Medical monitoring and care were provided by a group of voluntary medical personnel with different professional backgrounds (nurses, medical doctors and medical students) contacted by activists and through informal networks. The medical monitoring included regular checking of vital signs as well as the on-site treatment and documentation of physical and psychological problems. The hunger strikers showed symptoms like gastro-intestinal problems, pain, dizziness, kidney problems and neurological symptoms. Hunger strikers in critical condition were transferred to the emergency ward of nearby public hospitals. The hunger strike ended following negotiations with the immigration authorities promising minor concessions to the hunger strikers. All hunger strikers survived. The publications do not provide any information about possible long-term damage to their health, as no medical follow-up studies were conducted.

The second case involved a group of about 50 asylum seekers who started a hunger strike on a public square in a German city.[23] The hunger strikers made various demands on the authorities, first and foremost, the recognition of asylum for all participants. They were accompanied by supporters who declared solidarity with their goals and were permanently present at the hunger strike without participating in the fasting. The hunger strikers and their supporters erected a small camp of tents and fences to protect themselves (e.g., against bystanders, media reporting and weather). The hunger strikers and their supporters controlled access to the camp. As no agreement with the authorities and the crisis committee convened by the city administration was reached, the hunger strikers went on *dry fasting* (no ingestion of either food or fluids) on the fourth day. Medical monitoring and care on site were performed by health professionals with different professional backgrounds (medical doctors and paramedics) belonging to three different groups: (1) voluntary healthcare professionals, who were on site without being paid by an employing institution; (2) members of the public emergency services who were sent through a centralized management of those services and were on site as part of their professional activities; and (3) Medical consultants who were employed and paid by the authorities. The latter did not actively participate in medical care but assessed and monitored the health status of the hunger strikers and passed on information to the relevant authorities. Medical assistance, which consisted of regular checks of vigilance and vital signs and the on-site treatment of minor medical problems, was provided primarily by the voluntary healthcare professionals. As a consequence of *dry fasting*, a significant number of hunger strikers rapidly developed severe symptoms such as signs of dehydration and metabolic disbalance, reduction of vigilance, loss of consciousness or hypovolemic shock. If a hunger striker was regarded as critically ill, the public emergency service was called into the camp and the hunger striker was treated on-site or transported to a public hospital. As on the fourth day of *dry fasting* no agreement between the conflicting parties was reached, the hunger strikers' camp was evicted by a large contingent of police and with the help of the public emergency services. In the course of this forced eviction, members of the public emergency services had to take coercive measures against the hunger strikers. As a justification for the forced eviction, the public authorities stated that the life and health of the strikers could no longer be guaranteed due to the continued dry fasting. This situation assessment was based, among other things, on the statements previously made by members of the emergency service and the medical consultants assigned. The hunger strikers were transported to hospitals, and none of them died. Again, there is no follow-up on the hunger strikers about possible long-term health consequences. The findings of the publications on these two cases are helpful in understanding how the settings of hunger strikes in

[19]We understand ethical challenges following Schofield et al. (2021) and Salloch et al. (2016) as (a) *ethical dilemmas*, where two options may be morally justifiable but both are similarly problematic, (b) *ethical realization conflicts*, where one might be aware of what the morally right action would be but has trouble exercising these action due to internal or external constraints, (c) *ethical uncertainty*, where one does not know which is the ethically appropriate conduct, or d) situations characterised by an apparent *ethical deficit* or *ethical misconduct*. See Schofield, G., Dittborn, M., Selman, L. E., & Huxtable, R. (2021). Defining ethical challenge (s) in healthcare research: A rapid review. *BMC Medical Ethics*, *22*(1), 1–17; Salloch, S., Ritter, P., Wäscher, S., Vollmann, J., & Schildmann, J. (2016). Was ist ein ethisches Problem und wie finde ich es? Theoretische, methodologische und forschungspraktische Fragen der Identifikation ethischer Probleme am Beispiel einer empirisch-ethischen Interventionsstudie. *Ethik in der Medizin*, *28*(4), 267–281.

[20]Ibid; Vanobberghen, R., et al., op. cit. note 2; Vanobberghen, R., et al., op. cit. note 8.

[21]Haselwarter, D., et al., op. cit. note 1; Vanobberghen, R., et al., op. cit. note 2.

