

HEALTH LAW, ETHICS, AND HUMAN RIGHTS

Hunger Strikes at Guantanamo — Medical Ethics and Human Rights in a “Legal Black Hole”

George J. Annas, J.D., M.P.H.

Being Human, a collection of readings assembled by President George W. Bush’s Council on Bioethics, contains a powerful description of the force-feeding of Soviet political prisoner Vladimir Bukovsky, who was on a hunger strike to protest the refusal of prison authorities to provide a lawyer for a fellow inmate who was awaiting trial:

They started feeding me forcibly through the nostril. By a rather thick rubber tube with a metal end on it. . . . The procedure will be that four or five KGB guys will come to my cell, take me to a medical unit, put a straitjacket on me, tie me up to a table, and somebody will be still holding, even so I was tied down, holding my shoulders and head and legs, and one will be pushing this thing through my nostril. . . . It’s painful like hell I must tell you, because for some reason nose is very sensitive part of body and the tears will be filling your eyes and sort of streaming down because it’s so painful, and — awful thing.¹

This procedure was repeated daily for 12 days. Any participation by physicians in this force-feeding in the prison’s “medical unit” would almost certainly have been condemned by the Council on Bioethics. Of course, it is easy to condemn the brutal actions of Soviet-era jailers against political dissidents. It is much more difficult to address the acts of our own country, especially acts, different only in the degree, that have been used by U.S. military physicians against hunger strikers at Guantanamo Bay, Cuba.^{2,3}

On September 11, 2005, 131 prisoners at Guantanamo were on hunger strikes. At the end of 2005, that number was 84.² In January 2006, a new technique was introduced in the prison camp to break the hunger strike: the use of an “emer-

gency restraint chair.” The chair is described by its inventor, a former sheriff whose jailer had been injured by a prisoner, as a “padded cell on wheels.”⁴ His company has shipped 25 such chairs to Guantanamo. The prisoner can be strapped into one of them in six-point restraints, including not just the hands and feet, but also the head and torso, and safely transported to a medical care facility. The chair was not designed for either treatment or punishment. Nonetheless, at Guantanamo, beginning in early 2006, these chairs were being used to immobilize prisoners on hunger strikes and force-feed them. And it succeeded. As of February 22, 2006, reportedly only three detainees were still being force-fed in the restraint chairs, and in June 2006 that number remained the same.³

The medical records of the Guantanamo prisoners who have been force-fed in the restraint chairs, some of which have been introduced into evidence in pending lawsuits to enjoin further use of the chairs, contain what appears to be a preprinted “medical officer note” that is in many ways as chilling as Bukovsky’s description of his own force-feeding, especially because it reflects the detached clinical viewpoint of the physicians instead of the viewpoint of the prisoner:

Despite being advised that hunger striking is detrimental to his health, the detainee refuses to eat. Restraints were ordered for medical necessity to facilitate feeding the detainee. There is no evidence that medications or a medical process is causing this detainee’s refusal to eat. Detainee does not have any medical condition/disability that would place him at greater risk during feeding using medical restraints. Detainee was told that he will remain in restraints until feed and postfeed observation time (60–120 minutes) is completed. Detainee under-

stands that if he eats, that involuntary feeding in medical restraints will no longer be required.

GITMO Dr. _____

The medical records of 20-year-old Guantanamo prisoner Yousif Al-Shehri, for example, contain this identical entry twice a day for 8 consecutive days from January 18 to January 25, 2006, after which his records indicate that he ended his hunger strike and became “compliant.” The name of the physician who signed the orders has been redacted.

Force-feeding by physicians of competent prisoners on hunger strikes is widely condemned as being both illegal and unethical.⁵ But some controversies persist, most of which are related to the assessment of the prisoner’s competence and motivation, as well as the probable effect of a successful hunger strike on prison security.

THE GUANTANAMO HUNGER STRIKES

Various types of hunger strikes have been occurring at Guantanamo almost since it became an interrogation center for terrorist suspects in early 2002.⁶ As many as 200 prisoners have been on hunger strikes at once, and there were probably about 100 on hunger strikes in November 2005, when Secretary of Defense Donald Rumsfeld was asked, “Do you approve of the force-feeding of detainees [at Guantanamo] who are on hunger strike?” He replied, “I’m not a doctor and I’m not the kind of a person who would be in a position to approve or disapprove. . . . The responsible people are the combatant commanders.”⁷ In short, the policy of the Department of Defense is that the decision whether or not to force-feed a prisoner at Guantanamo is a military one to be made by the base commander; the decision about how to actually force-feed a prisoner is a medical one to be made by military physicians.

