SPECIAL REPORT

Hunger Strikers: Ethical and Legal Dimensions of Medical Complicity in Torture at Guantanamo Bay

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Abbreviations:
AMA: American Medical Association
BOP: US Federal Bureau of Prisons
DoD: Department of Defense
EMT: Emergency Medical Technician
GTMO: Guantanamo Bay detention camp
SOP: standard operating procedure
WMA: World Medical Association
UCMJ: Uniform Code of Military Justice

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Abstract:
Physicians and other licensed health professionals are involved in force-feeding prisoners on hunger strike at the US Naval Base at Guantanamo Bay (GTMO), Cuba, the detention center established to hold individuals captured and suspected of being terrorists in the wake of September 11, 2001. The force-feeding of competent hunger strikers violates medical ethics and constitutes medical complicity in torture. Given the failure of civilian and military law to end the practice, the medical profession must exert policy and regulatory pressure to bring the policy and operations of the US Department of Defense into compliance with established ethical standards. Physicians, other health professionals, and organized medicine must appeal to civilian state oversight bodies and federal regulators of medical science to revoke the licenses of health professionals who have committed prisoner abuses at GTMO.

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Introduction

Each hunger strike event presents unique ethical, legal, political, and clinical management issues. The situation at the US Naval Base at Guantanamo Bay (GTMO), Cuba,* stands out for the extent to which national security concerns have overtaken, distorted, and compromised medical ethics. In the wake of September 11, 2001 and the US invasion of Afghanistan, the US military and other federal services embarked on harsh interrogation of prisoners at Bagram Theatre Internment Facility in Afghanistan, Guantanamo Bay Naval Base in Cuba, and Abu Ghraib and other military prisons in Iraq.

Guantanamo Bay detention camp was established in 2002 as a detention center to hold individuals captured and suspected of being terrorists. While a small number of prisoners were prosecuted by military commission, most were held at length for intelligence purposes and subjected to very harsh interrogation techniques.[1] Over 500 prisoners were released under President Bush,[2] with 242 remaining at the start of the Obama Presidency.[3] The detention camp currently holds 166 prisoners, of whom 86 have been approved for release.[4]

In the past decade, hundreds of prisoners at GTMO have gone on hunger strikes "to protest their indefinite detention without legal process and inhumane treatment."[5] Public outcry over force-feeding first emerged in 2005, when it was confirmed that military physicians were involved in tube feeding prisoners against their will.[1] The most recent hunger strike began in February 2013 and involved over 100 prisoners in July 2013.

By August 2013, 44 of the 66 remaining hunger strikers were being force-fed via nasogastric tube.[4,6] The Department of Defense (DoD) justifies the procedure, euphemistically labeled "involuntary enteral feeding," on the basis of protecting, preserving, and promoting life. Force-feeding at GTMO begins upon initiation of the Base Commander after the prisoner has missed nine consecutive meals. Under current DoD policy, the process involves medical personnel physically restraining the prisoner to a

* Guantanamo Bay (GTMO) describes the Naval Base, including the detention center and the hospital.

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chair, snaking a nasogastric tube through the nose into the stomach, and supervising the daily continuous feeding or multiple 2-hour feedings.[7]

The force-feeding of competent hunger strikers is a gross violation of medical ethics explicitly prohibited by the World Medical Association (WMA), the American Medical Association (AMA), and other leading medical ethics authorities.[8-12] It is also implicitly prohibited by ethical codes requiring health professionals "to do good, and not harm, to patients; to respect patients' autonomy and not impose treatments without their consent; and to safeguard their confidences."[1,13] As Annas et al note, "[h]unger striking is a peaceful political activity to protest terms of detention or prison conditions; it is not a medical condition".[14] The current GTMO policy of force-feeding overrides the competent judgment of prisoners engaged in protest. Furthermore, the policy assigns the decision to begin force-feeding to the Base Commander,[7] replacing physician autonomy with the political judgment of custodial authorities.