[22]Vanobberghen, R., et al., op. cit. note 2; Vanobberghen, R., et al., op. cit. note 8.

[23]Haselwarter, D., et al., op. cit. note 1.

public or occupied spaces differ from those of prisons and detention centres.

2.2 | Distinctiveness of public hunger strikes

A public hunger strike is a situation that is per se highly complex and unstructured. Whereas in the context of prisons and detention centres, clinicians are usually directly employed or assigned by the (prison) authorities, different groups of healthcare professionals may be involved in public hunger strikes. Health care for the hunger strikers is provided not only by the official emergency doctors and paramedics but also by independent health professionals who are not employed or paid by any institution or authority.[24] These independent health professionals act on a voluntary basis and out of sympathy for the political goals of the hunger strikers. The hunger strikers have more degrees of freedom, choice and control over the situation than in detention. That could mean they can choose health professionals of their trust, they can control people's access to the site where the hunger strike is taking place or they themselves can moderate the communication with the public.[25] In custodial settings, health professionals employed by the institutions usually have access to medical infrastructure, including sufficient medical equipment, private spaces for consultations, documentation systems, laboratory analysis, radiological imaging and the possibility to monitor the hunger strikers in accordance with established clinical guidelines,[26] which can be difficult or impossible to realise in the public space. Although mass hunger strikes can also occur in prisons,[27] the number of hunger strikers is often small and their medical history is more or less known to the medical staff and/or prison authorities. In sum, health professionals involved in health care during public hunger strikes can usually not rely on the provision of a broad variety of healthcare resources and provisions are largely improvised.[28] Furthermore, public hunger strikes are often characterized by the presence of various actors other than hunger strikers and health professionals, such as authority representatives, the media or political supporters or opponents of the hunger strikers.[29] Another distinction from the detention settings is that the prison authorities generally have a legal (and moral) duty of care for those under their custody and are legally liable for their death or injury.[30] Such a regulated legal setting with regard to the health care of hunger strikers might be less pronounced in the case of public hunger strikes.

3 | ETHICAL CHALLENGES FOR PHYSICIANS INVOLVED IN HEALTH CARE IN PUBLIC COLLECTIVE HUNGER STRIKES

Based on an analysis of the existing empirical literature, as well as further conceptual and ethical discussion and analysis, we have identified the following four major ethical challenges for physicians involved in health care in this specific context of non-custodial hunger strikes: (1) establishment and maintenance of a trustful physician–striker relationship, (2) balancing of medicoethical principles in medical decision-making, (3) handling of loyalty conflicts in the provision of medical advice, service and treatment and (4) preservation of professional independence in the light of a risk of political instrumentalization.

The challenges are mainly described from the perspective of physicians who are involved in the health care for hunger strikers in public or occupied spaces. Yet, other health professionals could also be confronted with these challenges.

3.1 | The establishment and maintenance of a trustful physician–striker relationship

In general, mutual trust is a crucial requirement for a functioning physician–patient relationship.[31] It is a prerequisite for the realization of ethically justified treatment decisions.[32] Trust can be understood as a feeling of confidence and reassurance towards the physician and implies the expectation that doctors will do their best for their patients.[33] Mistrust can, for example, occur when patients are feeling (or being) coerced to endure medical measures against their expressed will or when they are feeling (or being) deceived about the purpose of a healthcare measure. The *Declaration of Malta* highlights the importance of a trustful relationship with hunger strikers in detention, as it is 'often the key to achieving a resolution that both respects the

