I’d like to thank the Institute of Medicine for holding this important discussion, and to particularly thank three people. First, Dr. Ward Casscells, who is not only committed to ethics and human rights, but is gracious and open in discussions with those of our outside the Pentagon, second, Professor George Annas, who was the driving force behind holding the workshop; and third, General Stephen Xenakis, MD (Ret), who has taught me so much about the clinical issues involved.

At first blush, the medical response to hunger strikes by security detainees poses the classic dilemma of clashing moral principles, autonomy and beneficence. While important, this approach oversimplifies the issue because of environments in which these decisions take place are often fraught with violations of detainee human rights that affect both the process of clinical decision-making and should affect the physician’s decision on the appropriate ethical response. I’d like to consider three questions:

• First, whether command directives on decisions to force feed implicate detainee human rights;
• Second, whether the physician has an obligation to inquire into and take affirmative steps to ameliorate human rights violations that may have led to the detainee’s decision to engage in a hunger strike;
• Third, whether a physician can ethically force feed if there is reason to believe the detainee’s hunger strike is indeed a result of human rights violations.

Let’s look first at command directives. The expectation that physicians exercise independent medical judgment is woven into the fabric of medical professionalism. But it is also the case that governments often seek to enlist or even coerce physicians to tailor their judgments and interventions in a manner that violates human rights, for example, to conceal the existence of torture or to deny women access to reproductive health information. The risks are particularly high in closed settings like prisons. As a result of this dual loyalty problem both the Geneva Conventions and human rights law require protection of clinical independence.

The case study today provides a classic case example: the physician’s decision to force feed is mandated not by clinical judgment but by command judgments about national security. Instead, the physician is told, "do whatever is necessary to bring this to an end." This means that fundamental human rights including rights to autonomy, to protest claimed abridgements of rights, and to appropriate health services in prison are not only at stake, but the physician is denied any opportunity to consider them.

One can imagine a harder case, where a clinical decision is not so obviously dictated – signals and pressures if you will rather than orders – or where the physician is asked to
balance security considerations against medical ones. Aside from physicians’ lack of competence to engage in such balancing, in such case non-clinical factors are being taken into account in circumstances where the human rights consequences for the detainee are enormous. This doesn’t mean that social interests – including non-clinical interest – can never prevail over patient interests, as in the case of mandatory reporting of child abuse by a patient, but as recommended by the International Dual Loyalty Working Group, exceptions to patient loyalty should be determined by standard-setting authority competent to define human rights obligations of a health professional.

The remaining two questions concern the physician’s obligation to inquire into and if necessary, ameliorate human rights violations that lead to the hunger strike; and whether, if human rights violations occurred, the physicians may ethically force feed. To provide proper context to answer these questions, we need to contextualize and deepen the case example, and I propose the following hypothetical, recognizing of course that we’re not here to discuss practices and conditions at Guantanamo Bay or other US-operated detention facilities. The hypothetical is based on a clinical interview and medical record review by Physicians for Human Rights, and described in a report we issued in June, and based on practices in the period 2002-2004.

Let’s assume first, that pursuant to standard operating procedure manual at Guantanamo in effect at least through 2004, that a detainee is kept in isolation for his first thirty days in order “to enhance and exploit the disorientation and disorganization felt by a newly arrived detainee in the interrogation process.” Let’s assume, second, as is well documented, that during lengthy interrogations, the detainee is painfully shackled to the floor. Let’s assume, third, that the detainee is subjected to the so-called frequent-flyer program that moved detainees frequently to keep them awake. Fourth, let’s assume that after a month the detainee exhibits bizarre psychotic symptoms, repeatedly attempts suicide complains of being tortured, and is treated with sedatives, anti-depressants and neuroleptics. Finally, let’s assume after three months he starts a hunger strike.

The first obligation of the physician asked to force feed, I think we can agree, is a medical one, to do a thorough assessment, in which these facts are elicited. I think it is increasingly clear that, upon learning of this abuse, physicians have a duty to take steps to stop it. This is usually expressed as a duty to report, contained in World Medical Association guidelines – both Malta and in the Declaration of Tokyo, concerning physicians and torture -- UN minimum standards for the treatment of prisoners and by the Defense Department itself. DoD’s guidelines are inadequate, though, because the obligation is only to report, not to inquire, and also limited to what are described as “violations of applicable standards,” and in the hypothetical, the use of isolation to disorient and disorganize the detainee was within standards.

There question of the scope of the duty to go beyond reporting to amelioration is unclear. In civilian life, physicians often have duties to report, for example, that a child is at risk of eating lead paint, but no corresponding obligation to assure that it is removed from the child’s home. But in a closed environment, I would argue for a higher standard, especially where the clinical interventions themselves are constrained by the abuses. For
example, suppose in my hypothetical the physician concludes that the detainee’s isolation is contributing to his decompensation but cannot influence the decision to end the isolation. I think the case for affirmative steps to stop ill treatment is strong.

This analysis also suggests an answer to the last question. It is well-recognized that a physician may not use his skills and knowledge to enable, advance, or permit torture or cruel treatment. In the hypothetical the patient has endured torture and other forms of cruel, inhuman and degrading treatment, and force feeding amounts to abetting and even facilitating it: instead of responding to ill treatment, the physician contributes to its continuation. The situation can perhaps be analogized to a physician called upon to provide treatment to a prisoner who is semi-conscious as a result of a beating, apparently dehydrated and shackled in his cell. The physician’s duty in such a case is to demand that the authorities remove the shackles and put the patient in a medical setting where he can proper treatment. If authorities decline, I think there is general agreement that the physician must refuse to participate in what amounts to a charade of medical treatment. It is a form, if you will, of ethically required conscientious objection, not to be used as a pawn in a regime of torture and ill-treatment. Similarly here, the physician should essentially refuse force feeding – not because of autonomy but because of an obligation not to advance torture and ill-treatment.

One final word. The case example assumes, as most ethical problems do, that the physician is expected to resolve these questions on his or her own. But in environments of security detention and other circumstances fraught with the potential for abuse, that is unrealistic and unfair to the physicians and to detainees. Physicians should not be expected to be heroic in the face of relentless pressure to conform, and so mechanisms should be in place to guarantee independence, recourse, and support. The responsibility falls in the first instance on the Department of Defense but also on the medical community more generally so colleagues are in a position to engage in ethical behavior in very difficult circumstances.