This article uses the terms health and medical professionals, personnel, and providers to encompass any licensed health professionals involved in force-feeding at GTMO. This includes physicians, nurses, physician assistants, paramedics, Emergency Medical Technicians (EMTs), and any civilian-trained military personnel termed medics or corpsmen who have sworn to uphold a professional code of medical ethics. While it remains unclear whether the medics/corpsmen involved in force-feeding have received any formal medical training outside the military system, those who do hold civilian licensure are required to practice in accordance with medical ethics and are subject to the civilian sanctions invoked in this article.

GTMO's force-feeding procedure has also been recognized as a human rights violation potentially constituting torture,[15-17] prohibited by international human rights treaties to which the United States is a signatory.[18,19] International opinion on the general legality of involuntary feeding is mixed, permitting the practice in some circumstances and prohibiting it in others. Yet where the issue has been adjudicated under international and regional law, courts have generally rejected the position that force-feeding a hunger striking prisoner against his or her will is permissible if done in a cruel, inhuman, or degrading manner—such as with excessive force, without medical justification, without ethical safeguards, or with unnecessary pain and humiliation.[10-22] The force-feeding procedures currently in use at GTMO are a clear violation of such standards.

Despite this international context of legal and normative prohibition, the United States continues to force-feed prisoners at GTMO with impunity, in part because the practice often carries the weight of US law. United States courts have thus far declined to interfere with GTMO medical policy on jurisdictional grounds.[17,23] State licensing bodies charged with physician oversight have avoided taking definitive action and thus remained effectively silent.[24] The practice of force-feeding has been ratified by the US military through a longstanding and extraordinary policy of vetting physicians and other health professionals assigned to GTMO.[25,26] This has the effect of proscribing these vetted providers from acting on independent ethical judgment and of closing all possible avenues for individual protest.[27]

In requiring medical direction of and participation in force-feeding at GTMO, the military authority establishes for military physicians a legal duty to carry out a practice that is manifestly unethical and departs in significant ways from federal correctional guidelines.[2,27] Despite mounting evidence that force-feeding is an inhumane and counterproductive response to hunger strikes,[28] neither the civilian nor military legal systems have prohibited the practice or punished the physicians involved. Without a change in DoD law and policy, the only option available to stop force-feeding at GTMO is civilian regulation of military health professionals, particularly physicians. The medical community must advocate forcefully to change GTMO policy and to mobilize state licensing bodies and federal regulators of medical science to revoke licenses for those health professionals who now comply with "lawful" (by DoD military policy) but unethical practice.

Ethical Violations and GTMO Policy

Dual Loyalty Conflicts

By definition, a hunger striker is a competent individual who refuses food on a voluntary, informed basis and without suicidal intent, with all preconditions confirmed by an evaluating physician.[9] It is important to distinguish force-feeding from artificial feeding. Artificial feeding involves the intravenous or nasogastric administration of nutrients and liquid, abides by the informed consent of the competent patient or his or her designated health care proxy, and does not involve coercion. Force-feeding, by contrast, involves the use of force and physical restraints to immobilize the hunger striker against his or her expressed wishes.[29] It is inherently coercive and constitutes battery.[30]

The ethical codes of any civilian-trained and civilian-licensed health professionals involved in force-feeding privilege patient autonomy and dignity,[31-35] including patients who are prisoners.[13,36] The WMA's Declaration of Malta in particular prohibits any physician participation in the force-feeding of hunger strikers.[9] A secondary ethical issue thus arises when force-feeding is authorized or even ordered by non-medical authorities. All health professionals have a duty to act ethically and to refuse to follow orders that go against their ethical principles. In practice, this duty is especially difficult to abide by for physicians employed in institutional settings, including prisons and detention centers, where the institutional authorities may require such force-feeding. Hunger strikes are at essence political events designed to bring issues of importance to prisoners to the attention of the public. Institutional physicians face increased risk of violating medical ethics due to competing responsibilities to their patients on the one hand and to custodial authorities and interests on the other.[37]

Malta anticipates dual loyalty conflicts and instructs all physicians to respect patient autonomy even when an individual could die as a possible outcome of his or her fast.[9] Recognizing the difficulty involved in maintaining a position of non-intervention, Malta suggests that a physician who is unable to accept a patient's decisions give way to a physician who will.[9,38] Personal morals, national security imperatives or "the norm of military detention"[39] cannot justify departure from principles of medical ethics developed to guide the decision making of physicians and other health professionals in a wide range of situational ambiguities and conflicts.[40] The GTMO force-feeding policy does so in two interrelated ways: privileging "beneficence" over autonomy, and diminishing "informed consent" to a procedural issue.