[24]Ibid.; Vanobberghen, R., et al., op. cit. note 2.
[25]Haselwarter, D., et al., op. cit. note 1.
[26]Chalela, J.A. & Lopez, J.I., op. cit. note 9; Eichelberger, M., et al., op. cit. note 14; Gétaz, L., et al., op. cit. note 11; Gétaz, L., et al., op. cit. note 12; Reyes, H., Allen, S. A., & Annas, G. J. (2013). Physicians and hunger strikes in prison: confrontation, manipulation, medicalization and medical ethics. *World Medical Journal*, *59*(1), 27–36; García-Guerrero, J. (2013). Hunger striking in prisons: ethics and the ethical and legal aspects. *Revista Espanola de Sanidad Penitenciaria*, *15*, 8–15; Vanobberghen, R., et al., op. cit. note 2; World Medical Association, op. cit. note 17.
[27]Kenny, M. A., Silove, D. M., & Steel, Z. (2004). Legal and Ethical Implications of Medically Enforced Feeding of Detained Asylum Seekers on Hunger Strike. *The Medical Journal of Australia*, *180*(5), 237–240. https://doi.org/10.5694/j.1326-5377.2004.tb05893.x; Oguz, N. Y., & Miles, S. H. (2005). The Physician and Prison Hunger Strikes: Reflecting on the Experience in Turkey. *Journal of Medical Ethics*, *31*(3), 169–172. https://doi.org/10.1136/jme.2004.006973
[28]Haselwarter, D., et al., op. cit. note 1; Vanobberghen, R., et al., op. cit. note 2.
[29]Haselwarter, D., et al., op. cit. note 1.
[30]Aitchison, G. (2022). Fragility as strength: The ethics and politics of hunger strikes. *Journal of Political Philosophy*, *30*(4), 535–558.
[31]In order to raise a red flag about the complexities of the patient role, resulting in implications for the relationship with the physician, the term physician-striker relationship instead of physician–patient relationship will be used in the following. Not all persons on a hunger strike need medical treatment. Especially during partial and total fasting, medical care might be unnecessary for the otherwise healthy striking person. Yet, strikers can benefit from medical monitoring during striking. They might want to speak to health-care workers and establish a relationship as a safeguard when their health deteriorates.
[32]Hoff, T., & Collinson, G. E. (2017). How do we talk about the physician–patient relationship? What the nonempirical literature tells us. *Medical Care Research and Review*, *74*(3), 251–285.
[33]Rasiah, S., Jaafar, S., Yusof, S., Ponnudurai, G., Chung, K. P. Y., & Amirthalingam, S. D. (2020). A study of the nature and level of trust between patients and healthcare providers, its dimensions and determinants: a scoping review protocol. *BMJ Open*, *10*(1), e028061.

rights of the hunger strikers and minimizes harm to them'[34]. The WMA further states that trust depends 'upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do'[35].

In the situation of a public hunger strike, the imperative of first building a trustful relationship can be difficult to realise. Even if physicians succeed, the relationship might be fragile. This can be due to the politically charged context and the potentially colliding interests of the involved parties. Especially health professionals who are assigned by a public authority (e.g., emergency doctors or medical experts) can be perceived as opponents in a political struggle. When hunger strikers do not expect such physicians to act in their best interests but to rather act on conflicting secondary interests, they might minimise the communication with them or restrict their access to the site of strike. Due to a lack of trust, strikers might not adhere to a physician's medical advice to stop fasting even if it is expressed with the interest at heart to prevent them from (further) harm.

For independent health professionals or neutral mediators (e.g., clinical ethics mediators), there might be higher chances of establishing a trustful relationship as long as they can assure their independence from the opposing government authorities.[36] Furthermore, in the public setting, hunger strikers may have—at least to some extent, and especially if voluntary physicians are involved—more options for choosing physicians they trust than in prison. Nevertheless, communication based on mutual trust is likely to be complicated by the characteristics of the setting, especially by a lack of privacy during consultations due to the group situation and a potential lack of rooms. The presence of media and official authorities can aggravate the problem, for example, when they inquire about confidential information on the strikers' health. In the specific case of hunger strikes of undocumented migrants, a general mistrust towards health personnel and their intentions may also be traced back to the experience of rejection and mistreatment while seeking medical care. This can be based on their own experience, their generation's experience or the experience of past generations.[37]

The difficulties in the establishment and maintenance of a relationship based on trust represent a major problem for physicians involved in hunger strikes. Without a trustful relationship, further problems can occur with regard to the realization of ethically appropriate treatment decisions, as the following section will highlight.

