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Collateral Damage: The History of United States Case Law on Today's Military

Hunger Strike Doctrine

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by

Adrian Jose Mora

2011

ABSTRACT

COLLATERAL DAMAGE: THE HISTORY OF UNITED STATES CASE LAW ON TODAY'S MILITARY HUNGER STRIKE DOCTRINE

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HYPOTHESIS/AIMS: In the Global War on Terror (GWOT), hunger strikes by detainees in Guantanamo Bay, Cuba have been managed by military physicians through force feedings. This thesis answers the question of how did the United States justify its current practice of force feeding prisoners against prevailing medical ethics? The author hypothesizes that U.S. case law history of approximately 1979 to 1997 enabled the current military doctrine to force feed international detainees in GWOT.

METHODS: A qualitative and comprehensive review of the relevant literature was undertaken. The sources used for conclusive analysis included press releases, ethics commentary, law reviews, medical association declarations, military law, international law, domestic law, court cases, judicial reviews, military manuals, and federal prison manuals.

RESULTS: The majority of decided United States court cases from the late 1970's through the mid 1990's upheld that the State may force feed a competent prisoner on a hunger strike and override the patient's right to refuse treatment and right to privacy. The U.S. military's current hunger strike policy follows similar opinion and procedural language established from the aforementioned case law history.

CONCLUSION: The preponderance of established rulings suggests that approximately 20 years prior to the hunger strikes of Guantanamo Bay in GWOT, the United States justified force feeding fasting prisoners. This national acceptance influenced the Department of Defense's stance on detainee hunger strikes. The military's procedural guidelines follow current federal prison regulations. Also, the official opinions by the military cite the federal prison system, federal law, and court language applied by consenting rulings. Key international jurisdictions and the bioethics community, including the United Nations, have ruled to uphold a hunger striker's right to refuse nutrition. The U.S. military's refusal to align with prevailing ethics also demonstrates the larger significance of U.S. case law to validate today's U.S. military doctrine. As such, the author suggests avenues of bioethics reform for military medicine.

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To my wife, Carolyn Rose Mora, for her endless support and sacrifice during my training away at Yale.

This work is dedicated to the men and women who care for those in harm's way during combat.

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INTRODUCTION

As a reaction to the Soviet Union's use of psychiatrists to persecute political dissenters, the American Psychiatric Association (APA) joined The Hastings Center, a bioethics institute, to address the broad issue of conflicting loyalties in medical practice during a five day conference in 1977 (1). The conference may be construed as the first formal attempt to categorize the professional conflicts in military medicine. In the published discussions, Arlene Kaplan Daniels, an occupational sociologist, described the concept of "mixed agency" to expose the dual loyalty dilemmas of military psychiatrists serving in the Vietnam War (1). Daniels remarked that "the difficulties facing [physicians] in understanding their role (as agents of social control) when they make decisions for institutions are compounded by their place in medicine" (1). Even before Vietnam, in the mid-19th century, the newborn American Medical Association (AMA) formally pledged allegiance to the Union by donating a commemorative stone to the Washington Monument; the stone, inspired by Anne-Louis Girodet de Roucy-Trioson's *Hippocrates Refuses the Gifts of Artaxerxes*, implies that physicians' dual loyalty commitments originated during Hippocrates' time (Figure 1) (2).

As a general concept, mixed agency revolves around the obligations of a professional to their institution versus the expectations of the served individual. Mixed agency arises in the civilian medical realm within the context of providers and their pressures from prisons, hospitals, pharmaceutical firms, and insurance companies (3, 4). Also, at times, epidemiological mandates of forensic medicine, child welfare, and communicable diseases force physicians to subjugate the patient (3, 4). Yet, the loyalty of the military physician to their branch of service reaches a greater degree of importance, in

that, this conflict occurs in higher frequency during combat with consequences of military significance (3).

The indoctrination of service members and medical personnel includes this sobering realization of military consequences. For example, Edmund Howe, a military bioethicist and lecturer at the Uniformed Services University of the Health Sciences (USUHS), described the higher stakes found in the military with the classic scenario of returning the soldier to the front lines:

If increasing numbers of soldiers are excused from duty by feigning illness, the ability of the military to accomplish its mission will be diminished. It is even possible that the war could be lost, and that society that depends on its military could be destroyed. In that even the number of civilians killed may be in the millions. (4)

Perhaps, Howe's scenario may be far-reaching but it serves a clear illustration that the medical officer impacts goals of military necessity. Such goals include war strategy, fighting strength, counterinsurgency operations, and intelligence gathering to protect society (4).

