COMMENTARY

Ethics Dilemmas in Managing Hunger Strikes

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There is no agreement on how to manage hunger strikers. The health professionals called to intervene in a hunger strike are faced with a dilemma: commit themselves to good order and discipline or comply with best practices for providing healthcare. Handling cases of hunger strikers confronts practitioners with the ethics dilemma of managing apparent intentional behavior that carries serious morbidity or mortality, but recognizing that hunger striking is a military and political tactic, and not a medical condition. The study by Reeves, *et. al.* published in the *Journal* enhances our understanding of the motives and psychology of hunger strikers. Their analysis indicates that improving communication with custody administration and mitigating unnecessarily aversive housing environments can likely reduce the incidence of hunger strikes.

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There is no agreement on how to manage hunger strikers. The hunger striker occupies the ambiguous zone between political/military domains and health. Commonly, policies set by prisons, the military, and other governmental agencies handle hunger strikers as disciplinary problems. The health professionals called to intervene in a hunger strike are faced with a dilemma: commit themselves to good order and discipline or comply with best practices for providing health care. On the one hand, the clinician encounters an individual who is often viewed as disruptive to the institution and setting, and whose actions may lead to serious morbidity or death. On the other hand, the basis and motivation underlying the individual's actions most often are not attributable to medical conditions, despite how visibly alarming the physical presentation.

The study by Reeves *et al.*,[1] "Characteristics of Inmates Who Initiate Hunger Strikes," enhances our understanding of the motives and psychology of hunger strikers. The authors reviewed the electronic medical records of 292 prisoners in the New Jersey Department of Corrections labeled as hunger strikers over 10 years for documentation of psychiatric diagnosis, confinement conditions, and reasons for ending the strike. Their analysis indicates that improving communication with custody administration and mitigating unnecessarily aversive housing environments can reduce the incidence of hunger strikes.

Case Profiles

A fundamental element of good clinical and forensic practice involves being patient-centered. Reeves *et al.* proffer that "(a)ttention to these characteristics [of the individual cases] may provide guidance for both medical and correctional authorities on how to decrease both the frequency and the duration of hunger strikes in prison" (Ref. 1, p 304). A confounding factor for both clinicians and custodial authorities is that the profile of hunger strikers is not characteristically uniform. For example, the inmates described by Reeves and colleagues differ strikingly from the detainees at Guantánamo (the location of much of my clinical experience). The authors describe inmates who initiate hunger strikes in a state prison as engaging in brief episodes (three days or less) that are not life-threatening, not driven by mental illness (even though nearly half are labeled with diagnoses), and most often displaying known maladaptive coping skills.[1] Their review indicates that most hunger strikes were initiated by lone individuals without coercion or coordination with other inmates, rather than by groups in protest, and were motivated by objections over disciplinary housing, desire for housing change, and interpersonal difficulties

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with custody. Resolution of the strikes seemed to follow changes in administrative procedures and conditions.

The detainees at Guantánamo who have engaged in hunger strikes project a contrasting picture. The numbers have varied up to approximately 150, and detainees have coordinated their activities in protest of policies and procedures to publicize their views. Several detainees have persisted on strikes for years and lost significant weight, and many have been willing to endure much hardship and discomfort, endangering their health to advocate for their cause. They have objected to detention without being charged in a court of law and to being accused of being terrorists on scant or circumstantial evidence, have felt insulted and demeaned by contempt for cultural and religious customs (particularly, handling of the Koran by non-Muslims), and have protested harsh conditions. The military authorities at Guantánamo have managed them by authorizing enteral feedings and subjecting noncompliant men to forced cell extractions (FCEs). Some individuals have been on enteral feeding protocols for at least seven years.

