

# The experiences of health professionals while monitoring a hunger strike among undocumented migrant workers in Brussels.

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## Research article

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# Abstract

**Background** In 2014, in Brussels, a group of undocumented migrant workers started a hunger strike. A loophole in Belgian migration law allows very sick people to stay in the country to recuperate. Undocumented migrants jeopardize their health to be able to obtain a temporary permit and a way out of misery. The monitoring of the hunger strike was done by young, committed but inexperienced health professionals.

**Methods** At the end of the hunger strike, two focus groups were held to find out the dilemmas confronting the health professionals.

**Results** Eighteen out of 29 health professionals participated. They mentioned their curiosity to gain new insights into living conditions among undocumented people and the reasons why they started the strike. They were puzzled by the paradox of wanting to die to get a better life and refusing medical advice. They wondered about their role and commitment as a caregiver. Some were deeply touched by the experience and reacted emotionally while others deepened their engagement. Symptoms of Secondary Traumatic Stress, such as re-experiencing and avoidance were observed. The participants themselves also proposed improvements to the monitoring.

**Conclusions** Even though only a small number of health professionals were questioned, we detected a lot of preoccupations and contradictions in their reactions. To be able to process these a close follow-up and evaluation of the monitoring of a hunger strike is mandatory. We also propose that prevention, early detection and treatment of Secondary Traumatic Stress should become part of formal medical education.

# Introduction

The struggle of undocumented migrant workers in Belgium has been characterized by many hunger strikes. These happen because a Belgian law states that an undocumented person can request an authorisation to stay legally in the country, initially for three months, if they are suffering from "an illness which poses a real threat to their life or physical integrity or which implies a real risk of inhuman or degrading treatment when there is no adequate treatment in their country of origin or residence"(1). Because they refused solid foods and only consumed sweetened beverages, the undocumented migrant workers' health deteriorated until they negotiated with the Immigration Office to be granted this three months permit to regain their strength. If they were able to get a job during this period, they were granted a longer permit and a way out of a life of misery and incertitude. In Brussels, between 2008 and 2015, 1158 hunger strikers from more than 18 countries participated in 15 different hunger strikes. In 2009, due to consecutive hunger strikes, the Belgian government implemented a general regularisation period of 3 months allowing more than 40 000 people to apply for asylum under special conditions. (2)

The participants in the hunger strikes occupied vacant buildings and looked for support groups and medical volunteers to monitor the strikes. Undocumented migrant workers in Belgium do not have access to social security, so all the medical care had to be for free or obtained from social welfare services, as

undocumented workers are only granted 'urgent medical care'. (3) The monitoring of a hunger strike in custodial settings (prisons, detention centres and hospitals) has been extensively documented in literature, but little is known about non-custodial settings. (4)

A health professional can be involved with hunger strikers in different ways. Employees of a custodial institution will be confronted with the problem of divided loyalty. Will they obey the guidelines of the authorities who are responsible for the health of the inmates and prefer to force-feed them to keep them alive rather than to respect the strikers' decision to refuse food until death? Other professionals will act as monitors for government institutions. They will retrieve data and information and pass this on to controlling institutions, but they will neither treat nor give advice to the hunger strikers. In non-custodial settings, the hunger strikers themselves ask independent health professionals to help them by giving advice, monitoring their medical parameters and intervening when necessary. This relationship comes closest to a normal, trustful dual relationship between doctor and patient. Hunger strikers must be informed beforehand of the role of the visiting health professionals. (5)

In 2014, a group of about 200 undocumented migrant workers, mostly families with children, were squatting in a vacant nursing home in a suburb of Brussels. Part of the group demonstrated every week in front of the Immigration Office to demand a more humane treatment of their fate. Following a lack of response, 45 of them started a hunger strike on 17 November 2014. Because the entire group was not consulted, this created a lot of friction. The hunger strikers requested medical assistance and a group of health professionals was formed to do the medical monitoring in response to a call on social media. The group consisted of two nurses, 10 medical students and 17 doctors, of whom eight junior doctors who had started their vocational training in Family or Internal Medicine. Most of them worked in multidisciplinary medical clinics in the suburbs of Brussels and had never monitored a hunger strike before; only one specialist and the main researcher (RV) were experienced. A doodle schedule was made with medical visits to the hunger strikers twice a week. Health professionals could sign up to indicate their availability. During the visits, vital signs, physical and psychological complaints and a suggestion for treatment were noted in the medical records of each hunger striker. The health professionals were in contact with each other on social media. At least twice a week a medical update was posted on this site. The monitoring was demanding: 45 hunger strikers were lying on mattresses close to each other, in one big room, with no space for privacy. Because they were squatting in the building and not paying rent or water and electricity bills, there were frequent blackouts and the two-hour visit had to be done with the help of candles or flashlights. Access to health coverage was only possible through a complicated procedure of 'Urgent Medical Care' which meant that buying drugs or doing medical check-ups like urine or blood tests was almost impossible. (4) The health professionals did not receive any remuneration for their participation. They were exposed to a lot of suffering: they were confronted with the multiple problems of whole families of undocumented people who had been surviving for years without access to legal work or help from the government. They were also confronted with the specific difficulties of the hunger strikers who prioritised their demands for legal permits over their own health, who refused normal medical care such as taking medicines or vitamins, and preferred to die rather than to give up on their demands.