The use of physicians to aggressively break a prison hunger strike raises complex medical ethics and legal issues that have been the subject of international debate for decades. U.S. courts have occasionally been asked to rule on the legality of force-feeding prisoners, and they have usually permitted it if done by a physician in a medically reasonable manner for the primary purpose of either preventing suicide or maintaining order in the prison.⁸⁻¹² I have written about hunger strikes

a number of times and in 1982 concluded, “We restrict the rights of prisoners in many ways. Force-feeding them rather than permitting them to starve themselves to death is probably one of the most benign.”¹² This is also the position the Department of Defense takes on the Guantanamo hunger strikes. As the most senior civilian physician in the Pentagon, William Winkenwerder, Jr., said in response to questions about breaking the most recent Guantanamo hunger strike, “There is a moral question. Do you allow a person to commit suicide? Or do you take steps to protect their health and preserve their life?”^{2,13}

But both my 1982 position and Winkenwerder’s 2006 position seem overly simplistic and mechanistic in the context of Guantanamo, and I grossly underestimated the pain and medical complications force-feeding can impose on a competent prisoner. Physicians must answer three related questions to determine their legal and ethical obligations to hunger strikers in prison: Is the prisoner on a hunger strike? When is it ethical for a physician to force-feed a hunger striker? And what means can be used by a physician to force-feed a hunger striker?

WHAT IS A HUNGER STRIKE?

Hunger strikes in prison are dangerous for both prisoners and jailers, but they are often the only way, or the last resort, for prisoners to protest the conditions of their confinement. Hunger strikes in prison can result in death when the government refuses to either negotiate or force-feed; this happened to members of the Irish Republican Army who went on a hunger strike in the Maze Prison in the early 1980s and to hunger strikers in Turkish prisons in 1996 and from 2000 to 2003.¹⁴

Hernan Reyes of the International Committee of the Red Cross has written the most authoritative article on hunger strikes, which he also terms “voluntary total fasting.”¹⁵ According to Reyes, fasting, voluntariness, and a stated purpose are all needed before a prisoner can be said to be on a hunger strike. Simply refusing to eat as a reaction to a specific situation, whether in frustration or anger, for example, does not qualify as a hunger strike. Thus, the initial rounds of fasting at Guantanamo in early 2002 in response to specific actions of the guards toward individual prisoners do not count.⁶ Nor do prisoners who refuse to eat as a result of severe depression or other mental illness, and with no goal in mind other

than their own death, qualify as legitimate hunger strikers.

The determination to fast until either political demands are met or death occurs may vary from person to person. This is especially true when fasting occurs in groups, since members of the group may be less free to break the fast; peer pressure must be taken into account by physicians when deciding whether prisoner-patient is voluntarily continuing to refuse food.^{14,15} The determination of the hunger striker will also suggest the likely medical consequences of continuing the hunger strike. Most hunger strikers, for example, have taken some water, salt, sugar, and vitamin B₁ at least for a time before asserting an intention to fast to death.¹⁴ Physicians should inform hunger strikers that intake of these nutrients considerably decreases the chances of permanent disability should the strike end before death (which is never the desired end point of a true hunger striker).

In its Declaration of Tokyo, the World Medical Association ruled out physician participation in the force-feeding of prisoners. Nonetheless, its more specific Declaration of Malta (Declaration on Hunger Strikers) permits physicians to attend to a prison hunger striker in the context of a traditional physician-patient relationship if consent and confidentiality can be maintained. As compared with the International Committee of the Red Cross's definition, the World Medical Association's definition of a hunger striker is much broader in that it does not require a specific goal: "A hunger striker is a mentally competent person who has indicated that he has decided to embark on a hunger strike and has refused to take food and/or fluids for a significant interval."¹⁶

SHOULD PHYSICIANS PARTICIPATE IN FORCE-FEEDING HUNGER STRIKERS AT GUANTANAMO?