Guidelines and Law

U.S. and international governmental agencies have responded differently to the challenges of hunger strikes. As noted by Reeves *et al.*, "case law, legislation, and regulations in the United States have [generally] supported force-feeding of hunger-striking inmates" (Ref. 1, p 303), despite a Supreme Court ruling in *Cruzan v. Director*[2] that competent adults have the right to refuse force-feeding, even if death will result. The U.S. district judge in a case in which I provided testimony criticized force-feeding at Guantánamo but agreed that the U.S. government could not let the detainee die. In fact, the detainee objected to FCEs and conditions of confinement that aggravated his medical conditions, and it is unclear that he would have died from refusing food.[3]

The most notable instance of not imposing force-feeding occurred in Northern Ireland in 1981 and resulted in 10 deaths. The policy of the U.K. government bowed to the ethics principle of patient autonomy and did not require physicians to force-feed prisoners against their will.[4] More alarming events across the globe followed, and hunger strikes in Turkey in the late 1990s led to an unprecedented number of deaths. The World Medical Association (WMA) drafted its first resolutions and revisions in response to the high incidence and dire consequences of hunger strikes and the challenges to governmental agencies over policies and practices. Essentially, the WMA stipulated that force-feeding is never ethically acceptable, and that physicians should not participate in or condone any such coercive procedures.

Ethics Dilemma

Handling cases of hunger strikers confronts practitioners with the ethics dilemma of managing apparent intentional behavior that carries serious morbidity or mortality, but recognizing that hunger striking is a military and political tactic and not a medical condition. Simply stated, do the clinician and forensic practitioner stand back and allow the subject to die or do they obey superiors and abide by governmental practices and policies that are the source and motivation of the subject's objections and protest? A case-by-case analysis may help resolve the dilemma confronted by the practitioner, but there are corollary and overriding questions of roles, responsibilities, social context, and political convictions that inescapably influence the expert. It is my belief that the clinical or forensic practitioner called in to advise or assist in hunger strikes cannot avoid the broader implications of the inherently fundamental political and military components when providing recommendations and advice for managing such cases.

An accepted interpretation of policies recommended by the American Medical Association (AMA) infers that force-feeding undermines principles of providing care with compassion and respect for human dignity and rights including informed consent. Thus, physicians are obligated to honor patients' decisions, even if not understood or agreed with. The use of restraints and aggressive action to enforce enteral feeding violates principles of using appropriate measures in accordance with clinical indications.[5] Physicians working with hunger strikers have been put in situations of being coerced or ordered not to comply with accepted ethics standards and principles of their profession.[6]

Some physicians, particularly those serving in the military in Guantánamo, disagree with AMA policies that oppose force-feeding and managing hunger strikers, regarding them as impractical in the face of threats to national security. Similarly, hunger strikes and other disruptive activity by prisoners undercut good order and discipline in correctional institutions. The practitioners adhering strictly to policies and principles advocated by the AMA and WMA

confront, and often disagree with, the politics and practices of the governmental agencies they are serving. However, they cannot escape the broader social and political implications of their actions. The clinical and forensic health care practitioner called to intervene with a hunger striker is on the front lines of larger social and political concerns. Without the public engagement of the respective professional organizations, the frontline practitioners face tense and difficult confrontations with authorities and agencies. Professional organizations, such as the American Academy of Psychiatry and the Law, may have good reason to sidestep active public engagement in politics and with governmental agencies, but the individual practitioner cannot escape tackling the ethics dilemma and challenges of managing the cases.

Understandably, the professional associations and organizations shun political advocacy that could lead to a breakdown in ethics-based practices, such as occurred in Nazi Germany, prewar Japan, and the Soviet Union.[7] Accordingly, a guiding principle of some associations and organizations has been to eschew or circumvent matters considered to be strictly political that could compromise the independence and impartiality of its members. Yet, the activities of a hunger striker in a U.S. prison or Guantánamo are recognized as fundamentally political, military, and social. The physician assisting with enteral feeding of a hunger striker unavoidably acts as, and is labeled as, an agent of the governmental organizations being served. The practitioners complying with governmental policies and agencies may understandably regard their actions as appropriately supporting the interests of good order and discipline, national defense, and common security.[8] However, the practitioners disagreeing with governmental and agency policies and practices do not enjoy license to act on the principles that undergird their opinions.[6]