"Beneficence"

The revised 2013 GTMO "Standard Operating Procedure: Medical Management of Detainees on Hunger Strike" (SOP) offers beneficence as its primary justification for feeding prisoners against their will.[7] The use of the words "benefit" and "patient" in

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such a context usurps the plain content of the English language and substitutes echoes of medical ethics for a reasoned analysis of the philosophical and ethical relationship between beneficence and autonomy. The DoD prison authorities do have custodial responsibilities for the welfare of their prisoners. The prisoners become patients only when their competent undertaking of a protest action makes them seriously medically ill and at risk of death (and as Annas, Reyes, etc. have noted, the onset of force-feeding at GTMO begins long before the prisoner is at serious risk of death.)[41]

The underlying structures of their detention are the reasons these prisoners have taken this potentially lethal decision. The DoD chain of command, the US military justice system, and the DoD prison authorities at GTMO have imposed conditions that give rise to the hunger strikes and then, against the express will of the prisoners, impose actions to keep them alive. The sophistic invocation of a term from medical ethics (benefit, beneficence) should not baffle us. The real issue is whether any medicalized intervention by an institution against the expressed will of a competent person (prisoner or patient) is a violation of autonomy—a principle codified and expansively discussed in contemporary versions of medical ethics and in human rights.[42]

The Declaration of Malta is unambiguous in stating that patient autonomy trumps beneficence in the context of hunger strikes: "'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimizing damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. *Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values* [emphasis added]."[9]

It is evident that the DoD authorities at GTMO are aware of and seek to avoid the overriding norms in medical ethics and human rights concerning autonomy. The American Civil Liberties Union has noted of the 2013 revisions: "Deleted is the 2005 SOP's language directing military personnel to make 'every effort … to allow detainees to remain autonomous' up to the point the military believes force-feeding is necessary. The current SOP does not mention autonomy even once."[43] This avoidance is further manifested in the overwhelming preference for the term "detainee" (287 instances) rather than "patient" (13 instances) in its medical protocol.[7]

"Informed Consent"

The violation of the fundamental right to informed consent to medical treatment underpins the ongoing debate over prisoner abuses at GTMO. The doctrine of informed consent was first articulated in the Nuremberg Code, which was issued as part of the court findings in the 1946-1947 Medical Trials at Nuremberg, Germany. Informed consent is rooted in the principle of patient autonomy and was conceived as a mechanism for empowering patients against medical paternalism.[44] Medical paternalism (the physician knows best) often can come cloaked within the principle of beneficence.[45] The doctrine of informed consent has arisen as a powerful counterweight to that paternalistic strain in medical practice and medical science.[46]

As evolved since Nuremberg, informed consent imposes a corresponding ethical and legal duty on practitioners to obtain authorization before undertaking any medical intervention, or else face liability for battery.[30] Modern interpretations of informed consent, in part reflecting the infusion of human rights norms, emphasize dignity and autonomy,[47-50] and are particularly strict when it comes to medical interactions with vulnerable populations such as prisoners.[8-12,51]

Within the human rights community, informed consent has grown to embody a most robust ethical claim upon clinical practice. As declared in the 2009 *Report of the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*:

> Informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being….
>
> Guaranteeing informed consent is a fundamental feature of respecting an individual's self-determination and human dignity in an appropriate continuum of voluntary health-care services. Informed consent in health, including (but not limited to) clinical practice, public health and medical research, is an integral part of respecting, protecting and fulfilling the enjoyment of the right to health as elaborated in article 12 of the International Covenant on Economic, Social and Cultural Rights and enshrined in numerous international and regional human rights treaties and national constitutions.[52]

Public outcry over the involvement of medical personnel in developing, monitoring, and implementing interrogations at GTMO [1,43-58] has shifted increasingly to the issue of informed consent in force-feeding. While exceptions to consent requirements exist for incompetent patients, competence is not the issue at GTMO. First, GTMO policy no longer explicitly references hunger strikes as suicides.[8] Second, the policy offers beneficence as its justification for intervention and contests the right of prisoners, rather than their competence, in their decisions to refuse food. Third, military physicians certify prisoners' competence[1] to "waive" their right not to be force-fed, and presumably their competence to refuse food as well.