Bioethicists from the civilian and military realms analyze and arrive at conclusions on the mixed agency of military physicians. Two opposing arguments warrant merit. One states that, because of the dual loyalty of the military physician, the very position of the military medical officer contradicts patient-centered medical care (5). The other camp, comprised of military physicians and officials, supports the military officer as the best solution to serve as the primary caregiver during combat (6).

In regards to the inherent nature of mixed agency, health law and civilian

bioethicists oppose the external commitments of the military medical officer. In the textbook *Military Medical Ethics* provided to medical students at USUHS, Victor W. Sidel and Howard B. Levy argue that the dual loyalty of the military physician renders this position ethically unjustifiable (5). Sidel and Levy speak as former military medical officers espousing physicians' social responsibilities even at the expense of a court martial, as exemplified in the case of Levy during the Vietnam War (5, 7); Levy served as a dermatologist in the Army and, on ethical grounds, refused to train Green Beret aid men on dermatological skills (7). These two authors outline that mixed agency leads to at least five ethical contraventions against the patient: subordinating patients' best interests, overriding patients' decisions, failure to provide care, and blurring the providers' noncombatant roles (5). The authors further propose that physicians carry a "special" responsibility to prevent war and, thus, they support disobeying orders on ethical grounds (5). After the Vietnam and Cold Wars, a relative paucity of opinion surfaced from academia. This calm may be attributed to the favorable outcomes and short stints of U.S. conflict through the 1980-1990's. After GWOT began, a reawakening occurred within biomedical experts to address the mixed agency problem and to present a call for patient-centered decision making. Maxwell G. Bloche, a member of Physicians for Human Rights and a health law bioethicist, frames that the Hippocratic Oath serves as the starting guidance for all physicians:

In denying their status as physicians, military doctors divert attention from an urgent moral challenge — the need to manage conflict between the medical profession's therapeutic and social purposes. The Hippocratic ethical tradition offers no road map for resolving this conflict, but it provides a starting point. The

therapeutic mission is the profession's primary role and the core of physicians' professional identity. (8)

George J. Annas, another bioethicist at Boston University, dictates that the concept of a true "mixed agency" for the military physician serves as a false deviation (9). Annas exclaims that, under all circumstances, military physicians are a "physician first, last, and always" (9). Yet, other commentators, such as Peter A. Clark, from Georgetown School of Medicine, recognize that the military dual loyalty issue reaches its boiling point when "being placed in the situation as physicians to these detainees....when the world is living in fear of yet another suicide bomb attack, places these military medical professionals in a delicate balancing act between loyalty to their patients and loyalty to their country." Yet, amidst the new strain of treating rogue terrorists, Clark concludes that the balance has shifted away from the care of these patients (10).

Against the current backlash of medical experts, military supporters have presented military-specific rebuttals to the aforementioned commentary. Supporters of military medical officers, as best apt to handle the loyalty of mission and patient, state that the qualifications of a military officer best fulfill the needs of the military and the esprit de corps of the very patients they treat (6). Another validation for the physician-soldier centers on the service that the military physician does for his or her country (6). William Madden, a military bioethicist writing to medical students at USUHS, conveys that the medical officer "is not violating his professional responsibility to relieve pain and suffering; rather it is being met in a special way" (6). In today's volunteer military, Howe illustrates that since individuals "autonomously choose to sacrifice for a greater good" then patient-soldiers expect that military physicians honor personal sacrifices to win

conflicts (4). Howe generalizes that military physicians lean towards a patient-centered practice and the exception occurs when “they encounter the extenuating circumstances requiring that priorities be given first to military necessity” (11). Also, in regards to Sidel’s commentary, Dominick R. Rascona responds as a current military physician and remarks that the role of the medical officer fills a legitimate societal duty during wartime (12). Medical decisions of the military constitute choosing the “lesser of evils” when diplomatic relations fail (12). Rascona contends that societies that follow the “just war” doctrine demand the virtue of duty from its citizens to “serve as soldiers and some doctors to serve as medical officers; it is only a question of who will subject themselves to the burden of this service” (12).

Ultimately, the solution between loyalties to the military versus the patient lies in striking the balance between both parties. Civilian analysts, such as Annas and Sidel, would most likely disregard an ethical spectrum and support a rigid patient-centered dogma of medical decision making. Nevertheless, at least currently, the military physician must have an established framework or he/she “can waylay” to “discover which master to serve” (13). One approximate strategy involves assessing whether “military necessity is not absolutely required” and, if not, then to practice patient-centered dynamics (4). For example, during the first Gulf War, military physicians vaccinated soldiers against Anthrax without consent to serve a high military objective of preventing mass casualties from the threat of biological weapons; typically, this mass effect decision rested on commanding officers and high ranking medical officers and not on the primary providers themselves (4).