3.2 | The balancing of medicoethical principles in medical decision-making

Physicians in health care in general and especially those involved in hunger strikes are often confronted with complex treatment decisions. When making treatment decisions in connection with or for hunger strikers, physicians can be facing not only interpersonal conflicts but also conflicts between principles of medical ethics.[38]

From a principle-based approach, the autonomous decision to fast and, as a result, run the risk of harming oneself (*autonomy*) stands in contrast to the physician's duty to promote the well-being of a patient. This duty means the promotion of the hunger striker's well-being by preventing negative consequences of striking to the striker's health (*beneficence*) and not to disproportionately harm the striker through medical actions (*nonmaleficence*). The realization of the strikers' autonomy has been a central principle in ethical considerations in hunger strikes in custodial settings. There is a broad consensus that in paradigmatic hunger-strike cases the arguments in favour of the principles of *beneficence* and *nonmaleficence* do not justify coercive medical interventions (e.g., forced administration of artificial nutrition and hydration) against the explicit autonomous will of a hunger striker.[39] This poses the question as to what qualifies an autonomous decision for hunger striking. According to the *three-condition theory* of autonomy,[40] autonomous decisions are characterized by *intentionality*, *understanding* and *freedom from coercion*. The WMA draws on these preconditions in their guidelines: it is within the physicians' responsibility to assess the hunger strikers' true will, their mental capacity and to ensure an understanding of all medical implications of hunger striking. The guideline also stresses the freedom of choice and identifies peer pressure as an important factor in the case of collective hunger strikes.[41]

Considerations as to whether a hunger striker's decision to stop eating (and drinking) is an autonomous decision are of central importance also in public hunger strikes. It can be difficult to assess whether the preconditions for autonomous decisions are met in the hunger-strike situation. A striker's autonomy can be limited by undue influence on the striker's decision to start or continue fasting due to the *collective* setting of the hunger strike. The commonly shared political goals, the peer pressure, the specific group dynamics and the authority of ringleaders can have a strong influence on an individual's decision to strike. In addition, the erection of physical barriers such as fences or tents to demarcate the camp and portraying them in the media can create psychological barriers that may influence their decision about whether to leave the situation. The group situation may also result in a lack of privacy, inhibiting conversations out of earshot of others. This can impair the opportunity for thorough anamnesis and examination of the striker. Lack of privacy and additional language barriers can hamper in-depth conversations

[34]World Medical Association, op. cit. note 17, p. 2.

[35]Ibid, p.2.

[36]However, so far clinical ethics mediators have not been present at the strikes that we looked at. It is probably difficult to establish their authority in the public space. Usually, they are employed by institutions (often hospitals), and institutional policies regulate their involvement in concrete cases.

[37]Vanobberghen, R., et al., op. cit. note 2.

[38]Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8 ed.). Oxford University Press.

[39]Gulati et al., op. cit. note 16; Jacobs, P. (2012). *Force-feeding of prisoners and detainees on hunger strike: right to self-determination versus right to intervention*. Intersentia; Kenny et al., op. cit. note 27; Oguz, & Miles, op. cit. note 27; Reyes, H. (2007). Force-feeding and coercion: No physician complicity. *The Virtual Mentor: VM*, *9*(10), 703–708. https://doi.org/10.1001/virtualmentor.2007.9.10.pfor1-0710; Silove, D., Curtis, J., Mason, C., & Becker, R. (1996). Ethical considerations in the management of asylum seekers on hunger strike. *JAMA*, *276*(5), 410–415. https://doi.org/10.1001/jama.1996.03540050070026; World Medical Association, op. cit. note 17.

[40]Beauchamp, T. L., & Childress, J. F., op. cit. note 38.

[41]World Medical Association, op. cit. note 17.

about the hunger striker's treatment wishes and values and the provision of information to understand all medical implications of a hunger strike fully. It can complicate the assessment of the hunger strikers' decision-making capacity. Furthermore, conversations about treatment decision-making should ideally be initiated by a physician at the beginning of the hunger strike, as the decision-making capacity might deteriorate due to the neurological impacts of hunger striking.[42] This suggestion might be problematic in practice due to the complex trust-building process. However, the presence of voluntary doctors who can build a trusting relationship with the strikers could be regarded as a favourable prerequisite.

A balancing of the medicoethical principles can also play a role in less acute treatment decisions. Hunger strikers may actively ask physicians for medical measures to enhance their abilities to continue the striking such as the provision of painkillers in order to control the symptoms caused by fasting. Although temporarily alleviating the hunger striker's suffering, the provision of analgesics can ultimately prolong the harmful situation of a hunger striker. A situation like that could be seen as a conflict between the principles of *beneficence* and *nonmaleficence*, and it could interact with the perception of trust of the striker, which is a crucial condition for medical decision-making.

