Manuscript title: “Physicians’ responsibilities towards a person on hunger strike: an ethical analysis”

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**Abstract**

This article discusses the ethical issues confronted by a physician while encountering an adult civilian (what is meant by “civilian”?, this is not clear, and in the context I think author means non-prisoner, but this is not clear) hunger striker and offers some normative indications. The ethical issues are identified and addressed with reference to the UNESCO Universal Declaration on Bioethics and Human Rights ( the author doesn’t explain here or later why this UNESCO declaration was chosen as reference, in stead of f.i. the ICCPR and ICESCR which are also legally binding for contracting parties)

**Keyword: ‘**Hunger strike’, ‘voluntary refusal of food’, ‘ethical dilemma’, ‘medical ethics’.

**Physicians’ responsibilities towards a person on hunger strike: an ethical analysis**

**Introduction**

Hunger strike is a voluntary refusal of food by a mentally competent person with an objective of accomplishing specific requests (1). Total or dry hunger strike indicates refusal of both food and water, whereas partial hunger strike consists of refusal of solid food only. Supplements such as vitamins and electrolytes may be consumed during the strike. It is a nonviolent form of protest and outcry against public injustice and undertaken as a last resort, when other measures fail. Sometimes, for some reason normal intake is refused and artificial nutrition is accepted. The rationale behind the selection of particular nutrition is to enable the striker to participate long enough to negotiate. (2). It is also seen as ‘weapon of powerless’ as it is frequently exercised in the prison (3); nonetheless it is also commonly practiced by civilians (I keep not-understanding the wording “civilian”) outside of the prison setting. (what about asylum seekers in non/semi/quasi/non detention facilities?)

Hunger strike is frequently increasing as many people around the world undertake it for various reasons which usually involve social, political or religious issues. Anesthetists in Poland went on hunger strike seeking an improvement in their medical equipment in 1997 (4). Similarly cancer patients in Israel resumed hunger strike to include cetuximabin (anti-cancer drug) in health insurance benefit package (5). Physician and Professor Dr. Govinda KC repeatedly went on hunger strike to protest against Nepalese government interfering in the education system (6). Five Australian doctors were on hunger strike as an appeal to the federal government to recognize the skills of overseas doctors (7). (the selction of cases seems to me quite arbitrary and certainly not representing the dilemma’s facing carers)

Immediate features of a person on hunger strike are thirst, dehydration, hunger, abdominal pain, dizziness and low blood pressure which get resolved once feeding resumes (8). The threats are more with prolonged hunger strike where the sensation of thirst and hunger is lost and the body compensates by using its own resources. Electrolyte imbalance, vitamin depletion, infection, hypothermia, and renal failure are commonly seen. Emotional lability, (liability would be strange) loss of competency, psychotic symptoms such as delusion, hallucination, dissociation and confusion were late features (9). Starvation colitis, bloody diarrhea due to hemorrhagic gastroenteropathy is also seen (10). Prolonged caloric deficiency in starvation produces many adverse effects and subsequent complications such as multiple organ failure, severe sepsis, ventricular fibrillation and even death (11). The other features are: decrease in body mass index, sleep disorders, somatosensory disturbances (12), Wernicke’s encephalopathy(13), refeeding syndrome (14,15), Wernicke–Korsakoff syndrome with altered consciousness and amnesia due to permanent neurological injury (16).

Hunger strike is a delicate situation and poses a threat to health and life, especially during prolonged strike. The year 2000 saw 57 prisoners and 7 outside supporters die out of hunger strike in Turkey (11). The determined hunger striker, whether partially (this means?) or completely fasting, often deliberately refuses treatment in any form and accepts its consequences. However they (?) depend on medical care to prevent any harm or illness .The treating doctors are faced with ethial dilemma’s. On one hand, they have a duty to save life, eliminate potential medical harm and safeguard health while on the other, they also have to a duty to respect the patient’s autonomy (including his/her wish that their deliberately refusal of all medical treatment or interventions is respected. This also means that the physician can intervene only when he/she is certain of the—competent will of the patient in hunger strike under their care. But how do they ascertain what is certain and what about the uncertain about their will?

Although a hunger strike is a voluntary act, peer pressure or coercion can have decisive influence. The validity of advance directive is also marked (I don’t understand this sentence).