The revised SOP states that "medical personnel will make *reasonable efforts* to obtain voluntary consent" but that "[w]hen consent cannot be obtained, medical procedures that are indicated to preserve health and life shall be implemented *without consent from the detainee*" [emphasis added].[7] Both the manner and purpose of the consent procedure require prisoners to stop protesting or agree to feeding in order to avoid a more invasive feeding by force. GTMO policy thus conditions the right of respect for patient autonomy on submission to medical (and ultimately institutional) authority—the opposite of what the ethical obligation of obtaining informed consent has been designed to achieve.

Guantanamo Bay detention camp policy distorts the meaning and purpose of informed consent by twisting the concept into one based on prisoner defiance rather than on respect for patient dignity and autonomy. In so far as GTMO policy treats a prisoner as a being to be kept alive rather than a being with agency, not to be subjected to force-feeding and restraints, it fails to honor those principles. The revised SOP violates both the letter and the spirit of Malta, which states, "[i]t is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will."[9]

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In reviewing the ethical and administrative arguments advanced by the DoD for its continuing policies on force-feeding, it appears that the military physicians have not absorbed the prevailing professional recognition that informed consent remains an absolute requirement even in institutional settings, including the military. The 1996 review of medical participation in US government-sponsored human radiation experiments elaborated on this issue of professionalism, with implications for both the individual providers and for the organizations that accredit their professional ethical behavior:

> Unlike basic ethical principles that speak to the whole of moral life, rules of professional ethics are particularized to the practices, social functions, and relationships that characterize a profession. Rules of professional ethics are often justified by appeal to basic ethical principles. For example, …the obligation to obtain informed consent, which is a rule of research and medical ethics, is grounded in principles of respect for self-determination, the promotion of others' welfare, and the non-infliction of harm.
>
> In one respect, rules of professional ethics are like the policies of institutions and organizations: they express commitments to which their members may be rightly held. That is, rules of professional ethics express the obligations that collective entities impose on their members and constitute a commitment to the public that the members will abide by them. Absent some special justification, failure to honor the commitment to fulfill these obligations constitutes a wrong. To the extent that the profession as a collective entity has obligations of self-regulation, failure to fulfill these obligations can lead to judgments of collective blame.[46]

Enforcing Medical Ethics Obligations in the Civilian Context

Applicable Legal Standard

In the US, the legality of feeding competent persons against their will depends on the status of the individual, his or her autonomy and privacy rights, and the government's interests in protecting life and other public policy objectives. Competent adults have a constitutional right to refuse life-saving medical treatment, including food and water. For free citizens, the balance weighs in favor of the patient. The two key Supreme Court cases have not decided the issue based on the right to die but rather on the right to bodily integrity protected by the Due Process Clause of the Fourteenth Amendment.[59,60]

While prisoners also have a constitutional right to refuse medical treatment, it is limited where legitimate penological interests are at stake.[61] Federal courts have generally upheld force-feeding in light of the state's interests in preserving life, preventing suicide, protecting third parties, maintaining prison order and security, and maintaining the ethical integrity of the medical profession.[62] This last notion is especially problematic and highlights the failure of the courts to recognize or apply any of the relevant medical ethics instruments and standards to the very situation for which they were developed.

For example, in a recent Connecticut Supreme Court case, the Department of Corrections argued that despite the Declaration of Malta's absolute prohibition against force-feeding, US case law "suggests that it is UNETHICAL to allow an otherwise healthy inmate to starve himself to death [emphasis in original]."[63] Another Washington Supreme Court decision permitting force-feeding held: "…[This court declines] to place medical professionals in the ethically tenuous position of fulfilling the death order of an otherwise healthy incarcerated individual. Therefore, we conclude that here the State has a compelling interest in maintaining the ethical integrity of the medical profession."[64]

