How to do a Hunger Strike

Solidarity doctors to provide medical support for hunger-striking climate activists

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Authors

PD Dr. Susanne Koch

Eileen Blum

including the experiences of the entire medical support team from the hunger strike in spring 2024

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INTRODUCTION

Hunger strikes by climate activists have been taking place in Germany since 2021. The focus of the hunger strikes is Berlin, as they have so far primarily been about climate policy demands to the federal government. The current hunger strike began in March 2024 with a hunger strike camp in the immediate vicinity of the Federal Chancellery.

We declare our fundamental solidarity with the concerns of the hunger-striking climate activists to campaign for a Paris-compliant climate policy in Germany.

The decision to go on hunger strike is made solely by the climate activists themselves. We respect the decision of individual hunger striking climate activists. A hunger strike poses a great risk to a person's physical health, so it is a basic requirement that the decision to go on hunger strike is based entirely on a free will decision. Similarly, the decision to break off, continue or intensify a hunger strike (e.g. starting a "dry hunger strike") must also be entirely self-determined.

The medical staff involved in the hunger strike in 2021 and currently in spring 2024 were/are faced with the challenge of

- an open, unstructured group
- lack of personal experience in the medical support of hunger strikers
- lack of information about the legal and ethical aspects that could arise from medical monitoring

We would like to close this gap and provide a short guide and practical help to all those people who are currently or will be involved in climate-motivated hunger strikes on a voluntary basis.

We make no claim to completeness and welcome comments, criticism and additions from competent sources!

ETHICAL CONSIDERATIONS

Politically motivated hunger strikes have always been part of functioning democracies, even if they are a very drastic, life-threatening form of protest. Hunger strikes were used by the suffragettes in England, in the fight against colonialism in India, in the apartheid system in South Africa and by protesters on Tiananmen Square in Beijing. The political changes achieved in these struggles are now part of our social self-image and are no longer questioned by democratically-minded people.

The climate crisis is threatening the existence of all of us and especially our children (https://www.ipcc.ch/report/sixth-assessment-report-cycle/) and the demand for political framework conditions that guarantee climate protection, which is vital for the survival of us all, will probably also be part of the self-image of societies / states worldwide in the future - if we still have functioning states by then.

Ignoring a politically motivated hunger strike for vital climate protection will not work.

To de-legitimize or criminalize a hunger strike motivated by climate policy in view of the millions of deaths worldwide already caused by the use of fossil fuels lacks any moral basis (EEA Report - Air Quality; https://www.eea.europa.eu/publications/air-quality-in-europe-2022; WHO environmental Pollution; https://www.who.int/health-topics/environmental-health#tab=tab_1).

Hunger strikes are a means of non-violent resistance and are primarily aimed at the government of a country, but also at the media public. The aim is to establish a political movement based on solidarity that can help to achieve political demands for a live-able, climate-friendly future for all people.

The response of those political and social groups/forces that still have no interest in effective climate protection is first and foremost "ignorance" followed by "de-legitimization" and "criminalization". This is a development that poses a serious threat to democratic states. It would be helpful, however, and more important, to finally raise public awareness of the dramatic, apocalyptic situation of the climate crisis and implement necessary climate policy action. Historically, only 78 companies are responsible for 70% of global CO_2 emissions. Since 2016, only 57 companies have actually been responsible for 80% of greenhouse gas emissions worldwide (https://esgnews.com/de/80%25-der-weltweiten-CO2-Emissionen-lassen-sich-auf-nur-57-Hersteller-zur%C3%BCckf%C3%BChren%2C-hei%C3%9Ft-es-in-dem-Bericht/; accessed 01.07.2024). It is not the personal decision of each individual in Germany/Europe or worldwide to live in a climate-neutral way. It is the political framework conditions, the lack of state infrastructure and the extra-moral self-interest of large fossil fuel players that are fundamentally hindering the necessary transformation. There are thousands if not millions of people whose greatest dream today is to finally live in a climate-neutral way and thus not contribute to the destruction of their own children's future (https://www.undp.org/press-releases/80-percent-people-globally-want-stronger-climate-action-governments-according-un-development-programme-survey).

But the framework conditions in many Western countries make this impossible so far! So we are all being forced to continue living a climate-damaging life and thus contributing directly to the destruction of our own children's future. Who can really want that?

Ultimately, a hunger strike for more climate protection demands the right to life and physical integrity - a human right, which is clearly and demonstrably not being respected by current policy.

In view of the existential threat to humanity posed by the climate crisis, people will most likely go on hunger strikes motivated by climate policy in the future. De-legitimizing or criminalizing this morally deeply legitimate, political, non-violent resistance in times of climate crisis divides the social discourse and only fuels the apocalypse further. In the worst-case scenario, this could lead to a further – and even violent - escalation of climate protests in Germany, Europe and worldwide. That worries us greatly!

MEDICAL ASPECTS

The following section provides specific, practical information on medical care for hunger strikers. We would like to point out that it is not possible to provide comprehensive medical care for hunger strikers in camps in the narrower sense. Medical care is often provided by students or professionals in their free time and there is no medical infrastructure. And it is clear that nobody can do it alone! A larger group of medical professionals should therefore be involved from the outset. Furthermore, the psychological burden on the people supporting the hunger strikers should not be underestimated! It is therefore helpful to involve supportive psychologists from the outset. Our recommendation is based on a similar text from the Association of Democratic Doctors (https://www.vdaeae.de/2024/04/03/hungerstreik-medizinische-betreuung/).

HUNGER METABOLISM

Three types of hunger strike

1. Complete abstinence from food ("**total hunger strike**"): Fluid intake in the form of water but without additives such as vitamins or electrolytes

2. Partial abstinence from food ("**hunger strike**"): Intake of certain nutrients in addition to water, such as vitamin supplements, electrolytes, milk or sugar. But don't be fooled, because this form of "partial starvation" can also lead to death.

3. Absolute abstinence from food and liquids ("**dry hunger strike**"): Abstaining from any intake of solid or liquid food, including water. This leads to death within a few days.