Balancing medicoethical principles appears to be a central challenge for physicians involved in health care for hunger strikers in public settings. However, such considerations are taking place in a context where various actors are placing different and conflicting expectations on physicians. As a result, physicians may face loyalty conflicts, as the following section will show.

3.3 | The handling of loyalty conflicts in the provision of medical advice, service and treatment

In their everyday practice, physicians face conflicts between undivided loyalty towards patients and pressure to use their clinical methods and judgement for social purposes and on behalf of third parties.[43] In a collective public hunger strike where different stakeholders pursue political goals, health professionals are especially prone to experience conflicts of loyalty. Loyalty is described as 'perseverance in an association to which a person has become intrinsically committed as a matter of his or her identity'.[44] Loyalty is not just a sentiment. It is an important practical disposition and may also be part of a professional role understanding such as a physician's loyalty towards his/her patients.[45] In the context of a hunger strike, dual loyalty conflicts have been described before, but what we find in a public hunger strike can also include triple or multiple loyalty conflicts.

Dual loyalty usually refers to a conflict between clinicians' obligations towards their patients and obligations towards another party, often an employer or a government authority. Such dual loyalties are well known, for example, in healthcare delivery in prisons and immigration detention centres.[46] In the context of hunger strikes in custodial settings, dual loyalty conflicts are a major source of role conflicts.[47] They can occur when health professionals are confronted with their employers' expectations to deliver life-prolonging measures against a striker's explicit and autonomous will, such as the (forced) administration of artificial nutrition and hydration. The *WMA Declaration of Malta* explicitly addresses dual loyalty conflicts, emphasizing that the physician's primary obligation should always be towards the individual hunger striker and not towards any third party.[48]

Similar dual loyalty conflicts may also occur in the context of hunger strikes in public or occupied spaces. While caring for the health of individual strikers, authorities or employers might demand from physicians that they promote or participate in coercive measures against the hunger strikers, assess whether their camp should be closed (e.g., because of its imminent danger to life and limb), or they could ask physicians to support forced eviction. Further, authorities (or employers) could ask physicians to disclose confidential information about the hunger strikers' health status in order to be able to evaluate whether coercive measures are justified.

A triple loyalty conflict can occur when a physician feels or acts loyal towards three parties involved: the individual hunger striker who asks for medical attention, the authorities (or employers) and *the collective of the hunger strikers*. For example, it may be the collective's interest that all hunger strikers consistently maintain or exacerbate the strike in order to maintain or increase the pressure on authorities. In a situation where individuals aspiring to break or leave the hunger strike seek the help of independent physicians, for example, in order to find a way out or by secretly asking them for food or water, a conflict of loyalty towards the individual versus the collective can occur. As these attempts would undermine the hunger strikers' common goal, the other hunger strikers might pressure physicians not to support non-compliant fellow hunger strikers in that way and they might even threat physicians to withdraw their trust and block their access to the site. Official authorities as a third party might claim loyalty by asking physicians to convince individual strikers to stop fasting. Physicians might hence be torn between their obligation towards the individual hunger strikers, the trust and cooperation of the hunger strikers' collective and the authorities. The degree and quality of the triple loyalty conflict might vary according to the assignment the physician has (independent or state-assigned), the

[42]Fessler, D. M. T., op. cit. note 12.
[43]Bloche, M. G. (1999). Clinical loyalties and the social purposes of medicine. *JAMA*, *281*(3), 268–274.
[44]Kleinig, J. (2022). Loyalty. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy (Summer 2022 Edition)*, p.1.
[45]Ibid.
[46]Briskman, L., & Zion, D. (2014). Dual loyalties and impossible dilemmas: Health care in immigration detention. *Public Health Ethics*, *7*(3), 277–286. https://doi.org/10.1093/phe/phu024; Pont, J., Stöver, H., & Wolff, H. (2012). Dual loyalty in prison health care. *American Journal of Public Health*, *102*(3), 475–480. https://doi.org/10.2105/AJPH.2011.300374
[47]Briskman, L., & Zion, D. (2014). Dual loyalties and impossible dilemmas: Health care in immigration detention. *Public Health Ethics*, *7*(3), 277–286. https://doi.org/10.1093/phe/phu024; Pont, J., Stöver, H., & Wolff, H. (2012). Dual loyalty in prison health care. *American Journal of Public Health*, *102*(3), 475–480. https://doi.org/10.2105/AJPH.2011.300374
[48]World Medical Association, op. cit. note 17.

relations that have been established and the overall medical, political and social urgency of the strike setting. If we include the public and the media in the equation, we could speak of a multiple loyalty situation. Physicians could feel or act loyal towards the public with regard to maintaining the social order, public health and safety, for example, by helping to terminate the strike or with regard to the public's right to information and transparency. This could increase pressure on them to talk to the press, potentially demarcating the limits of confidentiality.

