



Medical Ethics and Practice Challenges of Hunger Strikes in US and Military Prisons

Monday, April 8, 2013

Keck Center, Room 201
500 Fifth Street NW
Washington, D.C.

Meeting Objectives

- Identify the challenges and opportunities in medical and psychological care of hunger strikers in detention settings.
- Identify the strengths and weaknesses of existing ethical, regulatory, and medical practice standards.
- Develop options for improvements, including articulation of a medical standard of care, use of independent medical evaluations (by both individual physicians and expert committee consultation), training, oversight/chain of command, reporting, and support of the medical profession.

AGENDA

8:00 – 8:30 am	Breakfast available in the Cafeteria
8:30 – 9:00 am	Welcoming Remarks by George Annas and Sondra Crosby Origins and purpose of the meeting; Summary of past similar meetings; Meeting format; Review of agenda and possible outcomes
9:00 – 9:30 am	Self-introductions, including personal experiences with hunger strikes, of all participants

9:30 – 10:45 am	Personal Challenges Encountered in Dealing with Hunger Strikers <ol style="list-style-type: none"> 1. Hernan Reyes 2. John May/Marc Stern 3. Jack Smith 4. Frank Arnold 5. Sondra Crosby Commentary/Common Themes (Steve Xenakis)
10:45 – 11:00 am	BREAK
11:00 am – 12:30 pm	Discussion: Barriers to Resolving Hunger Strikes
12:30 – 1:30 pm	Lunch (Cafeteria)
1:30 – 2:15 pm	Group Discussion on Physician Enablers (Sondra Crosby) <ul style="list-style-type: none"> ▪ Existing regulations and training ▪ Existing ethical standards ▪ Existing employment structures ▪ Existing “chain of command” for consultation and reporting ▪ Others
2:15 – 3:00 pm	Discussion of Proposed Actions to Improve Current Situation (Sondra Crosby) <ul style="list-style-type: none"> ▪ Articulation of best practices/medical standard of care ▪ Unification of ethical standards ▪ Better reporting, transparency, discipline ▪ Improved training ▪ Routine access to independent physicians ▪ Others
3:00 – 3:15 pm	BREAK
3:15 – 4:00 pm	Proposals for Next Steps
4:00 – 4:30 pm	Summary of points of agreement and disagreement (Steve Xenakis) Thanks and Next Steps (Sondra Crosby)

Participants

Allen, Scott	School of Medicine, University of California, Riverside
Annas, David	SUNY Upstate, Syracuse NY
Annas, George	Boston University (Member CHR)
Arnold, Frank	Founder/Clinical Advisor, Medical Justice Network, UK
Crosby, Sondra	Boston University School of Medicine; Boston Medical Center
Grodin, Michael	Boston University School of Public Health; Boston Medical Center
Katz, Michael	Member, Committee on Human Rights
Kendig, Newton	Health Services Division, Federal Bureau of Prisons*
Kern, Donald	Immediate Past President, Society of Correctional Physicians Chief Medical Officer, NaphCare, Inc.
Lockette, Warren	Deputy Assistant Secretary of Defense for Clinical and Program Policy and the Chief Medical Officer of the TRICARE Management Activity*
May, John	President, Health through Walls Chief Medical Officer, Armor Correctional Health Services
Moreno, Alejandro	University of Texas Southwestern Internal Medicine Residency Program*
Reyes, Hernán	International Committee of the Red Cross (ICRC) (retired)
Smith, Jack	Director, Clinical & Program Policy Integration, United States Department of Defense
Squillace, Lynn	Fellow, Boston University School of Public Health
Stern, Marc	Consultant in Correctional Health Care Assistant Affiliate Professor, School of Public Health, University of Washington
Verba, Sidney	Chair, Committee on Human Rights; Harvard University *
Woodson, Jonathan	Assistant Secretary of Defense for Health Affairs*
Xenakis, Steve	Brigadier General (Ret), USA

*unable to attend

April 8, 2013

Summary of Meeting

Keck Center, Washington, DC

Conducted Under Chatham House Rules

1) Hunger Strike

Generally done for a political purpose and someone outside the institution must usually know about it. Hunger strikers are not generally suicidal, but want something changed and are willing to die if they do not obtain all or at least part of what initially requested.