The metabolic state during starvation and the physical consequences are influenced by various factors, the following presentation provides a general overview of the basic relationships.

During a period of starvation, the basal metabolic rate can be reduced by around 50 percent, resulting in a drop in heart rate, blood pressure and body temperature. The brain's glucose consumption can drop by up to 30% (from 140 grams per day to approx. 40 grams per day), which also reduces the brain's general performance.

When deprived of food, the body must first obtain the energy required to maintain important bodily functions from energy stores, then from the substance. Energy stores in the form of ***carbohydrates (e.g. glycogen*** in the liver), fats (e.g. subcutaneous fatty tissue) and finally proteins (e.g. muscles) are used in

succession to cover energy requirements. The lack of nutrients results in a so-called catabolic metabolic state, i.e. one that depletes the body's energy reserves. This can lead to a complete loss of strength (cachexia).

First of all, the energy reserves available in the short term are utilized. These include the glycogen in the liver, kidneys and muscles, which is converted into glucose. These quickly available energy reserves are around 1,600 kilocalories and are used up within 1-3 days.

The body can cover up to 72 hours without the formation of ***ketone bodies***, after which the body switches to tapping into its ***fat stores.*** To do this, it converts fatty acids into ketone bodies, which are an elementary source of energy and are essential for survival in times of hunger. Apart from glucose, they are the only compounds that the brain can utilize at all once it has adjusted to them after about three days. The fact that a starving person's metabolism draws on fat stores can sometimes even be smelled. This is because the ketone bodies, which are excreted via the kidneys and the air we breathe, also include acetone with its characteristic nail polish smell. The ketone bodies cause acidification in the body, a so-called metabolic acidosis. This metabolic acidosis caused by an increase in free fatty acids is similar to the acidosis caused by severe untreated diabetes. The body also loses water due to this acidosis. For this reason, sufficient fluid intake is particularly important at this stage.

Depending on the amount of calories consumed, up to 150 grams of body fat (triglycerides) are broken down into fatty acids (ketonic acid) and glycerol every day. Most of this is needed to supply energy to the brain, heart, kidneys and muscles. The increased production of ketone bodies temporarily inhibits protein breakdown (e.g. muscle breakdown). Light exercise training during the starvation period should be able to reduce the loss of protein in the muscles, but is only recommended to a very limited extent from around the third to fourth week, depending on how you feel, due to the additional energy consumption with increasing weight and strength loss.

As soon as the fat deposits are used up and the ketone acid level drops, a strong ***protein breakdown*** begins in the last hunger phase (skeletal muscles, heart muscle, ...). Around 50 to 70 grams of protein are then broken down per day. Mainly muscle proteins are broken down, but also proteins in other cells. The broken down proteins are either metabolized directly in the sense of catabolism or used for gluconeogenesis. After around two weeks, the metabolism switches to a further "protein-saving mechanism". The subsequent reduction in protein breakdown (in the range of 20 to 25 grams per day) leads to a reduction in urea excretion (urea = protein breakdown product) via the urine. The reduction of the protein concentration in the blood (hypoproteinemia) leads to the development of so-called hunger edema due to water accumulation in the tissue. The loss of protein also has a negative effect on the immune system. It has been shown that infections occur more frequently during starvation and that

existing infections can worsen or become manifest. This leads to physical weakness and visible muscle loss. After very long periods of starvation, for example when a third to half of the body's total protein has been broken down, death by starvation occurs.

In order to maintain the metabolism and other bodily functions, some ***vitamins*** and a stable distribution of ***electrolytes*** are essential for survival in addition to the pure energy supply. Due to the existing long-lasting metabolic acidosis, accompanied by dehydration, there is also a noticeable shift in electrolytes.

The body's reserves of most vitamins are sufficient even during long periods of starvation, provided a healthy diet and the absence of chron. diseases sufficient. However, ***vitamin B1 (thiamine) is*** critical here. The body's own thiamine reserves only last for about 4 weeks. The function of thiamine (vitamin B1) is based on its role as a coenzyme. Pyruvate, the end product of glycolysis, is introduced into the citrate cycle via the thiamine-dependent pyruvate dehydrogenase in the form of acetyl-coenzyme A (acetyl-CoA) [15]. The daily requirement of the coenzyme vitamin B1, which is particularly important in the metabolism of glucose, depends on the energy metabolism. The recommended intake is 1.3 mg per day for men and 1.0 mg per day for women. Long-term malnutrition (alcoholism, anorexia) can also lead to a critical thiamine deficiency, with signs of neurological deficits such as gait ataxia, short-term memory disorders and even Wernicke-Korsakow syndrome.

Day 1-3:

Metabolic situation

- Covering the glucose requirement from the body's own glycogen stores

Symptoms

- Feelings of hunger at first, soon subside
- Tiredness, possibly slight lack of concentration and reduced alertness, slight weakness, rarely restlessness.

Measurements

- Document the **confidential intake / information meeting** (see appendix), here the (1) **mental status** is particularly important! Hunger striker fully oriented, lucid, cognitively unimpaired, no depressive mood, no suicidal tendencies, not externally influenced to start the hunger strike, can understand the possible health / life-threatening consequences of a long-term hunger strike and assess the consequences well. If these points cannot be answered clearly, a psychiatrist should be consulted or the social psychiatric service should be called! (2) It is also important to appoint a person of trust for the hunger striker who, in case of doubt, can be appointed as a "legal representative" in the event of serious health problems. It is good to clarify this at an early stage so that everyone involved has time to deal with it calmly (if necessary, address the topic of living wills and health care proxies). (3) If there are contraindications to a hunger strike, the hunger striker should be informed about the considerable health risks. (4) Obtain a signature stating that from the second week onwards, even for healthy adults, further refusal of food is critical and that starvation beyond this point is against medical advice
- initial weight check, blood pressure, pulse measurement
- If possible, a blood sample: blood count, electrolytes: Na, K, Ca, phosphate, Mg, kidney: creatinine, urea, liver: ASAT, bilirubin, INR, blood sugar, HbA1