In January 2015, after 64 days of hunger strike and negotiations with the Immigration Office, the hunger strike ended with a feeble promise to review the participants' asylum records. Since then Europe experienced a peak of the migration flow, Eurostat estimated that in 2015 2,1 million people were found illegally present all over Europe. (6) This means that also in other European countries than Belgium, undocumented migrants can come up with the idea of demanding for their rights by hunger striking. Health professionals in these countries should be prepared to confront this challenge.

The aim of the present study is to describe the experiences and concerns of health professionals during the two-month medical monitoring of a hunger strike among undocumented migrant workers in Brussels and to examine the suggestions for improvement of this monitoring.

## **Methodology**

A qualitative and descriptive study was set up to determine how inexperienced health professionals reacted to the monitoring of a hunger strike in a non-custodial setting.

At the end of the hunger strike, the health professionals involved in monitoring were invited to participate in two focus groups. The eligibility criteria to participate in a focus group were being a student of medicine or nursing, being a health professional (nurse, general practitioner or specialist) and having participated at least once in the health monitoring of the hunger strike in Molenbeek from November 17, 2014 to January 19, 2015. The first focus group took place a few days before the hunger strike officially ended (14/01/2015) and the other was held one month later (13/02/2015). Both groups were facilitated by two senior doctors, both staff members of departments of Family Medicine at different universities, one with experience in the monitoring of individual hunger strikers and the main author (RV), who had already supervised 15 collective hunger strikes. Topics discussed were: how the health professionals felt during the monitoring, what struck them, what bothered them, what dilemmas they were confronted with, whether the monitoring had had an effect on their personal lives and how they thought the monitoring could be improved. All participants agreed with the conditions and signed the consent form.

Both discussions lasted about two hours. They were recorded and the tapes were transcribed and analysed in Nvivo by the main author (RV). Parent and child nodes were assigned and findings were compared with scientific literature found on Compassion Fatigue and Secondary Traumatic Stress.

The study was approved by the Medical Ethics Committee UZ Brussel[s] - VUB (B.U.N. 143201940934) All participants filled in and signed a consent form, and no participants received financial incentives.

## **Results**

### **Profile of participants**

The first focus group was attended by 10 persons (three medical students, one nurse and six doctors, of whom four junior doctors), the second one by eight persons (two students, one nurse and five doctors, of

whom three junior doctors). For most of them it was their first monitoring; only one doctor had years of experience. More than half of the health professionals who participated in the focus group were young and compassionate, often working with deprived groups in multidisciplinary clinics in Brussels (table 1).

<b>Table 1. Characteristics of the participants</b>	
gender	
man	8
woman	10
age	
19–29	12
30–49	4
> 50	2
Profession	
medical student	5
nurse	2
junior doctor	7
medical doctor	4

## Gaining new insights

The health professionals asked a lot of questions about the reasons why undocumented migrant workers would start a hunger strike. They believed that they did it to obtain papers, to be heard and to fight against injustice suffered. They also realised that other undocumented people in the past had obtained papers by hunger striking and that the same strategy might work for them. Others talked about the loneliness and exclusion of undocumented people and the shame they would experience upon their return to their home countries, where acquaintances had contributed financially to their travel, and that they would have to confess that their attempt to get a better life in Europe had failed. Health professionals were convinced that if there had been other, legal ways of obtaining legal documents, no one would have started a hunger strike.

Then they tell themselves that they are all alone and that they have to join the movement, that they cannot allow themselves to stay outside, to stay upstairs (with the people who did not join the hunger strike). (Junior doctor)

What is stupid to start with is that people have to go on hunger strike to be heard. (Medical doctor)

The participants were curious to know how it all started: had one person suggested starting a hunger strike and did the rest follow? How could 150 people reach a joint decision? Why did all the participants have the same profile (male, between 20 and 30, with African roots)? They also wondered how they stopped the strike. Some were puzzled to know whether the hunger strikers were happy about the presence of health professionals.