Loyalty conflicts as an ethical challenge focus on an intrinsic dilemma, which a physician may perceive (and might be more or less aware of) while being involved in health care in a public hunger strike setting. Beyond this intrinsic conflict resulting from obligations towards different actors, and as we will see in the next section, physicians may also be a target of political instrumentalization by different parties. This can be experienced as extremely challenging and poses a substantial threat to medical professionalism as well.

3.4 | The preservation of professional independence in the light of a risk of political instrumentalization

In its *Declaration of Seoul*, the WMA defines professional independence as a core element of medical professionalism and an essential component of high-quality medical care.[49] Professional independence is the 'assurance that individual physicians have the freedom to exercise their professional judgement in the care and treatment of their patients without undue influence by outside parties or individuals'.[50] In politically charged contexts, the legitimacy of physicians and the expectation that their medical decisions are respected is based to a large extent on their perceived independence from political interests.

Threats to professional independence are described in detention settings,[51] especially in the case of hunger strikes.[52] In the *Declaration of Malta*, the WMA states that physicians involved in health care for hunger strikes should remain independent of their employer with regard to medical decisions and must 'not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-medical reasons'.[53] A related ethical challenge for medical professionals involved in public hunger strikes is thus to identify and deal with situations of instrumentalization of medical practice and practitioners for political purposes, meaning that their medical care is used for the political ends of one of the parties.

While, in hunger strikes in prisons and detention centres, the professional independence of physicians is usually challenged by expectations placed on them by government authorities or other employing institutions,[54] 'potential instrumentalization is more multidimensional'[55] in a public setting. Different groups of physicians with different roles and obligations (e.g., emergency physicians, independent physicians) might be involved, and different stakeholders may pursue conflicting goals.

Medical personnel that is employed by the authorities or appointed by strikers is especially vulnerable to instrumentalization for their political goals. The authorities might be interested in a quick resolution of the hunger strike without strikers getting seriously harmed. This may include the physicians' participation in medical measures that are not—or not merely—medically but primarily politically motivated. Hunger strikers, on the other hand, might pursue both their political goal and their personal goal of preserving one's health by asking the physician to secretly perform measures that enhance their abilities to continue striking despite the accompanying symptoms (e.g., headaches). It is even possible that hunger strikers could anticipate the presence of physicians and may count on live-saving interventions such as intravenous infusions, resuscitation or hospital admissions as a safeguard to life-threatening deterioration of their condition or as an exit strategy. Medical reports, such as medical expertise about the hunger strikers' health status, might have a political value. They could be used by authorities to justify certain coercive measures or by the hunger strikers in order to put further pressure on the authorities. Furthermore, physicians may experience instrumentalization when being pushed to become spokespersons of the hunger strikers, for example, in front of the press or at political rallies. Their presence might lead to being portrayed as in support of the strikers' political goals.

4 | DISCUSSION

This article gives an overview of ethical challenges for physicians involved in hunger strikes in public and occupied spaces. Four main ethical challenges were identified: (1) establishment of a trustful relationship with the hunger strikers, which is complicated by the public collective hunger strike setting, (2) balancing and specification of medicoethical principles in medical decision-making (such as determining and weighing a strikers *autonomy* against the principles of *beneficence* and *nonmaleficence*), (3) multiple loyalty conflicts resulting from physicians feeling obliged to act according to colliding expectations by the individual hunger striker, the employing institution or authorities, the collective of the hunger strikers and the public, and (4) the difficulty to preserve professional independence with regard to a potential instrumentalization of healthcare professionals for political goals of the conflict parties. These challenges are not strictly separable, but mutually overlap and

[49]World Medical Association. (2020). WMA Declaration of Seoul on professional autonomy and clinical independence. https://www.wma.net/policies-post/wma-declaration-of-seoul-on-professional-autonomy-and-clinical-independence/

[50]Ibid: 1.