In GWOT, military physicians care for allied soldiers and enemy combatants alike.

Each patient population brings specific scenarios that confront the caregiver with the theme of mixed agency. A general situation involves a detainee's right to refuse treatment as highlighted in a case study by the The Hastings Center:

United States Special Forces capture a combatant in the mountains of Eastern Afghanistan whom they believe has vital information that would help lead to the arrest of a major suspected terrorist. He is transferred to a U.S. military hospital at an undisclosed location. The physicians at the hospital soon discover that he is suffering from renal failure, and they prepare to provide dialysis. The combatant refuses, however, stating that he would rather die than live as a prisoner of the United States. Uncertain how to proceed, the military nephrologist asks her commanding officer for guidance. The question of whether to override the prisoner's refusal of treatment is quickly relayed up the military hierarchy. Two days later, the Secretary of Defense delivers the order to initiate dialysis, despite the prisoner's refusal. The order cites as justification the pressing national security interest in keeping the prisoner alive for a thorough interrogation that would lead to the arrest of an important terrorist suspect. Is the decision the right course of action? (14)

Regarding enemy detainees, a similar scenario involves military physicians' managing of hunger strikes. In order to stop these protests, military physicians enact force feeds (15).

In GWOT, Guantanamo Bay (GTMO), Cuba has served as a detention facility since 2002. The ethics of managing hunger strikes of detainees has been publicized (15-17). A hunger strike defines the voluntary refusal of food in order to achieve a goal or demand (18). How does the military carry out its policy towards hunger strikes? The following

excerpt from a medical note cited in the *New England Journal of Medicine* provides a glimpse of the established procedures:

Despite being advised that hunger striking is detrimental to his health, the detainee refuses to eat. Restraints were ordered for medical necessity to facilitate feeding the detainee. There is no evidence that medications or a medical process is causing this detainee's refusal to eat. Detainee does not have any medical condition/disability that would place him at greater risk during feeding using medical restraints.

Detainee was told that he will remain in restraints until feed and postfeed observation time (60–120 minutes) is completed. Detainee understands that if he eats, that involuntary feeding in medical restraints will no longer be required. (19)

Do established ethical guidelines support this sequence of events?

Professional organizations responded to the medical ethics in GWOT. The World Medical Association (WMA), who the American Medical Association (AMA) is a signatory member, formed their *Declaration of Tokyo* in 1975, with an update in 2006, to address physicians' participations in torture and their treatment of prisoners as a global reaction to the atrocities of the Vietnam War (20). The Declaration mandates the prohibition of torture, either direct or indirect, by medical professionals (20). Examples of indirect involvement include sharing medical knowledge and observing torture (20). Also, the WMA dictated that physicians, and not third parties, should have complete authority over prisoners' medical care (20). Of note, the WMA addressed hunger strikes and judged that mentally competent prisoners have the right to refuse food and not be force fed (20). In 2009, the WMA reaffirmed *The Declaration of Tokyo* and urged national medical associations to hold physicians accountable to its instructions (21).

Along with their affirmation in Tokyo, the WMA published a separate declaration addressing their position on hunger strikes in 1992 and updated it in 2006 in response to the Guantanamo hunger strikes. Entitled *The Declaration of Malta*, the WMA gave a comprehensive position and favored a patient's autonomy to refuse nutrition, if, and only if, the patient is deemed competent and the individual's decision is voluntary (22). The Declaration further dictates that physicians should remain objective in their evaluation to the hunger striker by clearly documenting the informed consent process, physical findings, and mental competency of the prisoner (20, 22). Also, physicians should prevent coercion by other detainees or third parties and they should ascertain the patient's wishes in written advance directives (22).

In respect to prisoners of war, the Geneva Conventions of 1949 extend the advancement of humane treatment of all detainees as binding international law. The Conventions prohibit acts of torture, humiliation, and medical maltreatment towards prisoners of war (23). In regards to interrogation, prisoners are obligated to "give only [their] surname, first names and rank, date of birth, serial number, or equivalent information" and "no physical or mental torture, nor any form of coercion, may be inflicted on prisoners of war to secure from them information" (23). Also, the Geneva Conventions encompass their protections to cover all belligerents until "their status is determined by a competent tribunal" (23). In regards to medical care, prisoners receive immediate life saving treatment and triage of mass casualties should follow: "only urgent medical reasons will authorize priority in the order of treatment administered" (23, 24). During internment, prisoners obtain access to an infirmary, specialized care, appropriate nutrition, sufficient hygiene products, and monthly medical checks (23). Whether

captured insurgents or terrorists warrant prisoner of war status, the Geneva Conventions afford a blanket of protection amongst all belligerents, regardless of their presumed status. This protection forms the referenced Common Article 3 which delineates the humane treatment of all captors, including the prohibition of “cruel treatment” and “outrages against personal dignity” (25).