The core issues of autonomy, beneficence and sanctity of life revolve around hunger strike and lead to ethical dilemmas which can be further complicated by competency of the patient, dignity, vulnerability, informed consent, advance directives with care. Hence, the purpose of this study is to explore the ethical dilemmas of a physician when dealing with an adult civilian hunger striker and address them. The UNESCO Universal Declaration on Bioethics and Human Rights is taken as a framework as it provides guidelines of principles and procedures from an individual to a State even to formulate legislation, policies or other instruments when needed ( I find this an insufficient explanation why this weas chosen; see also my comment in the abstract) (17). This paper expects to help the physicians in adjunct to WMA Declaration of Malta on Hunger Strikers, by providing a deeper understanding and awareness of the ethical situation both normative and meta ethics. However, it does not discuss the ethical dilemmas involved in the care of children (pregnant women?), detainees or prisoners who practice hunger strike. Such situations, in fact, pose peculiar issues that would deserve separate analysis and discussion. (author does not explain why these categories, which are facing actually the most difficult dilemma’s, and on which most literature and guidelines are based, are excluded)

**Objectives:**

1. To identify the ethical issues of a physician involved in the care of an adult civilian hunger striker except prisoners, detainees or minors.
2. To address those ethical issues with reference to the UNESCO Universal Declaration on Bioethics and Human Rights.

**Methodology:**

A literature search and review on relevant articles were done to have a broader understanding of ethical challenges faced by a physician in the care of a hunger striker. The databases PubMed and Google Scholar were searched using the keywords: ‘hunger strike’, ‘fasting’, ‘medical ethics’, ‘ethical dilemma’, ‘physician’s responsibilities’ and ‘human rights’. The review was conducted from December 2015 to April 2016. Only full text articles published in English were reviewed. Those articles which did not discuss the medical and ethical aspects of hunger strike were excluded. The ethical dilemmas were then analyzed and addressed referring to the UNESCO Universal Declaration of Bioethics and Human Rights which encompasses the basic aspect of a relationship between a human being and medicine, as human dignity, rights, vulnerability, justice and social responsibility.

**Role of a physician**

The WMA Declaration of Geneva on Hippocratic Oath pledges physicians to have an utmost respect for human life thereby prioritizing health of a patient and hence is highly considered. It is the responsibility if a physician to treat and save life of a patient whenever their health deteriorates. One should not be judged or discriminated on any basis such as disease, ethnicity, gender, nationality and political affiliation and confidentiality is to be ensured (18).

The WMA International Code of Medical ethics suggests a physician to act in the patients' best interest while respecting their rights and preferences. Physician should judge independently and do what is best for the patient in terms of their own regard while maintaining highest standard of care (19). When a competent adult patient voluntarily refuses lifesaving treatment on the moral, religious, cultural grounds or conscience, he/she cannot be forcefully treated against his will. The principle of beneficence also requires physicians to an act in the benefit of the patient but respect for his autonomy contradicts it when a valid and informed refusal has been made.

The WMA Declaration of Malta on Hunger Strikers was developed to guide physicians to provide ethically sound professional care in 1992 which was revised in 2006. It values the obligation of physician towards an individual, hence, recommends a physician to respect their wish, prevent coercion or maltreatment and protest if it occurs. Advance instructions are to be followed unless they were made under coercion and force feeding contrary to an informed consent and voluntary refusal is unjustifiable and prohibited (1). This is a strange sequence: the WMA declaration of Tokyo of 1975 came first, the WMA declaration of Malta came later. Author does not sufficiently reflect on the differences and historical development.

The WMA Declaration of Tokyo-Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment prohibits natural, artificial or force feeding of hunger striking inmates against their wish. The decision to voluntarily refuse nutrition by a competent hunger striker after learning (?; after having been adequately been informed about) the consequences is to be respected and that doctors must never ignore or participate in such acts (20).

**Ethical issues in various circumstances**

Doctors involved in the care of hunger striker need to understand the complex physical, psychosocial circumstances and potential problems. The ethical challenges are obvious when dealing with inmates on hunger strike whose basic human rights are compromised. However, the challenges are still noteworthy when dealing with an adult civilian hunger striker who can freely exercise his/her rights (explain!). Ethical dilemma can emerge from the moment a physician patient relationship is established. (I miss the explicit mentioning of the position of the treating physician: often the hungerstriker experiences the doctor as part of the “system” that he/she opposes; this perception affects the – preferably independent – position of the treating physician)