Courts, recognizing that they lack the relevant institutional and medical expertise to evaluate prison policies, have generally shown a high level of deference to the state's claims that "medical ethics [requires that] everything possible be done" to treat prisoners.[65] Such arguments build on a flawed understanding that links interpretation of medical ethics to the state's statement of its penological interests. Medical ethics stand outside, separate and independent from what a particular prison believes to be the proper medical (or correctional) action. The hunger strike guidelines of the Federal Bureau of Prisons (BOP), ostensibly the model for GTMO's policy, similarly require authorities to undertake all measures to preserve life.[1,30] As recently as 2013, US Secretary of Defense Charles T. Hagel stated that the government has an "ethical responsibility to assure the health and well-being of every detainee and we're certainly doing everything we can to do that".[43]

Prisoners who have challenged force-feeding as a violation of the Eighth Amendment prohibition against cruel and unusual punishment have invariably lost. As Crosby et al note, in the case of medical care for prisoners, "cruel and unusual" has been interpreted to mean "deliberate indifference" to or "reckless disregard" for risks to a prisoner's health by prison authorities.[5] Under this standard, measures undertaken to "preserve life" pursuant to BOP procedures, even those using restraints, have not been viewed as mistreatment. Instead they have been seen as fulfillment of the state's affirmative duties to protect life and maintain prison order.

Recourse for Ethical and Legal Violations

The legal and regulatory system charged with overseeing the conduct of licensed health professionals in the US (whether in civilian or military institutional settings) has thus far shown little inclination to enforce the ethical prohibition against force-feeding. The conflict between ethical and legal standards, particularly in the correctional context, has two practical effects: it protects civilian physicians who refuse to participate and it avoids sanctioning physicians who do choose to participate.

On the one hand, where the legal standard authorizes force-feeding, civilian physicians who refuse orders to force-feed are protected by the regulatory and normative authority of their professional associations. The AMA has endorsed the UN Principles of Medical Ethics which prohibit professional relationships with prisoners for any purpose other than evaluating, protecting or improving physical and mental health.[1] This gives protesting physicians recourse to resign without facing legal or professional body repercussions. Nurses, physician assistants, paramedics and EMTs are similarly empowered by their professional codes and associations to stand their ethical ground.

On the other hand, since the civilian legal system does not sanction health professionals who do participate in force-feeding (in violation of medical ethics), no medical personnel have been prosecuted for their role in force-feeding prisoners at GTMO.[1] State medical boards, even when pressed for response, have declined jurisdiction, avoided definitive action following investigation, or simply remained silent.[24] Civilian official review of military practice at GTMO has also proven itself equally ill-suited to

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fostering accountability. For example, a 2008 Senate Armed Services Committee report identifying Army psychologists involved in developing abusive interrogation techniques has not led to sanctions against the named individuals.[1,66]

Two federal cases decided by Judge Gladys Kessler of the US District Court for the District of Columbia have weighed the legality of GTMO's force-feeding policy. In 2009, *Al-Adahi v. Obama* held that federal courts lacked jurisdiction to review conditions of detention at GTMO but noted that the procedure was constitutional. The judge reasoned that the use of the restraint chair was vetted by BOP officials, overseen by medical professionals, and initiated "only after using less restrictive measures."[23] Medical ethics do not surface in the decision and torture allegations are dismissed. On July 8, 2013, *Dhiab v. Obama* reiterated the court's lack of jurisdiction,[17] highlighting the failure of civilian law to effectively constrain physicians at GTMO.

Enforcing Medical Ethics Obligations in the Military Context

Applicable Legal Standard

Physicians serving in the military are subject to the same medical ethics obligations as civilian physicians, including the duty to act ethically and to abide by the prohibition against force-feeding. As with all military personnel, health professionals are only required to obey lawful orders.[37] However, when the military issues a policy that by definition is lawful within the military but by medical standards and international law is unethical, military health professionals face considerably more difficulty. Challenging a lawful but unethical order in a military context, under current DoD directives, means that military physicians at GTMO literally cannot invoke medical ethics as a basis for the challenge.[67]

The reason for this logical cul-de-sac is that as of 2006, the DoD not only does not require providers to adhere to professional medical ethics but instead requires them to adhere to separate military guidance. According to the Constitution Project's Task Force on Detainee Treatment, "the Army Medical Command and Office of the Surgeon General have made their own determinations about whether military health professionals' conduct complies with their professional obligations."[1] In effect, legal directives from the DoD explicitly and unilaterally remove military health professionals from the universal oversight of established standards of ethics and conduct. Instead they compel military health professionals to abide by military definitions of ethical obligations that privilege security and the appearance of ethical compliance over patient autonomy, patient dignity, and physician independence.