Medical recommendations

- Drink 2-3 liters per day, more if you feel thirsty
- Start vitamin / electrolyte intake:
  - Vit B1 100mg/day, later 200mg if necessary
  - Vit B complex 2x/week
  - Vit C 100mg / daily

- Kalinor 1x daily.
- Magnesium 300mg / day
- Phosphate 21 mmol/day
- if necessary simply Multi-Vit / Electrolyte Tbl 1x daily.
- Drink 500 ml of vegetable soup or 1 teaspoon of salt per 1-2 liters of water

- Light exercise training to strengthen the metabolism and immune system and counteract premature muscle loss
- Overall for healthy adults without complications

Day 4-13:

Metabolic situation

- Breakdown of fat deposits with development of ketoacidosis (increased ketone bodies in the urine)
- Up to 1-2 kilos of weight loss per day
- The electrolyte level remains stable, as electrolytes (sodium, potassium and others) migrate from the cells into the blood plasma to maintain the concentration there. CAVE: However, there may still be a "masked deficiency" (as we can only measure serum levels in the laboratory!). Therefore, vitamin / electrolyte replacement is recommended from the start of the hunger strike.

Symptoms

- Reduced body temperature (you freeze more easily), slowed heartbeat (bradycardia), lowered blood pressure (hypotension)
- To compensate for metabolic acidosis, deepened breathing may occur, possibly acetone odor breathing / ketone bodies in the urine

Measurements

- 1-2x per week confidential discussions / create a **visit sheet** (see appendix). Objective (1) to build up a relationship of trust for the later critical phase; (2) to regularly re-evaluate the hunger striker's own "red lines" without external influence; (3) to evaluate the current health situation in the course of the hunger strike.
- Weight check 1 to 2x / week (but it can be good for the visibility of the initiative to put the body weight of the hunger strikers online daily); blood pressure and pulse measurement, urine stix (ketone body profile) 1-2x / week

- **Create an online data sheet** where health data of hunger strikers can be entered for all medical support staff to view (especially if there are not enough medical support staff available and support must be provided partly online)

Medical recommendations

- See day 1-3
- Responding to the complaints of hunger strikers
- Overall for healthy adults without complications

Day 14-34:

Metabolic situation

- Depending on the amount of fat deposits and calories still consumed, protein breakdown, muscle atrophy, possibly water retention and the occurrence of diarrhea begin now
- Average weight loss of 300 grams per day

Symptoms

- Typical symptoms: Fatigue, dizziness, feeling cold, low pulse and blood pressure
- In the absence of or inadequate vitamin B1 supplementation, the first signs of a deficiency situation may occur after 28 days: Gait ataxia, paresthesia, pronounced fatigue, irritability, cognitive impairment, visual disturbances (double vision), impaired consciousness, disorientation

Measurements

- Confidential discussions 1-2 times a week, regular documentation of the hunger striker's mental / cognitive state very important. Otherwise, the aim is still (1) to deepen the relationship of trust; (2) to re-evaluate the hunger striker's own "red lines"; (3) to evaluate the current health situation over the course of the hunger strike; (4) to explain refeeding syndrome again and explain the possible risks of uncontrolled food intake.
- **Patient decree / health care proxy** (see appendix) recommended to be completed again (even if maximum therapy is desired in the event of clinical admission!)
- **Confidentiality declaration / release** (see appendix) to be completed, especially if the medical support team is to exchange information with media representatives or external medical personnel

- If possible, or if symptoms persist, repeat laboratory check recommended: Blood count, electrolytes: Na, K, Ca, phosphate, Mg, kidney: creatinine, urea, liver: ASAT, bilirubin, INR, blood sugar, HbA1; additionally Vit B1 and Vit B12
- Adjust food supplements if necessary
- Weight control daily; blood pressure and pulse measurement daily; urine stix (ketone body course) daily; blood sugar stix 1x/week, for values below 80mg/dl daily, for values around 60mg/dl 3x daily.

Medical recommendations

- Take infection prophylaxis seriously (sufficiently warm clothing/environment, mouth and nose protection for visitors if necessary; do not visit people who are ill (including those with a cold)).
- Inform hunger strikers about the current situation (termination under medical supervision or long-term damage to health) and the extent to which media presence is desired in the further course of the strike

Day 35- ...:

Symptoms

- Risk for
  - Circulatory collapse possible at any time
  - Coma / unconsciousness possible at any time
  - Dangerous cardiac arrhythmia / heart failure
  - Severe infection, including sepsis, multi-organ failure, death

- Possible symptoms of severe thiamine deficiency: disorders of the eye muscles ("**ocular phase**") with nystagmus (involuntary twitching of the eyeball), seeing double vision, squinting, dizziness, vomiting and difficulty swallowing and drinking as well as severe impairment of mental performance with poor concentration and, as the ocular phase progresses, finally loss of judgment! This phase is often reported by hunger strikers as the most unpleasant. The beginning of the ocular phase marks the beginning of the final phase of starvation and is an urgent warning signal for the beginning of a critical state of health -> ambulance call / hospitalization necessary

Measurements

- If possible, constant support from a permanent contact person

- Daily medical rounds or online contact / availability

Medical recommendations

- If actually necessary, end-of-life care (ideally involve a colleague with palliative medical experience), if necessary care in a medical facility
- Re-evaluate mental situation daily
- Handle infection prophylaxis even more strictly than before
- Inform hunger strikers about the current situation (termination under medical supervision or death). Clarify to what extent media presence is desired in the further course.
- If necessary, inform relatives again so that they can say goodbye OR hospitalization takes place and the hunger strike is broken off

SPECIAL CASE DRY HUNGER STRIKE

In the case of a **dry hunger strike**, death occurs within 1 to a maximum of 3 days. The first symptoms are speech disorders, dizziness and loss of strength, unconsciousness/coma, cardiovascular collapse due to massive dehydration. Depending on the outside temperature, however, exsiccosis due to sweating can also occur within 24 hours. The speed of the physical symptoms alone and the danger they pose make a hunger strike without water intake extremely dangerous. The brain, kidneys and thermoregulation are particularly sensitive to a lack of fluids.