Had the request for medical monitoring come from them? Or from outside? Because I sometimes had the impression that they weren't interested in their medical developments. (Nurse)

Almost everyone agreed that even if the hunger strikers said they wanted to die, they only wanted to be martyrs but would prefer to live. They argued that if they wanted to die, they would not have accepted the presence of medical personnel. The strikers said they wanted to go all the way, but they hoped the strike would end earlier, on their terms. Others expressed doubt:

I do not know if some are not ready to die, when you see those who cross the Mediterranean Sea, on inflatable rafts, knowing that so many before them drowned on the way and they do it anyway. (Medical doctor)

Some were puzzled by the paradox expressed by the hunger strikers of wanting to live but also to die for a cause, between having to be strong but getting weaker every day, of wanting to be heard but having no voice.

They are engaged in a fight where they stop eating so that their demands are met but when you see them, they are exhausted; they are very, very weak and therefore less able to fight. The physical strength lessens, but the mental strength must stay to do something in the long run. (Medical student)

They continue the struggle even if they are weak: by dying they can prove the horror of the situation. As health professionals we cannot do much, it's very difficult to let people deteriorate. (Junior doctor) The health professionals explained it was a very new experience for them: the atmosphere was totally different from what they were used to, even if they had been in contact with other undocumented patients during their medical practice. Simply visiting them in the squat, witnessing their dedication and stubbornness in putting their health at stake just to obtain legal papers, was overwhelming for some of them. It also increased their awareness of the socio-economic situation of undocumented migrant workers.

We are really getting out of the normal routine, and we are not even forced to do it. (Nurse)

It's an experience that you can give yourself to measure the level to which people can put themselves in danger... and you can go to feel it yourself, you can experience it yourself. (Nurse)

## **Expressing disagreements**

Some disagreed with the decisions taken. One health professional criticised the participation of the breastfeeding mother of a two-month-old baby in the hunger strike. Some also set limits on their

participation in monitoring: they would never attend a hunger strike if the claims could have been obtained by other means. They resented situations where an attendance list of participants had been used or if people from the outside, who didn't participate to the hunger strike, got involved in the discussions. Others were less self-assured:

We don't approve of the strike, but we let them take responsibility for what they're doing to achieve their purpose. (Medical doctor)

Many health professionals were concerned about the group pressure they felt. They resented the pressure from people outside the group of hunger strikers, meaning the people who lived 'upstairs' in the building and didn't agree with the strike. As the hunger strikers monopolised the best rooms on the ground floor, conflicts arose due to lack of communication and mutual understanding. But there was also a lot of tension inside the group: if someone decided to stop drinking, everybody would follow because they didn't want to lose face and so they tried to be more radical. A major point of dispute was taking vitamins: the spokesperson had prohibited vitamin intake because he said they were nutrients and therefore forbidden. A discussion was held to convince the spokesperson of the long-term health benefits of vitamins and other medication. One health professional testified to how he convinced other hunger strikers that the only way to stay part of the group was by taking medicines. Some saw this peer pressure as a sign of group culture, of the strong family ties in non-western cultures. The positive side was that they looked after each other and when somebody lost consciousness, they always called an ambulance.

The group feeling needs to be very strong because, I think, you never do a hunger strike all by yourself. (Junior doctor)

I think they are very convinced that they want papers for all of them, not only for themselves. (Junior doctor)

It was better not to mention that they were vitamins because vitamins are associated with food, but to say that we were preventing paraesthesia and ultimately relieving pain. Then they started to take them and there was a reverse group effect, that is to say the ones who took the vitamins explained to the others why they were doing so and everyone agreed. They felt relieved that everybody could take them. (Junior doctor)

By talking to the hunger strikers, the health professionals discovered the economic, political and ecological reasons why they had left their home countries. They felt revolted that our society did not show more solidarity or humanity and that the hunger strikers had to jeopardize their health to be able to be heard, that they were willing to die to obtain a more dignified life.

We live in a country with a lot of money and we do not know how to welcome people and put them to work. (Nurse)

## **Coping strategies**

To protect themselves emotionally some performed their jobs like robots: when asked them to do something they did it mechanically. Returning home after the job, they were overwhelmed and had difficulties managing their feelings. Some cried or had nightmares about the strike. They wondered if they were the only ones who were overwhelmed by the situation. They were tempted not to return to the place of the hunger strike and wanted to stay home in their own comfort zone. Finally they went back anyway.