Reeves and colleagues[1] suggest that discerning and analyzing in more detail the motivations, profile, and characteristics of individual hunger strikers may shape more effective and appropriate policies and procedures. Certainly, the findings and analysis of cases in the New Jersey Department of Corrections (NJDOC) provide useful information for modifying procedures and more effective management. The study influenced changes in disciplinary practices in the NJDOC, including abolishing detention, shortening or abolishing disciplinary stays for certain infractions, and changing the name of disciplinary housing to restrictive housing.[2]

Guantánamo Hunger Strikes

The U.S. government has not allowed similar analyses to be conducted of the motivations and mental state of hunger strikers at Guantánamo. The military contends that hunger striking is a tactic of asymmetrical warfare in support of a continuing terrorism campaign by detainees and threats to national security. I have conducted multiple psychiatric assessments of the mental state of detainees on hunger strikes, often with other independent physicians and mental health practitioners. Several detainees we evaluated for other purposes engaged in hunger strikes intermittently during their detention at Guantánamo. Not one expressed a wish to die, and all denied being suicidal. In fact, the detainees were adamant about adhering to religious prohibitions against suicide. Some detainees expressed opinions that participating in a hunger strike violated religious principles and that their understanding of Islam invoked prohibitions against intentionally injuring bodily organs (i.e., the stomach and digestive tract).

More than once, my colleagues and I evaluated detainees with evidence of psychiatric conditions that affected judgment and motivations. In almost all cases, the medical and psychiatric illnesses manifested by the detainees had not been adequately treated and contributed to continuation of their hunger strikes. In many instances, initiating a hunger strike was a personal action of despair and despondence over indefinite detention and inadequate treatment. The detainees regarded the environment and command climate at the detention camps as disrupting any constructive dialogue and the possibility of a decent and humane relationship with the authorities. They described the environment as coercive and perpetuating the harsh and abusive treatment endured when apprehended. For some, the conditions of confinement revived memories of harsh interrogations and abuse and constituted a credible threat of a return to those adversities.

Geneva Conventions

It is unclear that the laws of war apply to managing hunger strikers and the roles and responsibilities of practitioners asked to intervene. A universally accepted principle of warfare is that soldiers understand

the dangers of combat and possibility of dying. Therefore, assuming that a hunger strike is an act in support of asymmetrical warfare, we can construe dying because of a hunger strike as a legitimate tactic by a detainee acting as a combatant in pursuit of a cause or military objective. Detainees who undertake hunger strikes do not intend or want to die, but understand that the consequence of their actions may end in their demise. Some share the mentality of soldiers going to war and the dangers they face and undertake a hunger strike as the only available means to express their grievances.

Consequently, what questions arise about the implications for the clinician providing enteral feedings to the hunger striker in Guantánamo? Does the clinician deter or divert the hunger striker from legitimate soldierly conduct and risking his life in pursuit of an objective? By doing so, is a clinician, with an eye to health and welfare, acting as a pacifist or conscientious objector, opposing war and combat? Or by providing enteral feedings, is the practitioner intervening as if treating a wounded combatant, injured in the struggle or fight, and performing duties as healer universally recognized by the Geneva Conventions of treating all wounded victims captured on the battlefield? The roles and responsibilities of the practitioner stretch beyond the clinical arena into political, social, and governmental domains.

The U.S. government contends that it can act to prevent the death by starvation of hunger strikers and use enteral feedings to counter the detainee's actions and intent. The government authorities assert that the death of a hunger striker undermines the legitimacy of U.S. policies and procedures and aggravates the threat to national security. But many detainees experience the force-feedings as coercive, punishing, and painful and object to the government's reasoning that it saves lives, especially since they have not expressed an intent to die.[9]

Accordingly, the medic assisting with enteral feedings and mitigating the starvation of the hunger striker, acts as a proxy for the U.S. government in countering the hunger strike considered a tactic of asymmetric warfare used by detainees. Providing medical care, ostensibly for the health and welfare of the detainee, becomes "weaponized" and serves as a countermeasure in the sophisticated war on terrorism.