Initial phase

- Dry mucous membranes. Regularly moistening your mouth (e.g. rinsing with water) and applying a nasal ointment can help your own well-being.
- Strong feeling of thirst, inner restlessness, concentration problems

Water shortage

- Rising body temperature (thirst fever), loss of urine output
- Falling blood pressure with an accelerating heartbeat,
- Increasing confusion/hallucinations, headaches, speech disorders and seizures
- Increasing risk of thrombosis (pulmonary embolism, stroke, heart attack)

Possible causes of death

- Coma, brain death due to stroke, cerebral edema
- Heart failure due to myocardial infarction, malignant cardiac arrhythmia

CAVE: Especially when entering a dry hunger strike, there should be a clear agreement beforehand as to who feels able to accompany the person. Furthermore, it is essential to re-evaluate the mental/cognitive capacity of the hunger striker, and the possible involvement of emergency services and the desired interventions (living will) should really be clarified in peace and quiet and recorded in writing.

TERMINATION OF THE HUNGER STRIKE

After prolonged starvation, the body has undergone major changes. If you suddenly start eating again - for example, when breaking off a hunger strike - this can lead to so-called ***refeeding syndrome*** (https://link.springer.com/article/10.1007/s00108-018-0399-0).

Refeeding syndrome is triggered by shifts in fluid and electrolyte balance caused by hormonal and metabolic dysregulation, which in turn can be associated with food intake after prolonged starvation. The central feature is a low phosphate level (hypophosphatemia), although the constellations are often more complex and are associated with imbalances in sodium, potassium and fluid balance, blood sugar, protein and fat metabolism and/or a thiamine (vitamin B1) deficiency.

When high-calorie carbohydrates are first ingested, there is a high release of insulin to channel the glucose into the cells, but sodium-potassium pumps also increase the uptake of potassium and glucose into the cells. Magnesium and phosphate are also absorbed into the cells. The water follows by osmosis. This leads to reduced concentrations of phosphate, potassium and magnesium in the blood. The clinical symptoms are then derived from the type and extent of these shifts.

In the worst cases, cardiac arrhythmia, heart failure, pulmonary edema, rhabdomyolysis and kidney failure can occur. Initially, there are often only mild and unspecific symptoms such as nausea, vomiting and lack of energy, which can quickly worsen over time and can even be fatal in cases of doubt.

However, there is evidence of a lower and less pronounced occurrence of refeeding syndrome with normal phosphate, thiamine (B1), potassium and magnesium levels before the start of the reintroduction of nutrients. For this reason, supplementation of these four substances should be aimed for.

If the hunger strike is discontinued, refeeding syndrome should be discussed. Resuming the diet after a starvation phase of 1-2 weeks should only be done carefully and *clinical monitoring may be necessary*. A maximum calorie intake of no more than 1000 Kcal/day is recommended for the first 3-4 days, with

protein and fat being the primary sources. Glucose intake should be limited to a maximum of 150 grams/day, and no sweets or other free sugars should be consumed. After that, the daily calorie intake can be slowly increased depending on tolerance.

VOLUNTARINESS / PSYCHOLOGICAL / COGNITIVE ASSESSMENT

It should be expressly pointed out here once again that the medical support team is primarily responsible for assessing

- the **voluntary nature of the decision to go** on hunger strike
- psychological situation (**depressive mood, suicidal tendencies**)
- and cognitive abilities (**orientation, confusion, level of consciousness**)

of the hunger striker at the beginning of the hunger strike as well as during the course of the hunger strike. In order to build up a stable relationship of trust during the course of the hunger strike, these points should be clarified openly from the outset. **Ultimately, as a doctor, you would be liable to prosecution for failing to provide assistance if you did not intervene and initiate psychiatric or medical treatment immediately in the event of psychiatric or cognitive impairment.** This should be discussed with the hunger strikers and the support group at the outset.

It is a basic condition that the decision to go on a politically motivated hunger strike must be made 100% of one's own free will. This should be openly discussed in a confidential conversation at the beginning of the hunger strike. During the course of a hunger strike campaign, it should also be clarified whether the group is building up pressure to continue or escalate the hunger strike. However, we would like to point out here that in the hunger strikes 2021 and 2024 in Berlin, we have so far found that the support group has a tendency to dissuade the hunger strikers from continuing, especially when the hunger strike is well advanced, or to persuade them to stop.

People who go on a hunger strike in the context of a severe depressive phase or possibly even with suicidal fantasies should be presented to a psychiatrist (in Germany, for example, the Social Psychiatric Service should be involved). In the case of mental illness with self-endangerment, compulsory hospitalization may be possible.

Furthermore, during the admission examination and also during the course of the hunger strike, it should be checked again and again whether the cognitive abilities are still preserved to such an extent that the possible health consequences of the hunger strike are fully recognized. This may no longer be the case in the final phase of the hunger strike, for example. If there is no clear advance directive "against

medical treatment even in the event of confusion, impairment of consciousness, ..." from the hunger striker at the time, immediate hospitalization or calling an ambulance would be necessary.

RISK FACTORS / CONTRAINDICATIONS FOR A HUNGER STRIKE

In addition to mental / cognitive limitations, there are also physical conditions that should be considered a contraindication to a hunger strike. This simply means that these underlying conditions, age, pregnancy, ... can very quickly lead to physical complications that are not foreseeable.

Risk factors

- O BMI < 18 or > 30
- O Pregnancy / breastfeeding
- O Age < 21 years or > 65 years
- o Diabetic mellitus requiring treatment
- o chron. Heart failure
- o consuming, chron. diseases, cancer
- o *history of* suicidal tendencies, addiction, eating disorder or self-harming behavior
- o Chron . Liver disease, Chron. kidney disease
- o other chron. illnesses, regular use of medication

We would like to warn against the medical accompaniment of people with chronic illnesses / health conditions, as this can very quickly lead to unmanageable health complications.