A key mechanism involves the deliberate creation of arbitrary categories of ethical duties based on operational rather than professional role. Health care personnel assigned to "provider-patient" relationships with prisoners, including physicians, may be required to force-feed prisoners but must not engage in intelligence activities. Health care personnel designated as "behavioral science consultants," including psychologists, may be required to assist in interrogations but must not provide medical care except in emergencies.[1,54,68-70] These distinctions were ostensibly created to reinforce ethics in light of the involvement of medical personnel (eg, psychologists, nurse practitioners, medics, etc.) in highly publicized abuses, such as waterboarding and grave breaches of confidentiality. In practice, this distinction has separated health care professionals, particularly physicians, from their ethical obligations[1,68] —underscoring the 2004 statement by Dr. David Tornberg, former US Deputy Assistant Secretary of Defense for Health Affairs: "A medical degree is not a 'sacramental vow'—it is a certification of skill."[67]

The DoD screening of physicians for their willingness to participate in force-feeding takes the process of ethical distortion to another level of operational evasion. This policy has been in place since at least 2005[25] and bypasses a number of important safeguards designed to protect patient autonomy. Whereas Malta urges physicians to recuse themselves rather than override their patient's decisions,[9,29,38] the DoD screening policy deliberately seeks physicians who are committed to breaking hunger strikes through force-feeding. The combination of ethical override and vetting has produced an environment increasingly defined by unethical and abusive practices, some amounting to torture under all international legal and medical standards.

Recourse for Ethical and Legal Violations

There have been no military prosecutions of military health professionals engaged in force-feeding[1] because their participation is authorized as DoD policy. The general US legal justifications for force-feeding in institutional defense settings like GTMO have acquired the additional full weight and momentum of the US national security apparatus and ideology. In such an environment, there are few mechanisms available to military health professionals who seek to object to orders that are lawful but manifestly unethical.

Military prisons fall under a separate legal system governed by the Uniform Code of Military Justice (UCMJ). The courts-martial (the legal enforcement of the UCMJ) have jurisdiction over civilian contractors and military personnel who violate the laws of war and all parties have a duty to obey all lawful orders.[67] In 2005, the former commander of the US Navy Hospital at Guantanamo Bay, Captain John Edmondson, signed an affidavit stating that "the involuntary feeding was authorized through a lawful order of a higher military authority."[71] This justification remains active today.[72] And although this assertion of legality constitutes no ultimate defense and soldiers have a duty to disobey orders they consider to be fundamentally unlawful, in practice this principle is all but impossible to uphold. As Koch notes, "…the orders of a superior carry an a priori presumption of legality 'disobeyed at the peril of the subordinate' who must prove an order was unlawful. The penalties for refusing a lawful order are severe and may include ancillary charges of mutiny or sedition."[67]

Furthermore, there is little incentive to object when the policy comes down from the highest levels, when physicians have been pre-vetted for compliance, and when the policy itself shifts so much it is not entirely clear who has authority to do what. Beyond the legal consequences of attempting to challenge a lawful order within the military, profound professional repercussions may eventuate, since physicians subjected to these military legal consequences may face significant hardship in finding subsequent employment in civilian or military life. Some physicians have refused to participate in force-feeding, and in 2007, then-spokesperson for Detention Operations Navy Commander Richard W. Haupt indicated that the military does not punish this refusal.[73] This comment suggests that dishonorable discharge has not been pursued. Yet little is known about what has happened to military physicians who have objected to force-feeding. Even less is known about what has happened to the physicians who have raised no objections and do participate.

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The continuing participation by military physicians and other health professionals in force-feeding has contributed to the presumptive legitimization of this practice and further development of unethical policies.[1,53] At the same time, such policies have protected military providers from regulatory challenge. This structural entanglement has created two layers of professional ethics violations: military policy itself, which asserts the ethical basis for the practice, and the required renunciation by military physicians of the duty to behave as ethical professionals as defined by standards deemed to have universal application to those licensed in their respective fields in the US.