I was not really myself, but I was not really a caregiver either, I was a person who was putting up barriers to avoid being overly affected by what was going on, someone who does what has to be done but is detached from myself and my role as a caregiver. (Medical student)

The first time I arrived back home, I started crying and I did not know why, I was all alone at home, everyone was gone and then, yes,... I was wondering what had to happen before you started doing that and yes, it was very intense .. I do not know how to explain what I learned but I learned something, but I do not know what. (Junior doctor)

Many felt paralysed by witnessing so much misery. They thought their medical knowledge had fallen short: they saw no way to alleviate the suffering and perhaps hoped the strike would soon end. They also felt relief returning to their daily jobs where helping others was much easier.

A strange feeling is that every time I leave, I want them to stop ... I really want to receive an e-mail the next day that says 'ah, by the way, they stopped'. (Junior doctor)

What can we bring them with our limited means that they will accept, what can we do to help them?(  
Medical student)

## **Commitments as a health professional**

The health professionals were confronted with the question of how far their commitment to the struggle of the undocumented people was supposed to go: should they simply be present or do the medical monitoring, or actively support the movement? They wondered why they were helping the people who were on hunger strike and not the other families who lived upstairs. One remembered that she had been gently criticised because she did not participate in a rally organised by the undocumented people. Keeping track of their weight loss was acceptable but giving this report to the press or government officials was a step too far. Some feared losing their credibility as a health professional.

## **Our presence proves that we support them. (Junior doctor)**

If we don't do a good job we will lose our credibility as health professionals: so we make weight charts. As a researcher I describe nature and make a medical report, but that is as far as I go. (Junior doctor)

I limit my commitment to the medical side and I can indeed issue a medical report that the press can see, but it stops there. As a doctor, demonstrating with them and asking for papers for people whose background you do not know, that is a step too far. (Medical student)



Other health professionals got much more involved. They saw their commitment embedded in the analysis of the World Health Organisation that describes the right to health as one of the basic human rights.

Your medical role as a doctor depends on your definition of health. If you believe that as a doctor, you have to fight for the health of your patients, and you consider the (hunger) strikers as your patients, then their (right to) health will only be achieved when they have the right to exist in this country. (Medical doctor)

There are different sides to the term 'strike': there are strikes for work, strikes against the austerity measures, and then there is this strike because they have no guarantee of their basic rights and it's basically in this context that I wanted to support the people there. (Medical doctor)

## Improvements for the future

A lot of suggestions were made to make the monitoring easier. Health professionals should get together before the start of the hunger strike and an experienced doctor should provide information about managing the monitoring and how the international guidelines could be applied, provide information to the hunger strikers and convince the spokesperson that the medical advice (to take vitamins or medication) is to prevent the short and long term consequences of a fast. The experienced doctor should explain what the conditions are for professional monitoring: weights will be measured by the health professionals to provide regular media updates. The hunger strikers should write down in their own words how they want to be treated when they go into a coma. Consultations should be held in a separate room, where privacy is guaranteed, and outsiders should not interfere with people inside. The team should be multidisciplinary and the presence of a psychologist should be obligatory. Regular mail updates should be given and weekly medical meetings held. At the end of the strike, a medical report should be made for each hunger striker and everybody should be assigned to a general practitioner. A final evaluation, attended by everyone, is highly recommended.

I hope there will be no more hunger strikes, explain to the emergency physicians that we're on the same side, we're here to save people when they are in danger, .... That we do not support the hunger strike and that we're already doing triage on the spot so that they have fewer cases to take care of. (Medical doctor)

Wouldn't it be useful, if there is another strike, for a psychologist to come and talk to them about how far they want to go, until death... but they should discuss this with a doctor, and regularly, because I think the idea that 'we want to continue until we die' changes in the course of the strike. (Medical doctor)

## Discussion

The medical monitoring of a hunger strike among undocumented people generated new, different experiences in young, engaged health professionals. They were confronted with people who jeopardised their health for a higher goal, which made them curious about why and how people decide to start a hunger strike. They were puzzled by the paradox of being willing to die but hoping to survive, of

struggling while getting weaker. As health professionals they could not agree with harming the physical integrity of a person, or with pressure from the outside, but they also accused the Belgian government of failing to respect basic human rights. Witnessing this injustice made some put up barriers, others became emotional, a few limited their commitments and others saw the monitoring of a hunger strike as the endorsement of the Constitution of the WHO that states that 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' (7)