- a) When does a hunger striker become a patient? “Rule of thumb”: 72/72: total fasting for at least 72 hours - may be a hunger striker, may be a food refuser; way too soon to tell-- 72 days is the maximum survival, usually no medical necessity to intervene before 30, or even 40 days (if the patient was a young person in good health when starting the HS).
- b) Force Feeding
 - i) World Medical Association’s Declaration of Malta (2006): no medical ethics basis for force feeding a competent hunger striker—ever: “never ethically justified”.
 - ii) US federal policy (and individual states ex.: Connecticut) is well established that prisoners in federal custody will not be allowed to “starve themselves to death” if this is thought to interfere with prison order; but cases vary, no universally accepted law on this subject in US.
 - iii) Settled as an ethical matter and conflicting decisions as a legal matter; but the two are separate. That is the conflict with hunger striking.
 - iv) Competence is for a specific purpose (knowing the nature and consequences of a decision; thus a prisoner can be competent to go on a hunger strike even if the prisoner has a mental illness or is depressed).

2) Challenges for Clinicians Caring for Hunger Strikers

- a) Ethical and legal can overlap regarding responsibility
 - i) Difficult when you have a responsibility but not the authority that is comparable to that responsibility.
 - ii) Physicians should have authority over everything you are legally or ethically responsible for. In all cases, no non-medical authority should give orders to medical staff that go against principles of medical ethics.
 - iii) In prisons: warden has ultimate authority over everything, can override medical Decision, but power must be used very judiciously (and may require judicial order). Physicians have a duty to refuse orders that go against their ethical principles: may be difficult to do in countries or contexts where coercion and repression are present.

April 8, 2013

- (1) Superintendents and wardens talk about climate their responsibility is to maintain safety, security of the system.
 - (a) Food; visitation; and medical identified as related to maintaining climate
- b) No clear consensus on appropriate standard of care for hunger strikers; medical professionals often defer to courts.
 - i) Lack of specific guidelines that US physicians follow from place to place
 - (1) With ordinary medical practice long total hunger strikes are fairly unusual, you would refer to someone with special expertise
 - ii) Courts are overly deferential to institutions' claims
 - (1) Correctional culture: any autonomy on the part of the prisoner is a loss of control
 - (2) Over reaction may be leading to more incidents
 - (a) US prisons among the worst in limiting expression of individuality and human dignity
 - (b) Contributions of conditions of confinement as a main factor leading to prisoners going on hunger strikes
- c) Correctional Institution accrediting authorities do not have hunger strike expertise nor specific knowledge about standards of medical ethics
 - i) American Correctional Association expects facilities to have a policy

3) Role of the Physician

Elements of role as a clinician in a particular relationship with the individual who is in custody

- a) With a hunger striker, immediate concentration on end game (preventing death) is a mistake; almost never relevant as vast majority of fasting / hunger strikes do not get anywhere near the limit where death is imminent.
- b) Putting someone immediately on force-feeding wastes that whole month of time during which the doctor can establish trust with the hunger striker who does not need to be fed at this point.
 - i) Loss of credibility/trust with prisoner
- c) Physicians subverted to be part of the guard force - no clear separation of guards and physicians
- d) Establishing rapport, what is the quality of the relationship helps to answer questions re: motives, state of mind, outcomes/purposes of patient, whether patient has capacity
 - i) How would we want to set up guidelines for management of hunger strikes?
 - (1) Trust: how do you develop rapport?
 - (a) Medical director: responsible health authority - final say on what happens with medical decisions for prison facility – prisoners know that, always perceived as part of the system
 - (i) Always limits rapport you can build with prisoners – perception of prisoners is often “if you were a good doctor you wouldn’t be working in the prison”

April 8, 2013

- (b) Informed consent in a custodial setting must involve a conversation about what you can and cannot do
 - (i) No false expectations
- (c) Doctor's responsibility to inform the detainees about the risks, e.g., dangers of prolonged total fasting; also danger in re-feeding
- ii) Use of outside independent physicians
 - (1) US prison: What does the prisoner have a right to? Most jails and prisons in general if it's not a medical recommendation for a second opinion its generally not allowed; if allowed usually at the cost of the patient; if there seems to be legitimacy of an issue the system might pay.