The military has proven itself either unwilling to bring or incapable of bringing its own policy into ethical compliance. In 2005, in response to an FBI complaint, the Army Surgeon General investigated interrogation and detention policies in various operational theaters.[54] While the investigation found that the cumulative effect of the policies was "degrading and abusive," it did not find that they constituted "torture" or "inhumane" treatment.[53] Iacopino and Xenakis recently reviewed abuse claims from this period by nine prisoners at GTMO and found them to be credible. Yet none of the abuses were ever investigated or reported by medical personnel and there were no prosecutions.[1,74]

It is worth noting in this context that "degrading and abusive" actions would qualify as violations of international humanitarian law, in particular Geneva Common Article 3 which among other prohibited acts to inflict on those in detention singles out "outrages against personal dignity, in particular humiliating or degrading treatment."[75] The US has signed and ratified all four Geneva Conventions and integrated its elements into US domestic military law as the Law of Armed Conflict.[1]

The judge in the 2013 *Dhiab* case (described above) moved beyond her discussion in the 2009 *Al-Adahi* case. Rather than accept the government's arguments on force-feeding as she had done in 2009, in 2013 she took note of "what appears to be a consensus that force-feeding of prisoners violates Article 7 of the International Covenant on Civil and Political Rights which prohibits torture or cruel, inhumane, and degrading treatment." She then took the unusual step of appealing to change at the highest level: "…the President of the United States, as Commander-in-Chief, has the authority—and power– to directly address the issue of force-feeding of the detainees at Guantanamo Bay."[17]

Discussion

Historical Context

In the United States, the legal definition of torture requires the involvement of agents of the state.[1,16,76,77] The medicalization of torture, and the erosion of physician ethical independence and authority by the state, turns supposedly independent professional actors into agents of the state. This dynamic has contributed to what Lifton describes as an "atrocity-producing situation" at GTMO and other military detention facilities.[78] Since Nuremberg, physicians and ethicists throughout the world have viewed the encroachment of state interests into medical care and medical science as inherently problematic, with the "slippery slope" concept invoking two historically-based negative progressions: the state, once allowed to influence medical policy and practice for its own interests, can then move to dictate on a much broader swath; and physicians, once inured to state influence, become increasingly amenable to state directives.

Context is always pivotal to the slippery slope argument.[79] The Third Reich arose from unprecedented turmoil in Germany and many willing drivers of the Nazi agenda, physicians especially included, mobilized social, political, economic, and ideological forces to produce state-sanctioned mass atrocity from 1933 to 1945.[80] Yet since Nuremberg, and especially after the reports of physician participation in and leadership of US atomic radiation experiments, there has been growing recognition in the US and elsewhere that latent in the powerful conferred role of physician and scientist lies a vulnerability to "state misuse of professional power."[81]

At GTMO, military policy inverts professional medical ethics, replacing the independent ethical authority of physicians and other civilian-licensed medical personnel with the military statement of obligations to national interests. The Declaration of Malta states that physicians who are uncomfortable with the possibility of letting patients fast to death should give way to another physician who will respect autonomy.[9,29,38] Yet the vetting policy does the reverse: it allows the military command to remove a potentially objecting physician and replace him or her with a compliant one.

Call to Action

The situation at GTMO, including the impunity of physicians and other health professionals participating in prisoner abuses and atrocities, is disturbing and must be robustly and immediately addressed by US regulatory bodies as well as by international bodies. The international and US medical communities have shown themselves capable of ethical reform and sanction, stemming from the Nuremberg Code and continuing through the various international and US instruments on physician ethics and responsibilities. Many of these codified principles are legally binding on all US physicians and health professionals, including requirements of state licensure boards and requirements codified at the federal level for protection of human research subjects.[82] In the context of past hunger strikes involving physician participation, medical associations have lobbied for changes in policy and practice after perceiving deficient ethical guidance and lapses in compliance.[83] Additionally, medical associations in Chile, Brazil, Uruguay and South Africa have successfully sanctioned physicians in human rights violations.[24,84]

The DoD has shown itself to be sensitive to the perception of ethical compliance. The vetting policy, while perpetuating grave ethical violations, demonstrates a consciousness of the power of medical ethical guidance and of the consequences of departing from medical ethical standards. By asserting a preemptive set of professional obligations and recruiting only those military physicians willing to abide by that preemption, the military command implicitly acknowledges the high necessity of moving away from the established regime of norms and regulations for physicians.