A physician sees hunger striker when their health deteriorates and needs medical intervention. The patient has a right to accept or refuse such treatment. There has been a significant discussion in medical practice regarding the importance of the patients’ right for self-determination individual responsibility. But when their preferences do not coalesce with that of physician’s moral obligation it leads to ethical dilemmas. Despite the presence of clear and revised international guidelines, it still persists (explain). The following ethical issues have been identified from the literature:

1. The struggle of balance between principles: autonomy and beneficence or non-maleficence, when a competent adult civilian hunger striker continues to hunger strike and refuses medical intervention (21–23).
2. Force feeding a competent hunger striker against his/her wish (24).
3. Maintaining confidentiality of the patient while sharing information with mass media (25).
4. Psychological pressure from supporters, peers and media coverage which compels the striker to continue (8,26).
5. Should a physician still intervene during an encounter with an unconscious hunger striker who has previously declared refusal of nutrition (27,28)?

**Discussion**

1. The struggle of balance between principles: autonomy and beneficence or non-maleficence, when a competent adult civilian hunger striker continues to strike and refuses medical intervention despite alarming health conditions. Most of the time, hunger strikers are seen by a physician only when their health deteriorates and needs medical intervention ( in the preferable situation, the independent doctor is present to counsel the patient, gives appropriate information, evaluates with the hungerstriker the proportionality between his/her goals and the hunger strike). It becomes the ultimate duty of a physician to save the thweclared refusal of nutrition? ated dology.grity and transparenteir life as life in every form in every society is highly considered and valued (18). However, it does not hold true for everyone. Many strikers are ready to place theirvery society is demands primarily and life secondarily (is it that straightforward? My definition would be that hunger strikers may be so desparate in achieving their political/social goal, that they are willing to subordinate their helath/life interests to their political/social goals. They equally value their requests (strange sentence) (4,5,6,7). Despite their need for medical care, they do not consent to treatment especially when they are capable of forming a rational judgment. The obligation to treat is challenged by an obligation to respect their autonomy. Autonomy is the right of a patient to decide freely and voluntarily on matters related to them, such as treatment and other measures after being provided with complete information. They have a right to self-determination and (are accountable to whatever consequences; what does this mean? (19). Breaching it leads to an assault except for those who are not considered autonomous. But upholding their respect even in a competent person assertively can also lead to their slow and harrowing death (29) ( I regretto understand this form of ethical reasoning). Individual responsibility does not free physicians from their responsibility. They have a professional responsibility to provide honest, integrated, transparent scientific knowledge. They should try to understand the patient and his/her situation, inquire on their motives and build trust. Mental competency should be assessed during the full course of patient-doctor relationship and informed in detail regarding the starvation, its consequences and treatment modalities even though by definition a hunger striker is a mentally competent person (this sentence should be revised). If (what?) still denied voluntarily under a sound mind, then the physician has to respect their autonomy. Dignity is the human right with fundamental freedom which is the foundation of peace and justice and that the interest and welfare of an individual outweighs that of society. The first principle of the Universal Declaration on Bioethics and Human Rights in fact describes and urges to respect human dignity and human rights. In an effort to treat a condition or illness, physicians fail to treat the patient as a person and reflect their values as that of patient’s. Those who consider human dignity as an integral part of life are not benefited if their dignity is hampered while recovering life. Dignity is an inherent property of being human. It can be perceived differently by individuals and depends on their own values. One of the methods used to evaluate the ratio of benefit and harm is by personal ‘values’. Patients should be benefited in their own interest or in terms of their own values. Physicians are to use their skills to benefit patient and not themselves by the virtue of their profession. (17). It can also be dealt ethically by timely seeking legal consultation. A well informed written will (?) should be obtained. There should be a multidisciplinary approach to the patient with consequent behavioral therapy (I don’t understand this sentence following the previous). It can alleviate anxiety and promote autonomy by y consultation fic knowledge. to provide honest, integrated, bridging any gap and creating a better understanding.