Contraindications

- o Acute suicidal tendencies / depression
- o Current eating disorder or other mental illnesses
- o Lack of free, independent decision to go on hunger strike
- o cognitive impairments that affect the understanding of the health consequences of a hunger strike

Medical accompaniment of people with mental illnesses, cognitive impairments or existing suicidal tendencies or if it is suspected that the decision is not voluntary must be refused; in case of doubt, a psychiatrist or the local social psychiatric service must be consulted (see also paragraph on voluntariness, mental illnesses, cognitive assessment).

CONCLUSION

A hunger strike with substitution of 250 to 500 ml of juice and substitution of vitamins / electrolytes can keep the metabolism stable for longer and was tolerated by Wolfgang Metzeler-Kick for 90 days and by Richard Cluse for 70 days during the "Starve until you are honest" hunger strike in Berlin.

Survival of more than 10 weeks without the intake of nutrients (total hunger strike) can be practically ruled out. Some hunger strikers have survived for 50 to 70 days. Bobby Sands, an IRA hunger striker, died after 66 days and Holger Meins of the RAF in 1974 after 57, although the latter was (force)fed for a time and ultimately died as a result of the hunger strike.

However, the decision to stop drinking liquids can lead to death in just a few days.

Long-lasting organ damage can also occur during a prolonged hunger strike (over 3 weeks), which therefore continues even after the hunger strike has ended.

We consider it a basic prerequisite for the medical support of hunger striking climate activists to hold regular (2-3 times a week) personal one-on-one meetings, to clearly communicate the assessment of the current medical situation and to name the possible risks. Furthermore, the regular assessment of the psychological and cognitive situation of each hunger striker is a basic requirement. Finally, it should be repeatedly clarified whether the decision to continue or even escalate the hunger strike was made 100% of one's own free will. This can only be guaranteed in a confidential one-to-one discussion.

ORGANIZATIONAL

Previous experience of hunger strikes by climate activists shows that every hunger strike takes place in a more or less confusing, sometimes chaotic environment. In addition to a very small team of permanently supporting / starving people, everyone else is working on a voluntary basis. This means that the time they can give to provide support is limited and also depends on their other professional or family commitments. There is no clear structure and division of tasks, there is often a lack of information internally about the current situation,; … questions and problems that arise, are solved under time pressure.

The role of medical support within the specific hunger strike situation is not straightforward and is characterized by different, sometimes contradictory expectations. The indispensable basis for their own actions is the trust of the hunger strikers and the support team.

However, the longer the hunger strike lasts, the more likely it is that a dialog with external medical personnel will be necessary, e.g. rescue services, public health officers, emergency doctors or hospital staff. Such a dialog can be misleading; transparency towards the hunger strikers / the support team about the content and aim of the conversation is particularly helpful here. Conversations with representatives of state bodies should only be conducted in the presence of witnesses. IMPORTANT: Information about the state of health of the hunger strikers is subject to medical confidentiality, unless there is an explicit release from medical confidentiality or there are medical concerns about a "self-endangering situation".

STRUCTURE OF THE MEDICAL SUPPORT

As part of the hunger strike in Berlin in spring 2024, a clear structure of medical support was established over time, which enabled us as a team to ensure the most stable care/support possible, even alongside our day-to-day obligations.

Online structure:

- **Signal - Groups:**
    - *Medical / psychological support - discussion:* Participants include all hunger strikers, all people from medical / psychological support, all people providing on-site support in the camp. Current problems are discussed, but also agreements are made about who comes for a visit and when, who is going on hunger strike, when an intake interview could take place, when medical education on the subject of hunger strike is needed again in the camp (e.g. many new supporters in the camp again) ...

- *Medical documentation:* Participants are all hunger strikers and all people from the medical support, here only medical documents are shared (e.g. laboratory values from the family doctor, completed visit sheets, photos of injuries, ...)
- *Internal medical support:* Participants are exclusively people from the medical support team. Here, the assessment of the health situation of individual hunger strikers can be discussed internally, difficulties with time restrictions can be clarified, but also uncertainties of individuals regarding medical care can be supported within the group. In retrospect, we consider this group to be very important, especially in order to clarify different medical assessments regarding the health situation of individual hunger strikers internally. It has been shown that different, divergent assessments from the medical support team regarding the health of individual hunger strikers cause a lot of unrest in the hunger strike camp in general, which definitely also significantly exacerbates the psychological strain on the support group in the camp. It is therefore advisable for the medical support team to speak more or less with one voice.

- **Online documentation:**
  - *Vital signs of the hunger strikers:* Participants are all hunger strikers and people from the medical support team. Here, the hunger strikers enter their vital signs online every day so that the medical support team can keep track of the data on a daily basis. It is best to create an Excel spreadsheet with: Blood pressure, pulse, weight, BMI; from week two then 2x weekly urine sticks (question: ketone bodies, germs); and from week 4 (or if the BMI falls below 18) measure blood sugar 2x weekly; from blood sugar values around 60mg/dl switch to 3x daily blood sugar measurements.

On-site support:

- Visits / Accessibility:
  - *Admission interview* within the first week if possible
  - Initially, 2-3 visits/week are sufficient and you can be reached via the messenger service.
  - In critical phases, 24/7 medical support would be desirable, but is probably often not feasible. This was also the case during the last hunger strikes in Berlin. It would be helpful in these phases to set up *24/7 telephone availability* (a kind of on-call service).
- Medical support for the Supporties in the camp:
  - *Information sessions:* What happens during a hunger strike? When can we expect which health risks? When do we have to act and how? When to call 112? Furthermore, the availability of medical support should be clear to all support staff. These open discussions should take place approx. every second to third week, more often or less often depending on the frequency of change of support staff in the hunger strike camp.

- *Resuscitation training:* How do I perform a resuscitation? Practical training is ideal, as far as possible. Furthermore, clarify what exactly I say when calling 112: location, number of people, what is the specific problem (shortness of breath, unconsciousness, cardiac arrest, ...). This rea training should also take place every 2-3 weeks as required.