Given the relative intractability of US military and civilian legal precedent with regard to dual loyalty situations, particularly in the context of great deference given to military command necessity, the only (and also potentially the most persuasive) option facing those who wish to uphold the hard-won and still fragile ethical edifice constructed in the years since World War II is to appeal to the medical community.

All US physicians and other health professionals licensed to practice in the US, whether in civilian or military practice, are obliged to abide by the regulations of their state boards of licensure and by the standards for hospital privileges developed by all licensed hospitals and clinics in the US. In the case of

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physicians, participation in force-feeding at GTMO would, for these agencies, be deemed practice outside the prevailing standards for the practice of medicine by both these licensing bodies and the physician in question could stand to lose his or her medical license and clinical site practice privileges. The same is true for nurses, physician assistants, paramedics, EMTs, and any civilian-trained medics or corpsmen who are regulated by state licensing boards and required to practice in accordance with the medical ethics codes of their professions. These are the levers that enforce medical ethics and quality and they have developed in US medicine over the last 60 years.[85,86] These are also the levers that apply across all civilian and military jurisdictions in the US.

In this call for action, we urge that all military medical management protocols be immediately open to scrutiny by the AMA, the Federal Board of State Licensing Bodies, all state medical societies, the Institute of Medicine, and the regulatory arm of the Department of Health and Human Services. In the GTMO situation, the management protocols were deemed "classified" and unavailable to the public until released by the Al Jazeera Media Network.[87]

What is needed now is a concerted effort by these state and federal authorities, and respected US professional physician groups to apply the sanctions explicit in these regulatory bodies to US physicians who have violated the articulated standards of the practice of medicine as found in the federal and state frameworks and statutes that define ethical medical practice. Given the line of supervision in the clinical context, this leadership must come from physicians but encompass all health professionals sworn to uphold medical ethics. The civilian regulatory system has the specific authority to investigate and where necessary exact consequences on those individual physicians who agree to be recruited to GTMO and abide by the vetting procedures. A number of medical ethical authorities have called for such action over the last 20 years and we join them now.[11,12,14,15,24,83,84,88-92]

The medical community can also exert significant policy leverage on the DoD by calling for a change in GTMO policy and strengthening protections within the military chain of command for military physicians who protest lawful orders that are manifestly unethical according to international and national standards for physician practice. Health professionals, particularly physicians, are granted autonomy and power to the extent they uphold their professional ethical standards. The ancient admonition to "do no harm" has legal teeth in the US regulatory system that grants physicians and other health professionals their legal authority to practice medicine.

Conclusion

It is difficult to overstate the gravity of what is at stake, not only for hunger-striking prisoners subjected to force-feeding (a number of whom are already cleared for release)[1,4,72,92,93] but for the US medical profession as a whole. The situation at GTMO has aspects similar to torture seen elsewhere. Many observers have already pointed out profoundly disturbing parallels to the complicity of Nazi physicians and scientists in state-sponsored torture during the Third Reich.[24,44,56,71,77,78,84,94,95]

The organized medical community in the US has an inescapable obligation to challenge the current practices relating to force-feeding at GTMO. Recall the very slow drumbeat of history after World War II: the final judgment at the Nuremberg Medical Trials, issued April 1949,[96] the Declaration of Geneva, adopted in 1948 by the newly formed World Medical Association and last revised in 2006,[97] and the Nuremberg Declaration of the German Medical Assembly in 2012.[98] These three documents over a 60 year period demonstrate progress but also the ponderous pace at which the medical community has responded to its own extraordinary transgressions. This saga continues to haunt all health professionals throughout the world. How long will it take the US medical community to come to terms with, punish, and renounce this ongoing record at GTMO of medical participation in profound violations of medical ethics and supine submission to the dictates of the state?

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