Another legal source that guides military physicians is the Uniformed Code of Military Justice (UCMJ) which details punishable offenses that warrant court martial. Here, Articles 92 and 93 of the UCMJ deal with failure of obeying a lawful order and cruelty/maltreatment. Failure to obey an order constitutes:

Any person subject to this chapter who—1) violates or fails to obey any lawful general order or regulation; 2) having knowledge of any other lawful order issued by any member of the armed forces, which it is his duty to obey, fails to obey the order; or 3) is derelict in the performance of his duties. (26)

Cruelty and maltreatment correspond to: “any person subject to this chapter who is guilty of cruelty toward, or oppression or maltreatment of, any person subject to his orders shall be punished as a court-martial may direct” (26). Clearly, the Manual forbids abuse of patients and physicians must follow lawful orders as outlined by the Geneva Conventions and superior commanding officers.

Lastly, legal precedents through the justice system shed light on how the law applies in GWOT. One landmark Supreme Court case highlighted the emerging answers to detainee care in GWOT. The 2006 court case of *Hamdan v Rumsfeld* tested the executive branch’s ability to assemble special military tribunals to convict detainees of war crimes in relation to ties with Al-Qaeda (27). Furthermore, *Hamdan v Rumsfeld*

allowed for an initial judgment on whether the Geneva Conventions apply to the detainees in Guantanamo Bay (27). The Court decided that the Geneva Conventions do apply to detainees with at least the minimal protections afforded by Common Article 3 of humane/just treatment and medical care (23, 27). Common Article 3 prefaces with: “In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions” (23). As Justice John Paul Stevens clarified in his opinion:

The Court of Appeals thought, and the Government asserts, that Common Article 3 does not apply to Hamdan because the conflict with al Qaeda, being ““international in scope,”” does not qualify as a ““conflict not of an international character.”” That reasoning is erroneous. The term “conflict not of an international character” is used here in contradistinction to a conflict between nations. (27)

The review of applicable legal standards reminds the individual physician to understand how law has been interpreted. Such an understanding will allow for clearer decision making during combat towards the treatment of the wounded and the internment of detainees. Furthermore, the legal review and decisions of the Justice Department serve as a governing check for Department of Defense policy.

The ethical principles that mold the decision to force feed a patient embroil a physician’s stewardship to preserve life versus the autonomy of the patient. Regarding physicians’ personal convictions about the sanctity of life, military commentators contend that this ethical situation may be irreconcilable (17). The proposed justification for force feeding correlates hunger strikes as suicide and that all medical efforts are

permissible to prevent self-harm (17). Furthermore, detainees may suffer psychiatric disorders, thus blurring a detainees' competency, and the effect of peer pressure also confounds the voluntary basis of prison hunger strikes (10, 19). Also, non-medical explanations dictate that GTMO hunger strikers follow unconventional warfare and that allowing these deaths will corroborate a military failure with "global consequences" (10). Currently, the decision to force feed a detainee rests on the detention commander and this responsibility may free, or at least reduce, the military physician's moral burden (28).

Opponents, from the academia of health law and bioethics, state that aggressive action on competent individuals embodies a complete violation of medical ethics (19, 28). This camp contends that the aforementioned behavior takes away the autonomy of the patient. A counterpoint to a presumed military backlash from fasting deaths rests on prior suicides at the detention facility in Guantanamo; three suicides by hanging transpired and no such "risk to global security" has occurred (19). Also, the use of restraint chairs constitutes an unethical form to administer nutrition (19). As an exception, Annas concedes that force feeding may be justified in incompetent patients to serve their best needs but he concludes that most GTMO detainees are not deemed incompetent or suicidal (19). Also, commentators question that the commanders' ability to order force feedings does not free the military physician from carrying out the medical procedure and, as a consequence, breach medical ethics (10, 19, 28). Dissenters urged military physicians and leaders to stop force feeding and to follow declarations against the practice (19). This shift in policy will prevent this mixed agency scenario; a "physician first" doctrine would make it much less likely that any volatile orders would be issued in the first place (19).