INTEGRATION INTO THE PRESS WORK OF THE HUNGER STRIKE ACTION

Ultimately, the medical support team is probably so busy with medical support that taking on other tasks does not take up much space. However, it is essential to maintain close contact with the press office of the hunger strike campaign, as there are often press inquiries regarding the health of the hunger strikers. Ultimately, the aim of every "hunger strike for the climate" is to generate public attention and to put the political actors under moral pressure. Unfortunately, this is often achieved by exposing the sometimes dramatic health situation of the starving people.

- Implementation of press cooperation:
  - It should be clarified in advance, who from the medical support team agrees to *take part in press conferences* or to respond to *press requests to take* part in *filming.*
  - Depending on the content, a *confidentiality release* (https://www.bundesaerztekammer.de/fileadmin/user_upload/BAEK/Themen/Recht/Empfehlungen_aerztliche_Schweigepflicht_Datenschutz.pdf, accessed 01.07.2024 and see appendix) from the hunger strikers to the respective medical support staff is required for discussions with the press. A confidential discussion on this should take place beforehand during a regular visits or during the admission interview, in order to clarify the scope and content of the medical information shared publicly.

The health situation of the hunger strikers is also often taken up by media critical of climate protection, which on the other hand leads to a wider public being reached. Politicians simply cannot criminalize or de-legitimize a hunger strike for the climate, and the more dramatic the images/representations of the hunger strikers' state of health are, the more politicians will be unable to ignore them. Hunger strikes have always been part of political movements, they are one of the most dramatic forms of non-violent resistance against the power of injustice in this world.

Documentation:

- Written documentation of the admission interview, all visits, release from confidentiality, patient disposition for each hunger striker
- Keeping a copy of the documents with the hunger striker and in a place outside the protest site
- Conversations with representatives of government agencies should be discussed in advance within the hunger strike team, if necessary with witnesses, and the names of the conversation partners and key points on the content of the conversation should be documented. CAVE: Medical confidentiality also and especially applies to government representatives.

Legal situation:

Based on the declaration of the World Medical Association, here are three brief key points https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/:

1) Force-feeding is unethical and not legally permitted
2) The autonomy of the hunger striker must be respected; the condition is the free decision of the hunger striker for or against a possible treatment
3) There must be no mental illness (e.g. severe depression with suicidal tendencies, anorexia) or cognitive impairment (e.g. dementia, confusion). This casts doubt on the free decision of the hunger striker and medical placement/treatment against the will of the hunger striker in accordance with the law is given due to self-endangerment. In case of doubt, psychiatrically trained doctors or the Social Psychiatric Service should be consulted in order to reach a clear decision. Important: Prolonged hunger strikes can lead to states of confusion, unconsciousness, etc. during the course of the strike. In this case, the emergency services should be informed immediately, which will lead to maximum medical treatment in the situation if there is no explicit living will.

General legal situation:

Public hunger strikes are covered by the freedom of assembly, but in practice only up to the point at which the responsible state authorities see a threat to public order and break up the assembly - usually by force - on this pretext.

The scenario of legal repercussions for medical professionals in solidarity is conceivable and realistic in two respects: on the one hand, they themselves could become the target of legal action; on the other hand, the behavior of state bodies can also be a reason to go on the legal offensive, as was recently the case following the events in Berlin's Gürtelstraße (https://www.tagesspiegel.de/berlin/berliner-arzt-erstattet-anzeige-gegen-innensenator-henkel-5174125.html, accessed 01.07.2024).

The best possible documentation of your own actions is essential in order to be able to reconstruct events and decisions even weeks and months later.

ANNEX

Berlin emergency decree

To download: simply enter Notfallverfügung Berlin in your browser

https://www.berlin.de/sen/pflege/_assets/besondere-personengruppen/notfallverfuegung_okt_2023.pdf?ts=1705017669

Confidentiality release template Hamburg Medical Association

(see below attachment / info here)

https://www.bundesaerztekammer.de/fileadmin/user_upload/BAEK/Themen/Recht/Empfehlungen_aerztliche_Schweigepflicht_Datenschutz.pdf,

Further Literature:

1) Guidelines for the Clinical Management of people refusing food in detention settings & Prison; 2007

https://www.thelancet.com/cms/10.1016/S0140-6736(08) 61313-6/attachment/fcc3c768-48fd-4ba1-8887-692039a9e0c4/mmc1.pdf

2) Practical issues in the medical care of hunger strikers, 2014
https://www.vdaeae.de/2024/04/03/hungerstreik-medizinische-betreuung/

3) Norwegian Medical Association's Online Course Hungerstrike for Prison Doctors http://nettkurs.legeforeningen.no/mod/lesson/view.php?id=1429

4) Californa Correctional Health Care Service Mass Hunger Strike, Fasting, & Refeeding Care Guide http://www.cphcs.ca.gov/docs/careguides/MassHungerStrikeCareGuide2012-10-4.pdf

First Visit Date

Name **f /** m

Born:

Last food intake (date)

Height: **Weight: BMI:**

Health risks of a hunger strike

From a medical point of view, a starvation phase with sufficient intake of fluids for a period of ~ 10 days is harmless for physically and mentally healthy adults. In the case of existing contraindications or risk factors, starvation phases of a few days or more are questionable.

During a starvation phase, the body can reduce its resting metabolic rate by up to 50%, the core body temperature drops and the pulse rate and blood pressure also fall. During starvation metabolism, the glycogen reserves from the liver, kidneys and muscles are used up first in order to replace the lack of supplied energy. These reserves last for 1 to 2 days, after which the fat reserves are mobilized. This results in a ketogenic metabolic state (ketone bodies in the urine increase). Depending on the fat reserves, the calories consumed and the level of metabolism, this phase can last for different lengths of time, on average ~ 14 days. After this, the protein reserves are used to generate energy. Muscle protein is broken down, but blood proteins are also broken down. This results in visible muscle breakdown. As soon as the blood proteins are broken down, so-called hunger oedema can occur, as the osmotic pressure of the blood is reduced. Furthermore, there is a significant reduction in the immune response and the risk of infections increases considerably. Breakdown of the heart muscles can lead to heart failure, and any electrolyte imbalances can lead to severe, irreversible cardiac arrhythmia. Resuscitation attempts may be unsuccessful in this situation.