It is a violation of medical ethics for military physicians to treat competent patients against their will solely for military or political purposes or for punishment. The Department of Defense seems to understand this, and so it has publicly relied on two basic rationales for ordering military physicians to force-feed prisoners: it is in the best medical interest of prisoners, and it is done in accordance with regulations issued by the Department of Justice's Bureau of Prisons regarding hunger strikes in federal prisons.¹³

Both arguments seem reasonable, but neither fits the facts at Guantanamo. The first — that force-feeding is in the best medical interests of prisoners — is acceptable if it applies only to prisoners who are not actually on hunger strikes (as defined by the International Committee of the Red Cross), but rather have stopped eating because of a mental illness such as depression and can reasonably be declared incompetent to refuse treatment, including force-feeding, if and when such feeding is necessary to sustain their lives or health. So to the extent that an individual competency assessment has been properly conducted and the prisoner is found to fit into this category, force-feeding is medically indicated. This category is not likely to apply to many prisoners at Guantanamo, however. As Major General Jay W. Hood, the camp's commander, told a group of visiting physicians in the fall of 2005, the prisoners at Guantanamo are protesting their confinement; they are not suicidal.¹⁷

The second argument — that force-feeding is in accordance with regulations by the Bureau of Prisons regarding hunger strikes — requires a closer examination of these regulations.¹⁸ They are triggered when the person on a hunger strike "communicates that fact to staff and is observed by staff to be refraining from eating for a period of time, ordinarily in excess of 72 hours." On referral for medical evaluation, the inmate shall undergo a medical and psychiatric examination and be placed "in a medically appropriate locked room for close monitoring" (if necessary to accurately measure food and fluid intake and output). There, his or her weight and vital signs are to be checked at least every 24 hours.¹⁸ If and when the physician determines "that the inmate's life or health will be threatened if treatment is not initiated immediately," the physician shall make "reasonable efforts to convince the inmate to voluntarily accept treatment," including explaining the risks of refusing, and shall document these efforts. After such efforts (or in an emergency), if "a medical necessity for immediate treatment of a life- or health-threatening situation exists, the physician may order that treatment be administered without the consent of the inmate."¹⁸

Whether or not one thinks these are reasonable regulations, only a physician (not the warden) is permitted to make treatment decisions on the basis of them, and then only after rea-

sonable attempts to obtain voluntary compliance. To the extent that military commanders are making the decisions about force-feeding, the rules of the Bureau of Prisons are not being followed at Guantanamo. This may be why the immediate past commander of the medical group responsible for prisoner health care, Navy Captain John S. Edmondson, said that military health care personnel are screened before they are deployed to Guantanamo “to ensure that they do not have ethical objections to assisted feeding.”¹⁷ In addition, according to the rules of the Bureau of Prisons, 72 hours of fasting triggers a medical evaluation — it does not trigger emergency force-feeding, which generally occurs after weeks, if not months, of continuous fasting.¹⁸

U.S. courts have generally upheld actions like those authorized by the Bureau of Prisons at least as long as the actual force-feeding (misleadingly described as “assisted feeding”) is performed by a physician in accordance with good and accepted medical procedures and the prisoner is either suicidal or the treatment refusal presents a considerable security problem for the entire prison. In terms of U.S. constitutional law, competent prisoners have a right to refuse treatment, but prison officials may overrule it when they have a “legitimate penological interest,” which includes preventing suicide among prisoners and maintaining order in the prison itself.¹⁹ Of course, the major difference is that federal prisoners have access to lawyers, U.S. courts, and independent physicians to challenge treatments they believe are abusive.

MEDICAL MEANS TO FORCE-FEED HUNGER STRIKERS

The much more complex question concerning medical ethics is what a physician should do after a competent hunger striker becomes incompetent and it reasonably appears that he or she will die or sustain permanent injury without food, and there is no reasonable possibility that his or her demands will be met. Two positions have been articulated, neither of which is terribly persuasive. The World Medical Association holds that “when the hunger striker has become confused and is therefore unable to make an unimpaired decision or has lapsed into a coma, the doctor shall be free to make the decision for his patient as to further treatment which he considers to be in the best interest of that patient.”¹⁶ The World Medical Association nonetheless requires the physician to hon-

or the patient-prisoner’s previous decision to fast to the death unless the physician has informed the prisoner of his or her inability to honor this wish and can engage another attending physician for the prisoner.¹⁶ The Declaration of Malta has been described as “wholly inadequate” because of the discretion it allows physicians.²⁰

As compared with the World Medical Association’s statement, the position of the Royal Dutch Medical Association, drafted in response to hunger strikes by Vietnamese asylum seekers, is more specific and less ambiguous. It suggests that hunger strikers should have access to a “doctor of confidence” who will act as their physician and keep them fully informed of the medical consequences of the hunger strike, but also follow their wishes of nontreatment in case they become incompetent or comatose.²¹ To reduce uncertainty in the case of incompetence, the Dutch guidelines call for hunger strikers to sign a specific “statement of nonintervention” (similar to a living will) that directs their care and rules out artificial or forced feeding. This written statement is not to be made public unless and until the prisoner-patient actually becomes incompetent. Of course, it would be nice if all prisoners had access to independent physicians, whether they are called doctors of confidence or not. The major problem at Guantanamo, however, is precisely that the only physicians any prisoner has access to are the military physicians at the base. Moreover, the solution of a living will is no solution at all, since it suggests that the prisoner might have made confidential arrangements with the physician to “save” him or her before he or she dies or suffers serious harm, and so undercuts the power of the hunger strike itself.^{22,23}