Nevertheless, the military currently continues to use force feeding and successfully reduced the number of hunger to strikes from 164 detainees to only three protesters in 2006 (19, 29). Ultimately, the beneficence to maintain life confronts the patient's autonomy over his or her life. The review of military medical ethics, established guidelines, and expert commentary demonstrates a convincing demand to adhere to a patient's right to refuse nutrition. Therefore, when formulating the military's policy, how does force feeding competent individuals find its legitimacy? Here, a historical review and analysis emanates the consequences of domestic penal history on today's international military policy. The final aim is to decipher how the United States arrived with its current hunger strike policy and, furthermore, what avenue of reform needs attention in this current dilemma of military medicine's mixed agency. A clear and widely accepted solution to the issue of hunger strikes will improve military medicine and its impact on the global reputation of the United States and its military.



Figure 1. Hippocrates Refuses the Gifts of Artaxerxes, 1792, French. Oil on canvas.
Keeping his allegiance to Greece, Hippocrates refuses gifts by the Persian emissaries to convince him to aid plagued enemy soldiers.

STATEMENT OF PURPOSE

This analysis assesses the influence of United States case law history on the Department of Defense's policy of managing hunger strikes by enemy combatants. The author hypothesizes that the case law history of approximately 1979 to 1997 justified a State's right to force feed mentally competent prisoners undergoing hunger strikes and that this series of court decisions enabled the U.S. military's policy of force feeding detainees of the Global War on Terror. Secondary aims of the study are to elucidate how domestic policy influences U.S. military medicine, the relationship of the bioethics community with military medicine, and possible avenues for advancement in military medical ethics.

METHODS

The primary author undertook a comprehensive literature review in history of military medicine and military medical ethics. The central theme of mixed agency arose as a source of conflict in many physician scenarios. A review of the current literature showed that some unprecedented mixed agency situations have occurred in the Global War on Terror, specifically involving the care of detainees. One such situation is the managing of prisoner hunger strikes by the United States. The author reviewed the relevant literature of the hunger strike situation in GWOT using press releases, government conferences, non-government organization investigations, intra-government investigations, and ethics commentary. To investigate the origins of hunger strike policy, the author undertook interdisciplinary research of United States case law history, federal prison regulations, military regulations, international judicial opinions, international laws, and established ethics declarations. With the review of the evidence, the primary author arrived at conclusions of the influence of domestic court history on the military's hunger strike doctrine. The manuscript was reviewed by Dr. John H. Warner and Dr. Richard S. Young and appropriate revisions were included.

NOTE: The opinions and conclusions of this thesis are solely of the primary author and do not, necessarily, reflect the opinions or views of the United States Government, Department of Defense, or Department of the Navy.

RESULTS AND DISCUSSION

In addressing the issue of hunger strikes, the Assistant Secretary of Defense for Health Affairs (ASDHA), Dr. William Winkenwerder Jr., simply said in 2006, “There is a moral question....Do you allow a person to commit suicide? Or do you take steps to protect their health and preserve their life?” (15)

The United States military pursued the preservation of life of its Guantanamo detainees at all costs. Indeed, force feeding procedures involve nasogastric tubes and, at times, restraint chairs (15). A central question to ask is: how did the United States military arrive at force feeding competent prisoners? Formally, what established and accepted framework set the stage to force feed prisoners?

Specifically, the ethics of hunger strikes began to emanate in the U.S. Court system around the 1980’s through the mid 1990’s. This period of domestic law rulings constructed the starting platform of force feeding prisoners in the United States. A closer review of the respective court cases will set the further argument that U.S. domestic policy framed, if not at least influenced, today’s military policy of hunger strikes.

In 1979, the Supreme Judicial Court of Massachusetts heard what it considered the first case addressing a prisoner’s right to refuse life saving treatment. The Court remarked that the “judge below found that it raised novel and important questions of law” (30) . Kenneth Myers, a young competent male prisoner, developed kidney failure due to glomerulonephritis and, as such, the inmate received life-sustaining dialysis. After one year of treatment, Myers began to refuse dialysis to protest his transfer to a medium level security prison and to voice his desire to return to the minimum security facility (30). The court decided, in *Commissioner of Correction v Myers*, that the State had the right to

provide treatment without consent because of the “State's interest in upholding orderly prison administration and [the] evaluation of this interest takes account of the threat posed to prison order, security, and discipline by a failure to prevent the death of an inmate who attempts to manipulate his placement within the prison system by refusing life-saving treatment” (30). Myers’ case outlined the circumstances of when the State can impose its will on prisoners. In contrast to a previous case in 1977 of a terminal ill and mentally incompetent patient, in *Superintendent of Belchertown State School v. Saikewicz*, Myers’ case demonstrated the importance of the prisoner’s motive and medical condition to submit to medical intervention. The Court felt that since Myers was not terminally ill and dialysis proved an immediate life-saving procedure, then the State possessed a great investment to keep him alive (30).