If no **vitamin B1** is supplied, the first symptoms of deficiency would appear from 2 to 3 weeks, such as a clear unsteadiness of gait, followed later by swallowing disorders and visual disorders (double vision, nystagmus, squinting) (Wernicke-Korsakow syndrome: encephalopathy, gait ataxia and oculomotor disorders), cognitive impairments occur, with memory disorders and even loss of judgment. The occurrence of visual disturbances must be considered a critical sign.

With a previously balanced diet, no further severe vitamin deficiency disorders should occur in the course of 6 to 8 weeks of starvation phases. As a precaution, a vitamin B complex tablet and vitamin C should be taken 1 to 2 times a week.

A **dry hunger strike** (no food, no drink) can be survived for ~ 2-4 days. Dizziness and speech disorders occur first, followed by loss of consciousness and even coma.

A hunger strike (water only) can be survived for ~ 40 days. A hunger strike with the addition of juices, vitamins and electrolytes can be survived for different lengths of time depending on the constitution, amount of juice, etc.

There may also be long-term health consequences, in particular **neurological impairments, e.g.** memory disorders, polyneuropathies, etc.

Prolonged periods of starvation can lead to **cardiovascular complications**, with severe cardiac arrhythmia and even cardiac arrest and death. Due to the impaired immune system, severe infections can occur, with **septic progression up to** multi-organ failure and death. Electrolyte imbalances can lead to severe kidney disease (persistent kidney disease is also possible). The consequences of severe electrolyte shifts can also lead to impaired consciousness and severe delirious symptoms, including coma. The risk of death during prolonged periods of starvation has been expressly pointed out.

After more than 10 days of starvation or a BMI < 18.5, the risk of **refeeding syndrome increases** when food is resumed. Refeeding syndrome corresponds to a serious metabolic derailment (hypophosphatemia, electrolytes, glucose metabolism, thiamine deficiency) and can be fatal. The catabolic metabolism that develops during the hunger strike switches to anabolic carbohydrate metabolism when food is reintroduced, resulting in a critical intracellular drop in ATP levels. This can lead to severe organ dysfunction, with seizures, delirium, coma and death. The symptoms of refeeding can develop very quickly and are then rapidly life-threatening. Therefore, the resumption of food should only take place under close medical supervision in a clinic (publication handed out by Wirth 2018). The calorie intake should initially be a maximum of 1000 kcal/day and contain ~ 1.2-1.5 g/kg body weight of protein, whereby the glucose intake should urgently be limited to 150 g per day in order to avoid a strong release of insulin. Suddenly high insulin levels in particular can lead to significant electrolyte shifts, which can result in cardiac arrhythmia, heart failure and even death. It should be noted in this context that the determination of serum phosphate is not a reliable parameter for the actually important intracellular phosphate concentration (the intracellular phosphate concentration is physiologically 14 times higher). In people with healthy kidneys, phosphate should be administered prophylactically.

Recommended substitution: **Vit B1** 100mg/day, later 200mg if necessary**; Vit B complex** 2x/week**, Vit C** 100mg/day**, Kalinor** 1x daily**, magnesium** 300mg/day**; phosphate** 21 mmol/day**;** if necessary simply Multi-Vit / Electrolyte Tbl 1x daily**,** add vegetable broth or 1 teaspoon of salt as required, **at least 2.5 to 3 liters of liquid,** urine should be light yellow.

(Note: this text does not claim to be complete!)

General medical history

Previous illnesses and operations:

Allergies:

Medication:

Addictive substances:

Last menstruation: **Probability of pregnancy:**

Social anamnesis

Profession:

Family/social support or other contacts for psychological support:

General practitioner:

Current psychological findings

Risk factors present?

- **BMI < 18 or > 30**
- **Pregnancy / breastfeeding**
- **Age < 21 years or > 65 years**
- **Diabestes mellitus requiring treatment**
- **History of eating disorders, suicidal tendencies, self-harming behavior or mental illness**
- **Chron. Liver disease / Chron. Kidney disease / Chron. heart failure**
- **consuming, chron. diseases, cancer**

Are there any contraindications?

- **Acute suicidal tendencies**
- **Current eating disorder**
- **Other mental illnesses / cognitive limitations that impair free independent decision-making in full possession of mental faculties**

Contact person for emergencies:

Emergency decree (available ? / If not: Who would be the person(s) of trust in case of doubt?

Release from the duty of confidentiality (what is desired / not desired in relation to press releases):

Information bans: Are there topics / relatives / media / content that may not be passed on?

Brief summary of the information session:

Legal notice:

This is merely a voluntary medical accompaniment to the best of our knowledge and capacity. It is explicitly pointed out once again that appropriate medical support is not possible due to the lack of local infrastructure and the lack of time and personnel capacities of the medical team.

From a medical point of view, the resumption of food is urgently required after 14 days of hunger strike, and at least 2.5 liters of liquid should be drunk daily.

..... hereby declares that, contrary to medical advice, it will continue to refrain from eating after 14 days / or even from drinking fluids.

_____ _____

Doctor **on hunger strike**

Release from the duty of confidentiality

I, (surname, first name) _____,

wohnhaft _____,

hereby release Mr./Mrs. _____,

from the existing medical confidentiality obligation towards me for the purpose / the organization

1. _____

2. _____

3. _____

4. _____

with regard to the following documents / information / data

1. _____

2. _____

3. _____

4. _____

Towards the following persons / organizations / media

1. _____

2. _____

3. _____

4. _____

from the duty of medical confidentiality.

I am aware that I can revoke this declaration of release from the duty of confidentiality at any time with effect for the future.

_____ _____

Doctor **on hunger strike**

Visit sheet / physical status

Name: **Hunger strike day no:** **Date:**

Status collected by: **Time:**

Vital signs

Weight (kg)	BMI (kg/m³)	Blood pressure (mmHg)	Pulse (/min)	Temp (°C)	Breathing rate

Cardiopulmonary status

Heartbeat rhythmic?	Heart murmur?	Lungs on the same side?	Pulmonary noises?