[51]Pont, J., Enggist, S., Stöver, H., Williams, B., Greifinger, R., & Wolff, H. (2018). Prison health care governance: Guaranteeing clinical independence. *American Journal of Public Health*, *108*(4), 472–476.

[52]Gulati et al., op. cit. note 16.

[53]World Medical Association, op. cit. note 17, p. 1.

[54]Gulati et al., op. cit. note 16.

[55]Vanobberghen, R., et al., op. cit. note 2, p. 8.

influence each other. For example, when clinical independence is at risk, there may also be a risk of instrumentalization of medical practice and practitioners for political purposes. Yet different loyalties do not necessarily involve instrumentalization by others, and instrumentalization does not necessarily lead to the experience of loyalty conflicts. We identified several aspects of ethical challenges arising for physicians in public hunger strikes that are not adequately addressed by the existing ethical guidelines and debate and, hence, may benefit from further attention from empirical and normative researchers.

First, trust as a crucial feature of the physician–striker relationship is highlighted in the WMA Declaration of Malta[56] and various other medicoethical publications in the context of hunger strikes in detention.[57] Both in detention and in the public setting, medical professionals employed by official institutions or authorities might be perceived as opponents and hence not be able to establish a trustful relationship with the hunger strikers. In contrast, voluntary physicians, often present during hunger strikes in noncustodial settings, are more likely to be trusted if perceived as truly independent from the interests and goals of state institutions or authorities. Some authors also suggest the employment of independent physicians in the context of prison hunger strikes, for example, from the Red Cross or other neutral organizations.[58] Yet, ultimately, the control over which medical staff have access to the strikers will be in the hands of the prison authorities. Especially in repressive settings, the option to involve 'neutral' physicians, therefore, could be doubted by the inmates. However, in the noncustodial setting, hunger strikers have more control over the situation, for example, granting or denying physicians and authorities access to the camp. The option to choose a physician should hence be considered as a favourable opportunity for realizing a trustful relationship. While the importance of a trustful relationship is undisputed and the role of voluntary physicians might be crucial, future medicoethical considerations and guidelines should focus on the prerequisites for the realization of a relationship based on mutual trust, for example, granting privacy and opportunities for individual conversations in the collective setting or recommendations for the communication with authorities or the media on health-related issues.

Second, according to the standard view of individual autonomy, it is the doctor's responsibility to ensure that a decision to commence a hunger strike was made in a state of total mental competence, voluntarily, free from coercion and with an informed understanding of the consequences for one's health and well-being. Living up to this responsibility might be more challenging in the public hunger strike setting than in detention. In prisons or detention centres, authorities have more control over the setting. If they are willing, they can provide spaces for private conversations, which are the basis for the assessment of a hunger striker's ability for self-determination and an opportunity to provide information on health-related consequences of the options. Physicians are more likely to have access to the hunger strikers' medical history, laboratory tests, diagnostic tools, and so forth, to inform the strikers about the individual risk associated with hunger striking. Although collective hunger strikes can occur in custodial settings,[59] authorities have more opportunities to separate individual strikers from the group in order to minimise group pressure. In contrast, in the context of a public collective hunger strike, it might be more challenging to assess whether a decision to fast was made truly voluntarily, well informed and free from coercion.

In short, decision-making is challenging in a public hunger strike setting due to the complex context in which the strike occurs, for example, due to the relations in which a striker stands, the dynamics of a more or less organized setting, the lack of privacy, the media attention and potential group pressure on site and the heavily burdened life situation for which the strike is being pursued. Future guidelines and ethical considerations should focus on how strikers and physicians could anticipate and deal with these issues to enable ethically justified medical decisions under such circumstances.