In the year 1982, three separate court decisions regarding hunger strikes were handed down in Georgia, New York, and West Virginia. Georgia presented the first ruling and concluded opposite to *Myers*. Here, in *Zant v Prevatte*, Ted Anthony Prevatte was a death row inmate and underwent a hunger strike so that he may be moved to a different prison (31). Prevatte argued that his hunger strike was protected under the right to privacy (31). In contrast, the State of Georgia exclaimed the prison’s desire to preserve the inmate’s life (31). The Court decided that Prevatte was a “sane and competent” person and that the State failed to demonstrate evidence to save his life, especially since Prevatte was on death row (31). Furthermore, the Court exclaimed that prisoners do retain their right to privacy and that the prison system should not make life and death decisions (31). In the following years, the *Prevatte* decision to protect the medical autonomy of prisoners will join the minority of cases that favor hunger strikers. Three

months after *Prevatte* in Georgia, *Von Holden v Chapman* reverted to justify the force feeding of mentally competent prisoners (32). Mark D. Chapman, who murdered John Lennon, initiated a hunger strike with the intention to starve to death and draw attention to child hunger (32). Chapman explained his hunger strike fell under his right to privacy and freedom of expression (32). The Supreme Court of New York decided that the right of privacy does not constitute the right to commit suicide and the prison system is permitted in restricting individual expression for disciplinary order (32). Of note, Judge Denman recognized that “the preservation of life has a high social value in our culture” (32). The previous statement highlights the great psychological block of allowing hunger strikes in the United States. In West Virginia, *White v Narick* also ruled in favor of a prison’s responsibility to preserve a hunger striker’s life (33). Here, the Court also disagreed with *Zant* and exclaimed that the Georgia decision disregarded “compelling civility” against the loss of life and the “manipulative” indiscretions of prisoners (33). *Narick* and *Chapman* demonstrated that despite a precedent case favoring a prisoner’s autonomy, aligning decisions would be difficult to follow from other jurisdictions.

The remaining cases of the 1980’s struck similar decisions. In 1984, *In regards to Caulk*, Joel Caulk was subjected to enteral feeds in the State of New Hampshire. Caulk was a prisoner serving concurrent sentences and awaited further charges in the State of California; Caulk’s fate rendered him a prisoner for life (34). Thus, Caulk decided to starve to death and declared that he was not committing suicide in the following statement: “Absolutely not. There is a qualitative difference between what I am doing and suicide. I am allowing myself to die. My life is over. As far as I’m concerned my life has ended, only the dying remains. It’s not an overt act. I’m not killing myself. I’m allowing

myself to be taken, it's time" (34). Again, the State argued that the overriding principles were to preserve life and maintain the integrity of Caulk's criminal sentence (34). The State implied that, if the prisoner were allowed to die, then he escapes his full imprisonment and thus would "frustrat[e]" the criminal justice system (34). The sole dissenter, Judge J. Douglas, sided with Caulk's right to privacy and argued that the State did not prove that fasting was a danger to disciplinary order. For the first time in this respective case law history, Douglas cited the intrusiveness of enteral feeding via a nasogastric tube to outline a breach in medical ethics:

No novocaine was used during the insertion of the tube. He suffered a great deal of pain and discomfort as a result of the constant irritation of the tube on his throat and nasal passages. His efforts to resist the painful swallowing reflex caused him to suffer severe headaches. The tube was removed due to the danger of imminent ulceration of his throat and nasal passages. (34)

Despite Douglas' siding with a prisoner's medical right, the judge acknowledged the severity of the consequences in permitting hunger strikes and, therefore, proposed five precautionary steps: maintain consistency in prison policies, ascertain the prisoner's competency, obtain informed consent, waive any criminal liability of the penitentiary, and withhold resuscitative efforts (34). Judge Douglas represents another minority opinion in hunger strike case law. In 1989, Albert Garza, a patient in the United States Medical Center for Federal Prisoners (MCFP) in Springfield, Missouri underwent a religious fast according to Sephardic Judaism principles (35). In *Garza v Norman*, the prisoner invoked his freedom of religion as legitimacy to refuse food (35). The United States Circuit Court of the Eight District maintained that religious fasting, within the right

of free exercise of religion, in a prison setting is not absolute and that the prison system has a vested interest to preserve the inmate's life (35).