4) GTMO is a Special Case

- a) Prisoners could be confined for rest of their lives, etc. (no hope)
- b) No specific policy that addressed care of detainees until 2005 (policy memorandum in 2004 to treat detainees in a manner similar to own personnel who are in custody) (six month rotations of medical staff—guard force has primary relationship, care providers do not establish “rapport” or trust)
- c) providers have responsibility for health care, if opinion of attending physician is that continued fasting/refusal of fluids would likely result in permanent harm or death, recommendation must be taken to joint task force commander who has the ultimate authority to order intervention.
 - i) Camp commander and court are essentially the same, no checks or balances
 - (1) DoD has consulted with Imams- considered just having Imam instruct GTMO strikers that strike is prohibited by Islam (which prohibits suicide)—but can be rationalized as martyrdom rather than suicide
- d) Instruction is public (must force feed if necessary to prevent death or self-harm), but SOPs on hunger strikes are not available (q. should medical SOPs ever be classified?)
- e) State of medical profession is big on prevention: GTMO has become a case study in what not to do in response to a hunger strike, and even how to push detainees into going on hunger strike
 - Culture of extreme levels of control should be studied as a prevention measure.

5) The UK as a Possible Model

Treatment without consent is assault, reliance on advanced directives-involuntary resuscitation forbidden; access to independent physician at very early stage of hunger strike is facilitated. **See:**

Department of Health: *Guidelines for the clinical management of people refusing food in immigration removal centres and prisons*

<http://www.globallawyersandphysicians.org/storage/UK%20Protocol.pdf>

April 8, 2013

6) Next steps:

a) Collect data on hunger strikes

- i) Establish areas of uncertainty-know what we don't know
 - (1) International comparison: does the absence of force feeding result in death? (e.g. no deaths in UK since Bobby Sands hunger strike); Does force feeding cause death? (e.g., two Palestinians in the early eighties);
- ii) Establish smaller group(s) to identify specific data points
 - (1) Bureau of justice statistics
 - (2) International data-what's available? (Cochrane study?)
 - (3) Other organizations interested in prison data, could fund?

b) Review of best practices/standards of care for clinicians

- i) Group model?
 - (1) Informal process: clinical team, bring in mental health case workers who have rapport with patients and perceived as more neutral, also nursing staff who have more frequent contact, custody side: case managers/others in custody chain of command

c) Increase methods of professional support

- (1) Independent expert medical group to consult
 - (a) Who and where would that be? How compose and fund? Make known to physicians working in detention centers?
- (2) Educational campaign within correctional field
 - (a) Can be informal - correctional physicians are a small world
 - (b) Training for people going to GTMO - opportunity for collaboration with correctional professionals
 - (c) Medical director and health services director working together – opportunities in accreditation/professional bodies
 - (d) Revision of NCCHC policies regarding hunger strikes
 - 1. A communication from this event to interested organizations
 - a. NCCHC has asked society of correctional physicians to provide a curriculum of education for correctional physicians
 - 2. Work with national correctional organizations and medical organizations to take a formal position on hunger strikes consistent with the WMA's Malta Declaration.

d) Work to revise DoD Instruction/SOPs at Guantanamo and BOP regulations on hunger strikes to prevent force-feeding of competent hunger strikers and other rules consistent with WMA's Malta Declaration. Publicize problems with existing guidance/regulations. (Note: legal standards vary; Geneva's Common Article 3 is major legal guide at Guantanamo; the 8th amendment to the US Constitution is major guide in US)

April 8, 2013

- e) *Committee on Human Rights Meeting:* share results of meeting; discuss role of Committee in follow-up activities. (e.g. letter from IOM or Academies leaders suggesting need for outside medical consultants to visit Guantanamo soon to advise physicians there on the ongoing hunger strikes?)
- f) *Attendees to keep in touch and work together to try to improve medical care of hunger strikers and support physicians who follow medical ethics precepts in their treatment of hunger strikers.*