A further confounding factor is that the U.S. government does not recognize the detainees as legitimate combatants and does not afford them some commonly accepted protections and rights under the Geneva Conventions. Unlike prisoners in U.S. correctional institutions, many detainees have been imprisoned for years at Guantánamo without substantiation of the charges against them and justification of their confinement. In contrast, U.S. prisoners are incarcerated after proper adjudication in a court of law and know the terms and circumstances of their sentences. Detainees at Guantánamo live under murkier conditions, uninformed about when or how they will be released. Recognizing that some detainees initiate hunger strikes in protest of indefinite confinement, it is questionable that the clinician assisting with enteral feedings ultimately improves the health and welfare of the prisoner. The codes of medical ethics of both the AMA and WMA maintain that subjecting detainees and prisoners to enteral feedings undermines the principles of autonomy and beneficence. The WMA endorses policies enabling the health professional to act as an intermediary and help the detainee affirm his integrity, but perhaps compromise and take some nutrients, without undermining his political objectives or sense of agency.

Role and Responsibilities

The role and responsibilities of the psychiatrists called to intervene with a hunger striker are generally circumscribed by guidelines of the respective agencies and institutions and conform somewhat to the recommendations of the professional organizations such as the WMA and AMA. The duties involve assessing for competence to engage in the behavior and the presence of mental illness or disease and the evidence that the subject is acting independently and not under coercion. In fact, the expert called to assist with a case provides broader consultation and advice. Reeves *et al.* state that probing and deconstructing the causes and elements of hunger strikes in U.S. prisons can help change the conditions and environment motivating the behavior. The expert ascertaining that the prisoner is competent, that is, his conduct is not the product of serious mental illness or disease; he is acting independently without coercion, but demonstrates limitations that impair the capacity to manage the distress and adversities of confinement, encounters the challenge of recommending changes to authorities in the interest of the prisoner's health and welfare. The option for an expert to provide such consultation and advice seems more likely

in U.S. prisons and correctional institutions governed by respective federal and state law.

The role and responsibilities of the expert called to Guantánamo are influenced by different political and military factors. The specified duties of ascertaining competence, and the presence of serious mental illness, and assessing independence without evidence of coercion are also set in guidelines and regulations, as recommended by the professional organizations. Unlike hunger strikers in U.S. prisons, however, many detainees are subjected to forced enteral feedings directed by government authorities. Some observers suggest that the enteral feedings have become a theater for both the government and prisoners to play their respective roles in the public arena. The expert called to assess and advise eventually becomes drawn into the interactive drama that unfolds.

Political, social, and military factors influence the state of mind of the hunger strikers and may influence their conduct. The evaluating psychiatrist may also be caught up in the web of the interaction between government actors and the strikers. As has been acknowledged over the years, hunger strikes constitute effective means of peacefully protesting in the absence of other mechanisms. In many cases, the psychiatrist cannot escape being caught up in the protest or the struggle.

References

1. Reeves R,Tamburello AC, Platt J, *et al*: Characteristics of inmates who initiate hunger strikes. J Am Acad Psychiatry Law 45:302–10, 2017
2. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990)
3. Xenakis SN: Ethical challenges in treating detainees and prisoners of war. Curr Psychiatry Rep, in press
4. Reyes H, Allen SA, Annas GJ, *et al*: Physicians and hunger strikes in prison: confrontation, manipulation, medicalization and medical ethics, part 2. World Med J 59:97, 2013
5. Lazarus J: Physicians' ethical obligations to hunger strikers. BMJ 2013;346:f3705
6. Annas GJ, Crosby SS, Glantz LH: Guantanamo Bay: a medical ethics–free zone? N Engl J Med 346:101–3, 2013
7. Xenakis SN: History of the Japan Science Council. Unpublished Thesis. Princeton, NJ: Princeton University, 1970
8. Gregg BM, Marks JH: When doctors go to war: perspective. N Engl J Med 352:3–6, 2005
9. Task Force Report funded by IMAP/OSF: Ethics abandoned: medical professionalism and detainee abuse in the "War on Terror." New York: Institute on Medicine as a Profession/Open Society Foundation, November 2013. Available at: http://imapny.org/wp-content/themes/imapny/File%20Library/Documents/IMAP-EthicsText Final2.pdf/. Accessed July 9, 2017