Before proceeding forward, a diversion into a Supreme Court case in 1987 warrants a closer look. In *Turner et al. v Safley et al.*, the Supreme Court reviewed prison regulations restricting inmate correspondence and marriage (36). The Supreme Court applied a "reasonable relationship" standard to assess a prison's regulation on the infringement of individual rights (36). At this juncture, the *Turner* decision represented the first case by the Supreme Court to develop a litmus test on prison policies. The "reasonable relationship" standard sharply contrasted with the "strict scrutiny" traditionally applied by the courts towards the infringement of personal liberties (37). The Court defined a regulation as reasonable if it served a legitimate government purpose and if other alternatives existed (36). Also, the Supreme Court weighed the prison's resources to permit the individual liberty and whether a lack of options justified the regulation (36). This more lax review of prison regulations cemented the lower court rulings of the decade and enabled prisons to continue to deter hunger strikes via force feeds into the 1990's.

At the turn of the decade, the Supreme Court of the United States heard a similar case regarding prisoners' rights. In *Washington v Harper*, Walter Harper began to refuse psychotropic medications and soon decompensated to become violent and a threat to others within the prison system (38). Washington argued that the use of a prison medical committee to determine whether to treat him without consent violated the Fourteenth Amendment Due Process clause (38). The Supreme Court ruled against Harper, citing the landmark case of *Turner*. Justice Kennedy asserted the usefulness of *Turner*, in that, it

“[applies] in all cases in which a prisoner asserts that a prison regulation violates the Constitution, not just those in which the prisoner invokes the First Amendment” (38). Also, the Court ruled that the medical board contained the appropriate due process safeguards and the best qualifications for such decisions (38). In the same year, Pennsylvania decided to pursue force feeding on Joseph Kallinger, who underwent a hunger strike due to a vision he experienced (39). In *Commonwealth of Pennsylvania v Kallinger*, the Court cited *Harper* to validate the force feedings of its prisoners (39). Following in 1995, *Schuetzle v Vogel*, the Supreme Court of North Dakota used *Turner* and *Harper* to allow the prison medical system to administer insulin and nutrition to a non-consenting patient (40). Even recently, in 2003, the Appellate Court of Illinois ruled to force feed Eldon Millard who underwent a hunger strike due to his facility transfer; here, the court sided against Millard by applying *Turner* and similar previous cases (41). Of note, in Millard’s case, the dissenting Judge Knecht outlined that the State did not show convincing reasons why “penological interests” are involved (41). Ultimately, Knecht believed that Millard continued to have the right to refuse treatment (41). Clearly, the litigation of the 1980’s and 1990’s, with the support of the Supreme Court, cemented a longstanding deference to the U.S. prison system.

Eleven years after the *Zant* decision, the State of California judged in 1993 in favor of a prisoner’s right to hunger strike. The Court affirmed that a competent adult can make decisions regarding their refusal of medical treatment regardless of the medical consequences and that the State cannot force such medical treatment unless there is a clear threat to public safety (42). In *Thor v Superior Court*, Howard Andrews was a quadriplegic inmate dependent on medical assistance with his bodily functions, including

feeding (42). Andrews began to refuse food and medicine and the attending physician sought authorization to place a feeding tube into Andrews' stomach (42). In a revolutionary tone, the court's opinion described that the refusal of medical treatment embodied a fundamental right for prisoners and non-prisoners, regardless of status or motive (42). Unlike the previous cases mentioned, the *Thor* case opinion effectively cited the stances of the bioethics community, such as The Hastings Center and the California Medical Association, to demonstrate that patient autonomy frames the practice of medicine (42).

In 1996, *Singletary v Costello* the Florida Court of Appeals weighed the State's interests against the prisoner's right of privacy. The review of the State's interest included preservation of life, prevention of suicide, protection of third parties, and the integrity of the medical profession (43). With the facts of the case, the Court ruled that the State did not have overriding evidence to overturn the prisoner's right to refuse mandatory nutrition (43). As seen, *Costello*, *Zant*, and *Thor* comprised the only three cases that protected a prisoner's right to refuse nutritional intervention. In contrast, over a dozen cases supported the state's ability to force feed competent prisoners during the same time period.

Not relating to prisoner hunger strikes, a landmark Supreme Court case in 1990 starkly contrasts its application of patient autonomy in the non-prison world. In *Cruzan v Director, Missouri of Departmental Health*, the Court upheld the right of patients to refuse medical treatment by the Due Process Clause of the Fourteenth Amendment (44). Here, Nancy Cruzan suffered an automobile accident that rendered her in a persistent vegetative state with no hope of recovery (44). Cruzan's parents requested to discontinue

her enteral feeds and assisted medical efforts (44). The Supreme Court ultimately rejected the parents' wishes under the pretense that Nancy Cruzan never gave clear directives to discontinue care if she were in a vegetative state (44). Thus, the Court judged that only the patient maintains the right to refuse treatment and medical decisions made by others should rely on the patient's consent (44). Following in 1997, the Supreme Court upheld the ban on assisted suicide in *Washington v Glucksberg* and further reaffirmed the right to refuse treatment in *Cruzan* by differentiating this right as explicitly distinct from physician assisted suicide (45). The cases of *Cruzan* and *Glucksberg* demonstrate the lesser degree of patient autonomy afforded to prisoners (37).