Third, dual loyalty conflicts between obligations towards the individual hunger striker and third parties such as the employer are well described in the ethical literature, for example, in the *Declaration of Malta*. It is undisputed that professional independence is a crucial element of medical care and professional legitimacy. Physicians should act in their patients' best interest and independently from the political goals of employers or authorities.[60] The potential influence of the hunger strikers' collective as part of a triple-loyalty conflict has yet to be investigated. Conflicts resulting from colliding interests of the individual striker, the hunger strikers' collective and other stakeholders may arise, for example, if individuals are trying to find a way out to break the strike or when medical professionals have to communicate with the media or the authorities. The hunger strikers' collective might be considered a more powerful third actor in the public setting with more freedom and agency. Voluntary physicians, who are on site independently and on their own accord, are allegedly less in danger of loyalty conflicts towards and instrumentalization by authorities or employing institutions. However, voluntary medical professionals may experience more closely the hunger strikers' individual and collective burdens and distress and develop a more nuanced, empathetic understanding of their situation. For instance, cases of migrant hunger strikes as described above are often embedded in a broader political struggle, where physicians may perceive a moral obligation to advocate for the health and well-being of marginalized and vulnerable groups. In the eyes of the strikers, the boundaries between political activism and the physicians' role as a mere provider of health care may be blurred. Hunger strikers may regard certain physicians as allies in their political struggle or use their engagement as a tool to achieve a specific goal. These challenges,

[56]World Medical Association, op. cit. note 17.

[57]See for example, Irmak, N. (2015). Professional ethics in extreme circumstances: responsibilities of attending physicians and healthcare providers in hunger strikes. *Theoretical Medicine and Bioethics, 36*(4), 249–263; Reyes, H. (1998). Medical and ethical aspects of hunger strikes in custody and the issue of torture. *Research in Legal Medicine, 19*(1).

[58]Reyes, H. op. cit. note 57.

[59]Kenny et al., op. cit. note 27; Oguz & Miles, op. cit. note 27.

[60]World Medical Association, op. cit. note 17; Gulati et al., op. cit. note 16.

arising from the voluntary physicians' role, require more attention in future guidelines and ethical debates.

As we have described in this article, some of the challenges are similar to those in the context of hunger strikes in custodial settings[61] and are addressed in the WMA *Declaration of Malta*.[62] Despite this overlap, knowing how public collective hunger strikes can aggravate or create new challenges is essential. On the other hand, the presence of voluntary physicians, who are more likely to establish a trusting relationship with the hunger strikers, may also facilitate the realization of ethical treatment decisions.

By identifying specific ethical challenges of public collective hunger strikes, our article can serve for ethical theory-building and ethical guidance in multiple ways: as material for further theoretical normative discussions, for example, about professionalism and *ethos*, loyalty conflicts or instrumentalization; for the development of ethical guidelines; as preparatory material for health professionals on the verge of being involved in hunger strikes and as an agenda for measures to ensure ethical health care for hunger strikers. Besides physicians, other health professionals could find confirmation of their experiences and future directions for orientation through this article, among others public health officials, policy-makers, paramedics, nurses, social workers, psychologists, chaplains or clinical ethics mediators (or consultants).

5 | CONCLUSION

This paper can serve as a basis for endeavours to expand ethical guidelines and orientation for preparing healthcare professionals for their professional duties and assignments during public collective hunger strikes. Some of the ethical challenges of collective hunger strikes in public and occupied spaces are similar to those addressed in the existing ethical debate and guidelines, while others have been neglected. Future ethical debate and potential—specific or inclusive—guidelines should focus on how to establish a trustful physician–striker relationship and how to realise autonomous treatment decisions in the complex context of a dynamic and often unstructured setting of public collective hunger strike. The presence of voluntary health professionals may offer opportunities to establish a trustful relationship with the hunger strikers, which is one of the prerequisites for the realization of ethical treatment decisions. Their role should receive more attention in public hunger strikes and in hunger strikes in detention. Furthermore, the loyalty towards a hunger strikers' collective and other actors and stakeholders in a public hunger strike should be the subject of further investigation.

ACKNOWLEDGEMENTS

This work is part of a dissertation (Dr. med.) at the Medical Faculty at LMU Munich. We thank the English-speaking proofreaders Christine Haselwarter, Eva von der Gönna and Christiane Frey. Open Access funding enabled and organized by Projekt DEAL.

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How to cite this article: Haselwarter, D., Kuehlmeyer, K., & Wild, V. (2024). Ethical challenges in health care during collective hunger strikes in public or occupied spaces. *Bioethics*, *38*, 549–557. https://doi.org/10.1111/bioe.13306

[61]Gulati et al., op. cit. note 16.
[62]World Medical Association, op. cit. note 17.