1. Force feeding a competent hunger striker against his/her wish: Hunger strikers willfully put their lives at risk for a cause and prefer their movement to be responded however they do not wish to die and hence, not suicidal (23). Yet, it has also been considered an act of suicide due to the fact that voluntary starvation to the point of death is suicide. The act of suicide is still illegal in few countries e.g. Malaysia (30). An individual who exercises their right to freedom of expression or basic human rights through hunger strike can be opposed by the state or country which identifies it as an act of suicide. They are force fed in the interest of the society which has a duty to protect an individual’s life (24). Force feeding is feeding an individual against their will which usually involves physical restraint and intervention to provide nutrition (31) Although aimed to prevent starvation, it is an anticipated rigorous form of treatment so physicians should neither force feed nor be forced to feed against their professional values. When physicians are legally obliged to force feed, should law win over ethics (24)? Does the sanctity of life surpass an individual’s rights over themselves? It has also been indicated that while feeding the physician should try to employ the least deleterious method and humane way. But once the respect for autonomy shifts to the interest of the society, it makes no difference whether they turn to humane force feeding or artificial feeding ( I don’t understand this reasoning). Artificial feeding although considered less aggressive, is sstill not ideal (why? It is still intruding the human body. Please be clear on reasoning!!). The fact that the force feeding is lawful does not mean that it is ethical or irrefutable (author forgets regrettably to refer to force-feeding cases, such as the G-bay cases in USA, documented by PHR)). It interferes with an individual’s human right, integrity and dignity hence is deemed inappropriate. The Universal Declaration on Bioethics and Human Rights in article 3.2 states that ‘…the interests and welfare of the individual should have priority over the sole interest of science and society’. Autonomy, personal integrity and consent are few other principles of the declaration are violated. Force feeding disrupts human dignity by depriving patients of their rights. Autonomy is misplaced when a mentally competent person is no longer considered an individual being but as a means. It harms further when the procedure is directed against their valid consent and personal integrity. Article 28 of the declaration advocates against the application of its principles in contrary to human rights and dignity. In fact any act contrary to human dignity is objected by the declaration (17). Physicians have a moral obligation to educate and bring social awareness about the harmful practices of force feeding. They should challenge and eliminate them. It is also recommended to have a multidisciplinary approach with solidarity and cooperation at national and international level.
2. Maintaining confidentiality of the patient while sharing information with mass media: With the globalization of news, the social media and relevant authorities keep track of the health of the strikers. Physicians are expected to share information regarding the hunger striker to the general public (where is this coming from? The physician has no role at all in sharing information to social media; the physician has a role to play in defending his/her hungerstriking patient from the confusing, compelling etc dynamics of media/peer groups/ etc.) . However, care should be taken to divulge only the relevant information (what is that?, the doctor has no role in divulging information) to others and not those which are revealed during examination and treatment.ot those which t Prior consent and discussion regarding the information to be shared has to be obtained because of potential threat and harm (18,19). Once, the greater population is involved, the amount of knowledge shared must be sorted and disseminated (1). Although general information regarding the course of the strike and precautions taken may be discussed to maintain transparency in care, confidential medical information must be well protected. Informed consent is affirmative of altruism not only to the physician but also to the patient because it cannot be deceived or intimidated (I don’t understand this sentence). The declaration requires a physician to obtain consent even when disseminating to the family members. Such information should not be revealed for purposes other than mentioned? in the consent. Involving the hunger striker appropriately in decision-making during informed consent not only promotes his autonomy but also his dignity and wellbeing (17).

