The challenge of hunger strikes and the risk of medical complicity in abuse and torture in U.S. detention facilities.

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Hunger strikes have posed a major challenge to health professionals charged with detainee care in U.S. detention facilities. According to press reports, in 2005, at least 131 detainees staged hunger strikes, and in 2006, the number was at least 86. These reports represent the low end, as accurate data about the number of hunger strikes are hard to come by.

The response to these hunger strikes has been concerning. The press has reported force feedings that were undertaken early on in the strike where there was likely no legitimate medical justification in an effort to "break the strike," a significant violation of medical ethics and basic human rights. Prolonged force-feeding of individual strikers continues to this day. Forced feeding may involve physically restraining the detainee in a chair and passing a nasogastric tube through the nose and esophagus into the stomach. This is an uncomfortable procedure in the case of informed consent. It is potentially psychologically traumatizing when done against the will of the patient.

The most widely accepted medical ethical guidelines on hunger strikes are the World Medical Associations Declaration, which has been adopted by the American Medical Association. According to that guideline, force-feeding of a competent and informed

patient is never justifiable, as autonomy of the patient to consent to an invasive medical procedure trumps the duty to preserve life at all costs.

The issue of possible medical complicity in human rights violations of detainees is deeply disturbing and provocative. For anyone familiar with the professionalism of military medicine, it seems unlikely if not downright impossible that U.S. military health professionals would ever engage in violations of detainees' rights, directly or indirectly. In discussing the problems surrounding the management of hunger strikes in U.S. detention facilities such as those at Guantanamo, I hope to shed some light on how good doctors come to do bad things.

First, while doctors should be more ethical than most people, the fact is that they are as vulnerable as anyone else to rationale for abandoning professional ethics. This is particularly true in settings where a competing loyalty, such as loyalty to the security or military mission comes into conflict with medical professional ethics and standards. This phenomenon is known as dual loyalty.

Doctors are also vulnerable to the rationalization of "exceptionalism," or the notion that the current challenges in this war make traditional medical ethics "quaint," or no longer relevant or applicable. In fact, medical ethics in the military tradition were developed exactly to prevent this kind of abuse. Possible and imminent threat, potentially catastrophic, is not new to the theatre of war or the tradition of military medicine, and

such threats do not change the fundamental responsibility of the physician to respect the autonomy and human dignity of his or her patient.

While we can certainly discuss the conflict between the duty to preserve life versus the duty of honor an informed and competent refusal of an invasive medical procedure, even when death may result, I'd like to broaden the discussion to address the context of the hunger strike.

As a former prison doctor and medical director, I am often asked what parallels exist in correctional medicine for the management of hunger strikers. While there are many parallels, it may be more important here to highlight fundamental differences.

In U.S. jails and prisons, inmates have access to many alternative means of addressing legitimate complaints, such as grievance procedures, access to their lawyers, family, the courts, and the press. In addition, continuous outside review of conditions in facilities by the public, advocates, legislative bodies and most importantly the courts lead to facilities that are less likely to violate constitutionally guaranteed rights such as habeas corpus and violations of cruel and unusual punishments.

Detention settings that do not respect human dignity raise the risk of hunger strikes and complicate their successful resolution.

The lack of such protections and alternative means of resolution of legitimate disputes in U.S. detention facilities such as Guantanamo is the faulty foundation that actually sets the stage for 1) more hunger strikes and 2) hunger strikes that are clinically more difficult resolve the strike without the use of force. In other words, it is the very structure and flawed design of the facilities that set the stage for human rights violations and place health professionals at high risk of facing dual loyalty conflicts that can result in medical complicity in abuse or torture.

There are other barriers to the successful resolution of hunger strikes in these settings that result from both the context and from flawed policy. They include:

1. Failure to respect the patient's autonomy to make an informed refusal.

This is the fundamental flaw of the hunger strike protocols employed by DoD. They require health professionals to engage in an invasive medical procedure in the face of an informed refusal of a competent patient. This is in direct conflict with widely accepted medical ethics as articulated by the World Medical Association and adopted by the American Medical Association.

[Consent: exam or assault?]

2. Lack of doctor-patient trust and clinical autonomy.

It is virtually impossible for a physician to perform his or her duty in the absence of trust between the doctor and the patient. In detention settings this challenge is great under the best of circumstances. The extent to which the doctor can gain the trust of the patient is directly proportional to the level of autonomy the physician has from the non-medical chain of command. Physicians seen by the patients a subordinate to the security staff are less likely to be trusted. Physicians who act against the patient's interests will not be trusted at all.

Press reports have described simultaneous forced feeding of groups of hunger strikers in order to "break the strike." This is a complete violation of medical autonomy, consent issues aside. Care must be individualized and be motivated by the interests of the patient, and directed by a clinician. Use of physicians or other health personnel to force-feed detainees in order to maintain order is asking health professionals to participate in an assault on their patients and irreparably damages the foundation of trust.

3. Lack independent review and care options outside the chain of command.

The lack of outside consultation and review by clinicians removed from the chain of command further complicates the clinician's task. This robs the clinician of key tools that can be used to develop trust and provide non-confrontational alternatives to resolution of the strike. It also robs the process of legitimacy and integrity.

Summary

Forced feeding without consent is simply one example of the risk of medical complicity in torture. In settings where basic human rights and dignity are not protected, it is difficult for doctors, caring professionals who are in the human dignity business, to do their job in a manner that is consistent with professional values and ethics.

Current detainee policies and practices are problematic because they place physicians and other health professionals in high-risk settings where they often must choose between respecting the rights of their patients and loyalty to command. In this environment, even the best physicians are at risk of compromising their ethics and allowing abuse and even torture to occur. In some cases, health professionals themselves may even play an active role in patient abuse and torture.

While the hunger strike policies and procedures of the DoD could be greatly improved, in facilities where basic human rights are not respected, doctors, no matter how decent, cannot resolve the problem of hunger strikes by clinical interventions alone. Without respect for basic human rights, the ethical practice of medicine is impossible.