CNS

Orientation (at the time/person/place/situation)	
Glasgow Coma Scale (GSC 3-15 pts)	
Öffnen der Augen [Spontan = 4, Bei Ansprache = 3, Bei Schmerzreiz = 2, Kein Öffnen der Augen] **Beste Verbale Antwort** [konversationsfähig, orientiert = 5, konversationsfähig, desorientiert = 4, Einzelworte (*"Wortsalat"*) = 3, sinnlose Laute = 2, keine verbale Antwort = 1] **Beste motorische Antwort** [Bei Aufforderung = 6, gezielte Bewegung bei Schmerzreiz = 5, ungezielte Bewegung auf Schmerzreiz = 4, Beugesynergismen = 3, Strecksynergismen = 2, keine motorische Reaktion = 1]	
Memory disorders / word-finding disorders	
Mood / depression / suicidal tendencies	
Confusion / Delirium	

Abdomen

Bowel movement	Bowel sounds	Pressure pain	Nausea/vomiting	Micturition

Skin / extremities

Skin color	Peripheral edema	Extremities warm / dry	Peripheral pulse	Sensitive deficits

Urinstix

Ketone bodies: **Leukocytes:** **Erythrocytes:** **Proteins:** **Nitrite:**

Blood glucose (mg/dl):

Note examiner:

Self-assessment of hunger strikers:

Brief summary: Declaration of the World Medical Association of Malta November 1991

https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/

Note: we have replaced "patient" with hunger strikers, and inserted the non-binary spelling

1. ... Although hunger strikers generally do not want to die, some are prepared to accept death in order to achieve their goals. Doctors ***need to find out the true intention of the hunger striker,*** especially in collective strikes or in situations where peer pressure may be a factor. An ethical conflict situation arises when hunger strikers who have been given clear instructions not to resuscitate reach a stage of cognitive impairment. Although doctors feel obliged to resuscitate them due to the principles of mercy, respect for the individual's right to self-determination prevents doctors from doing so if there is a valid and informed refusal *(living will - inserted).*

2. ... All doctors are bound by medical ethics in their professional contact with vulnerable people, even if no treatment is provided.

3. ***Respect the autonomy*** of hunger ***strikers****.* Doctors must respect the autonomy of hunger strikers. ... Hunger strikers must not be forcibly treated if they refuse. *Forced feeding violates informed and voluntary refusal and is therefore unjustifiable.* Artificial feeding carried out with the explicit or implicit consent of the hunger striker is ethically justifiable.

4. ***"Care" and "harm".*** Doctors must use their knowledge and skills for the benefit of their patients. This is the principle of "care", which is supplemented by the principle of "avoidance of harm" or primum non nocere. These two principles must be in balance. "Care" means respecting the wishes of the hunger strikers and promoting their well-being. "Avoidance of harm" means not only minimizing harm to health, but also not forcing treatment on people with decision-making capacity or forcing them to end the hunger strike. Care does not necessarily mean prolonging life at all costs, regardless of other values.

5. ***Clinical independence.*** Doctors must remain objective in their assessments and must not allow third parties to influence their medical judgment. They must not allow themselves to be pressured into violating ethical principles, such as medical intervention for non-clinical reasons.

6. Confidentiality. Although ***medical confidentiality*** is important for building trust, it is not absolute. It can be lifted if other people are seriously harmed by the non-disclosure of information. As with other patients, the requirement of confidentiality should be respected for hunger strikers unless they consent to the disclosure of confidential information (e.g. *press work - inserted*) or the disclosure of information is necessary to prevent serious harm.

...

9. Doctors must carry out an assessment of the mental capacity ***(mental state / cognitive ability assessment)*** of the hunger strikers. This involves checking that a patient who wants to go on a hunger strike does not suffer from a mental disorder that would severely impair their ability to make decisions about their health. Patients with severe mental disorders cannot be considered hunger strikers. Rather, their mental health problems need to be treated than allowing them to jeopardize their health with a hunger strike.

10. Doctors should take a detailed medical history of the hunger striker as early as possible, ... This should include explaining the medical consequences of any illnesses they may have. Doctors should ensure that hunger ***strikers understand the potential health consequences of a hunger strike and warn them of the health implications in plain language beforehand***. Doctors should also explain how damage to health can be minimized or delayed, ... As the hunger striker's decision to go on hunger strike can have serious consequences, it is crucial to ensure that the hunger striker truly understands the health consequences of a hunger strike.

11. ... In addition, the ideas and wishes of the hunger striker with regard to medical treatment in the event of a prolonged hunger strike should be recorded.

...

12. Doctors should ***speak*** to hunger strikers ***in private***, i.e. out of earshot of other people, ...

13. Doctors must make sure that it is the ***hunger striker's voluntary decision*** to refuse food or medical treatment. Hunger strikers should be protected from coercive measures. Doctors can often help to achieve this goal and should be aware that coercion may come from the peer group, the authorities or others, such as family members. ...

14. If a doctor is unable to accept the hunger striker's decision to refuse medical treatment or artificial feeding for reasons of conscience, then the doctor should make this clear at the outset and refer the hunger striker to another doctor who is willing to accept the hunger striker's decision.

...

15. Doctors may consider it reasonable to ignore previously given instructions to refuse treatment if, for example, they believe that the decision to refuse treatment was brought about under pressure. If, after being revived and regaining mental capacity, hunger strikers reiterate their intention to continue the hunger strike, this decision should be respected. It is ethical to allow a hunger striker to die with dignity, but it would be unethical to subject them to repeated interventions against their will.

16. ***Artificial feeding*** may be ethically acceptable if the hunger striker with decision-making capacity consents to it. It is also acceptable if hunger strikers who lack decision-making capacity have not previously given instructions to refuse artificial feeding without coercion.

17. ***Force-feeding is never ethically justifiable.*** Even if it is intended to have a curative effect, feeding involving threats, coercion, compulsion and the use of physical force is a form of inhumane and degrading treatment. ...