1. Psychological pressure from supporters, peers and media coverage which compels the striker to continue (8,26): The attention that hunger strikers receive from their supporters with ample media coverage can compel them to continue the hunger strike. Such psychological pressure can be hard to assess (25). If not taken into consideration, it can be wrongly presumed and cause serious harm or death. The determination and exercise of will power to hunger strike to an extreme circumstance should be followed by a meaningful and in depth counseling. The psychiatric assessment should be done (such evaluation requires interviewing the patient in isolation form his/her peergroup, since peer-group pressure identification is crucial), not only to determine one’s competency and voluntariness to initiate or continue the hunger strike but also to warm them of the psychological changes during transient state of hunger and fatigue (26). However, the information must be carefully disseminated so as not to influence or nudge towards a particular decision making. The fundamental principle of non-stigmatization in violation of human dignity, human rights and fundamental freedoms per article 11 of the declaration urges the physician to view hunger striker as a patient and not as a tool. It also emphasizes the essentials of vulnerability and integrity as an inherent of human being and that it cannot be identified solely by exercising autonomy and giving informed consent. Vulnerability and integrity should be recognized and respected by physicians to establishing symmetric relationships with the patient and to protect them even when they don’t complain (17). Vulnerability is a general characteristic of the human being referring fragility both innate and those brought by natural or social conditions such as disease or poverty. It expresses the normative requirement for special care. More is needed than non-interference; they need assistance.
2. Should a physician still intervene during an encounter with an unconscious hunger striker who has previously declared refusal of nutrition (27,28)? (the author does not or insufficiently advocate the necessity of a continuous patient-doctor relationship from the beginning of the hungerstrike though the deteriorating competency) Hunger strike if carried out for longer duration can result in mental deterioration and compromise the competency of the individual (26). Whenever possible a physician should assess the hunger striker from day one of the strike to determine their wish to continue the strike or have an intervention when they become unconscious. When dealing with an unconscious patient, the physician has to keep in mind one’s wish and values. Advance directive is a tool to respect patient’s wishes in anticipation of deteriorating health and inability of decision making by promoting autonomy. It can be implemented either by proxy or instruction or both (32). However, they should be handled diligently in presence of reasonable doubts. Any undue doubts about the individual's intention and instructions can lead to its failure and in situations where the decision was made has changed radically since the individual lost competence, it becomes invalid. But what happens when no advance instructions exist and discussion is not possible? The WMA Declaration of Malta on Hunger Strikers recommends that the physicians act in accordance with expressed wishes, values, health and in their best interests. Moreover, in the absence of any such indications, the physician has to elect the best course without interference from third parties (1). This is easy said than done. An unconscious patient with previously declared or undeclared will refusing nutrition plainly poses ethical challenge. A written will refusing treatment cannot be a sole determinant when caring for an unconscious patient especially when they are seen for the first time as its authenticity or validity of the decision to refusal at that time cannot be guaranteed (33). It lacks information. If the advance directive is acknowledged, the autonomy is respected but a life is risked. But if treatment is provided the qualms surrounding its validity, then a life is saved and it as well will give the individual an opportunity to express their wish. So, physicians should rightly intervene and resuscitate. Resuscitating and establishing a meaningful communication to elucidate more facts regarding the patient can be considered as the special measures taken to respect their dignity and integrity at that crucial time. In addition, it creates an environment for the patient to give free and informed consent which otherwise would not have been known or likely be misinterpreted (32). The resuscitation of an unconscious patient is also supported by the fact that the declaration instructs physicians to undertake special measures to protect the rights and interests of those who are incapable of exercising their autonomy (17). In the conflict between beneficence and autonomy, both of which are derived from the inherent dignity, the physician exercises the role of beneficence by assessing and informing the patients of their clinical conditions and needs. ‘The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others’, is to be respected per article no. 5*.* Article 7 states, ‘the person concerned should be involved to the greatest extent possible in the decision-making process of consent, as well as that of withdrawing consent’ highlighting the importance of refusal. Physicians can still be ignorant or uncertain about the patient’s preferences, wish or values. Hence, it cannot be assumed randomly and make substituted judgments. This cannot be simple as a DNR (Do Not Resuscitate) expected from an underlying chronic illness because as initially mentioned they wish to have their requests fulfilled and not die. It has also been suggested that a traditional view regarding patient’s interest in their term can undermine medical care in the long run, increase the potential for unfairness and leave physicians without adequate guidance. A way to overcome this situation gracefully is to embrace physicians as having a pro than putting a strict obligation (34). Advance directives, even tough have a significant limitation over the autonomy of the patient, should be taken into consideration during decision making of those who are incapable as it can be either legally binding or not.

Alas again, decision making should be professional, honest, and in line with best available scientific knowledge and methodology.

**Conclusion:**

A hunger strike poses ethical challenges to the physicians. When dealing with competent hunger striker, the physician should assess him/her regularly, acknowledge his/her autonomy, discuss their preferences, inform him/her adequately about the consequences of the hungerstrike, discuss the proportionality between the political/social goals and the consequences of the hungerstrike and obtain it a well written detailed will in writing and signed. Patients should be well informed about their condition, its consequences and treatment alternatives. They should be communicated well to verify external coercion and relocated to a safe place if psychological pressure is determined. An informed consent should be obtained from a patient for any procedure and sharing of information. Confidentiality should be maintained. A valid decision should be respected even when deny treatment. Treating them against their wish might cause more harm than good by hurting their dignity. So, those who willfully refuse nutrition even at the face of death should not be force fed. In case of an unconscious hunger striker, advance directives have to be considered which help physicians to treat them ethically. If a physician is well acquainted with the hunger striker and believes that the advance refusal corresponds to that of the patient’s values then he/she has a moral obligation to follow it. However, if a patient is being seen for the first time or uncertain of the advance refusal, then he has an obligation to treat him/her.

**Limitations:**

1. It does not discuss the ethical responsibilities of a physician in prison, detention and in minors.
2. Limited articles on the topic.
3. Two databases were searched using the keywords.
4. Only articles published in English were reviewed.

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