A possible consequence of exposure to traumatised patients was described by Charles Figley as Secondary Traumatic Stress: "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). (8) Since then a lot of articles have been written about the subject, especially the effect on social workers, mental health personnel, nurses in emergency or oncology wards, professionals working with people living with HIV, sex workers, survivors of sexual abuses or terrorist attacks, even law enforcement agents, journalists and caregivers working with refugees. (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) Only a few articles focus on physicians. (20) (21) (22) The symptoms of Secondary Traumatic Stress can emerge at psychological, behavioural, physical or professional level and include intrusion or re-experiencing, avoidance and arousal symptoms. (23) (24) (25)

In our study we did not investigate the symptoms of Secondary Traumatic Stress. Exposure to the traumatised hunger strikers was short, but even then we observed signs of psychological and behavioural reactions such as re-experiencing, not wanting to go back to the scene or underestimating their contribution. The same problems were described in professionals and caregivers working with traumatised refugees coming from Latin America and North Korea. During in-depth interviews, more than half of these respondents showed signs of Secondary Traumatic Stress. (17) (26) We also noticed that medical students and less experienced junior doctors who participated in the monitoring were especially vulnerable to these symptoms. This analysis was also made in a Romanian study where students who started studying medicine for altruistic reasons were more vulnerable to Secondary Traumatic Stress than classmates who started their studies because they were more tempted by the respect and recognition the job would bring. (27)

In Belgium no studies have been implemented to investigate Secondary Traumatic Stress in caregivers. One study conducted by Adriaenssens et al. in 2007–2008 examined whether traumatic events played a role in the development of Post-Traumatic Stress Disorder in emergency room nurses at 15 Flemish general hospitals. The results showed that one in four nurses exceeded the sub-clinical cut-off for Post-Traumatic Stress Disorder. (28) (29) Even though the symptoms can be almost the same, Secondary Traumatic Stress will be experienced by secondary exposure to trauma while Post-Traumatic Stress Disorder is a disorder caused by direct confrontation with a traumatic event. The participants in this study were not exposed directly to trauma in the way that emergency personnel are. Another recent study was done on the prevalence of burnout in Belgian health professionals and discovered that 6% exceeded the threshold in three burnout dimensions (i.e. emotional exhaustion, depersonalization and personal

competence) and 13% in at least two. (30) Because burnout can also co-occur with and even lead to Secondary Traumatic Stress, prevention and possible treatment of both ailments should be of high concern to health authorities. (10) (31) (32)

The participants in our study suggested a lot of improvements in the monitoring of a hunger strike with special attention to interventions that can prevent Secondary Traumatic Stress : multidisciplinary, the presence of a psychologist, weekly meetings and a final evaluation. To our knowledge, information about Secondary Traumatic Stress is not part of formal medical education, but health professionals should be made aware of the possibility, risk factors and first signs of Secondary Traumatic Stress. (33) (34) The risks of health professionals being exposed to traumatised patients cannot be underestimated.

The strength of this study is that for the first time health professionals have been able to express and share their experiences after the monitoring of a hunger strike in non-custodial setting. This study also disclosed the vulnerability of health professionals and the importance of trauma education in the curriculum. Its weaknesses are that only a small sample of persons participated and that no validated inventory tests or checklists were used to quantify the psychological distress and somatic complaints of the participants. This would have added to the scientific value of this study.

## **Conclusion**

During the medical monitoring of a hunger strike of undocumented migrant workers in Brussels, young, inexperienced, committed health professionals were exposed to many ethical dilemmas. This changed their overall view of being a health professional and triggered their concepts of trust in the relationship with a patient, the implication of social determinants of health and their social commitment. Confronted with the hardship of undocumented people's daily living conditions, some developed symptoms of Secondary Traumatic Stress (re-experiencing, avoidance behaviour). Close monitoring and evaluation of the medical team is needed to detect and treat these symptoms. Because all caregivers can be exposed to traumatised patients, their formal education should include information on the development of Secondary Traumatic Stress and how to prevent it.

## **Declarations**

### ***Ethics approval and consent to participate***

The study was approved by the Medical Ethics Committee UZ Brussel[s] - VUB (B.U.N. 143201940934)

### ***Consent for publication***

All participants filled in and signed a consent form, and no participants received financial incentives.

### ***Availability of data and materials***

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

### ***Competing interests***

The authors declare that they have no competing interests.

### ***Funding***

No funding was received for this research.

### ***Authors' contributions***

RV conducted the focus groups, analysed and interpreted the data in Nvivo and wrote the first draft of the manuscript. FL, DD and JV contributed to the following drafts. All authors read and approved the final manuscript.

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