U.S. military officials have said that they will not permit anyone at Guantanamo to “fast to death” because of the likely consequences concerning international propaganda, which could pose a global security risk. Since the first three suicides by hanging at Guantanamo in June 2006, however, this rationale is less persuasive. All three of these prisoners had been hunger strikers at one time or another, and at least one of them, Ali Abdullah Ahmed, had been repeatedly subjected to the emergency restraint chair. Dr. Winkenwerder’s position that the military can rewrite the Declaration of Malta to permit earlier intervention because it “only makes good sense” to force-feed hunger strikers before they become

incompetent or are “near death” is also not persuasive.²⁴

Prevention of the deaths of incompetent prisoners is a laudable medical goal. The use of emergency restraint chairs for force-feeding, however, can never be ethically, legally, or medically justified — even in the case of an incompetent suicidal prisoner whose competence was determined by a qualified psychiatrist. A prisoner who needs to be forcibly restrained in this device for force-feeding is almost certainly strong enough to be in little or no health danger from continuing a fast. The primary justification for the use of this device for force-feeding seems to be punishment rather than medical care.^{2,3} The use of any medical intervention as punishment is prohibited by all relevant international treaties, principles of medical ethics, and U.S. constitutional law.^{25,26} The restraint chair is the functional equivalent of the Soviet straitjacket. Use of the restraint chair for “postfeed observation” during which the prisoner must urinate and defecate on himself or herself seems designed more for humiliation and subjugation than for medical treatment.

MEDICAL ETHICS AT GUANTANAMO

There seems to be real tension between the physicians at Guantanamo, most of whom are under the command of the Navy at the hospital, and the Army commanders who are in charge of the prisoners and their interrogations. It is often argued that a physician in the military should rarely have to decide whether to be a military officer first and a physician second or a physician first and a military officer second.²⁷ At Guantanamo, however, the choice is stark. Military physicians cannot follow military orders to force-feed competent prisoners without violating basic precepts of medical ethics never to harm them by means of their medical knowledge. New medical instructions from the Department of Defense, dated June 6, 2006, acknowledge that involuntary treatment should be preceded by “a thorough medical and mental health evaluation of the detainee and counseling concerning the risks of refusing treatment” and that any treatment should be “carried out in a medically appropriate manner.” These instructions would rule out the use of emergency restraint chairs, but nonetheless continue to permit force-feeding of mentally competent prisoners.^{13,24}

Guantanamo has been called a “gulag,” an

“anomaly,” “the legal equivalent of outer space,” and a “legal black hole.” The Supreme Court ruled in *Hamdan v. Rumsfeld* in June 2006 that the Geneva Conventions have full force in Guantanamo as a matter of both U.S. and international law.²⁸ This ruling reversed the Bush Administration’s policy on Guantanamo and has been widely hailed, especially by military lawyers. The Court also ruled that Geneva’s Common Article 3 applies to all prisoners in custody. This article not only bans the use of tribunals that are not “regularly constituted” (the issue in *Hamdan*), but also requires all prisoners to be “treated humanely” and explicitly prohibits “cruel treatment and torture” as well as “outrages upon personal dignity, in particular, humiliating and degrading treatment.” Four of the justices also ruled that the protocols to the Geneva Conventions, although not ratified by the United States, are binding international laws. This is important, since the protocols specifically prohibit interference with actions by physicians that are consistent with medical ethics. Treatment of incompetent hunger strikers in prison remains complex. Use of the restraint chairs to break a hunger strike by a competent prisoner, however, is a violation of both medical ethics and of Common Article 3 of the Geneva Conventions, which after *Hamdan* all Department of Defense personnel have been ordered to follow.²⁹

Force-feeding at Guantanamo and the *Hamdan* opinion provide the opportunity for the U.S. military to adopt as formal military doctrine the rule that a physician in the military is always a physician first and a military officer second. They also provide the President’s Council on Bioethics with an opportunity to take a position on one of the most important international bioethics issues of our day. American military physicians always have the obligation to disobey an unlawful order and the option to disobey an order that is contrary to medical ethics, but the “physician first” doctrine would make it much less likely that any such orders would be issued in the first place.

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From the Department of Health Law, Bioethics, and Human Rights, Boston University School of Public Health, Boston.

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