The recorded opinions of military authorities reflect the principles and decisions of the U.S. Court system. The military implies legal justification in the Joint Task Force Guantanamo's motto of "Safe, Humane, Legal, and Transparent" (46). Joint Task Force (JTF) Guantanamo forms the multi-branch command of the detainee facility in Guantanamo Bay, Cuba. The official newspaper for the command, *The Wire*, contains numerous instances where command officials defend their doctrine of treating hunger strikers. In 2005, the Deputy Commander and Senior Medical Officer went on the record to explain that the responsibility of the detention facility centers on the health of the prisoners and that enteral feedings are "humane" and "minimally intrusive" (47). This rationale conforms with the preservation of life doctrine upheld in U.S. Courts and the acceptance of minimally invasive procedures cited in cases like *Myers*. In relation to the use of restraint chairs, JTF officials implied securing prison order from the speculation of detainees' "character and temperament" (47). In 2007, another *Wire* article delineated the facility's motives for force feeding. CAPT Ronal L. Sollock, the Joint Medical Group

commander, expressed that the responsibility of the medical group is the “preservation of life” and the “unnecessary loss of it” due to hunger strikes (16). Furthermore, the article cites that the Department of Defense Standard Operating Procedures for detainee hunger strikes follows the guidelines of the Department of Justice, Bureau of Prisons; here, the command directly recognizes that U.S. domestic policy towards hunger strikes serves as formal justification (16).

JTF-Guantanamo takes an effort to assimilate the theme of preservation of life into their accounts of enteral feedings. Hospital Corpsmen form the equivalent of paramedics and are trained in the daily operations of feeding hunger strikers. A page in the official JTF website chronicles the details of force feeding detainees (48). The command asserts that the feeding procedures are “safe and humane” (48). Furthermore, a description outlines the definition of hunger strikers and the overall mission towards the preservation of life:

Detainees are considered hunger strikers if they miss nine consecutive meals and they demonstrate intent to go on a hunger strike. Once a detainee is considered a hunger striker, he is closely observed for any deterioration in his health that can be life threatening. When it is determined his hunger strike has continued to the point where his health is in jeopardy, an individual nutrition plan is created for each detainee to ensure each receives the proper nutrients to sustain them safely and humanely. (48)

Apart from the senior officers of the command, this description demonstrates that the expressed philosophy to prevent death applies to the lower ranks in the detention center.

In 2006, Dr. William Winkenwerder, the Assistant Secretary of Defense for Health

Affairs (ASDHA), held a media roundtable with several news organizations to discuss several detainee health care policies (29). In this interview, Winkenwerder repeatedly used U.S. domestic legal policy to support military hunger strike procedures.

Winkenwerder stated that the goal of military detention aims to “preserve the life” of the detainee in accordance with United States law, specifically with Title 28 of the Code of Federal Regulations (29). Also, when asked about restraint chairs, Winkenwerder proffered legal arguments that the chairs increase the safety of prison medical staff (29). Winkenwerder cited the *Declaration of Malta* to support that resuscitation efforts fall in line with force feeding hunger strikers (22, 29). This statement by the Assistant Secretary fails to address that *Malta* states that such approach should be the exception--when prisoners have not expressed their desires and that repeated fasts should be respected (22, 29). This omission by Winkenwerder suggests that military policy derives on careful selection of supportive documents and highlights the importance of the overwhelming support of U.S. legal precedent. In 2007, Winkenwerder was relieved as ASDHA by Dr. S. Ward Casscells (46). Casscells, in an article posted in the JTF website, quotes previous State arguments that “no U.S. law or religion approves of suicide” (46). As shown, Casscells and Winkenwerder demonstrate a clear Department of Defense reliance on domestic philosophy framed by the U.S. legal system. As recently as 2009, the American Civil Liberties Union (ACLU) drafted a formal letter to Secretary of Defense, Robert Gates, addressing the ethical stances against force feeding and its contradiction to cases like *Cruzan* and *Glucksberg* (49). In response, the Deputy Assistant Secretary of Defense for Detainee Affairs, Sandra Hodgkinson, raptly wrote that the military practice of hunger strikes follows the Federal Bureau of Prisons and with U.S. legal standards (50).

Apart from the official viewpoints from government officials, the published hunger strike policies between the domestic and military are similar in principle and wording. The United States Bureau of Prisons, an agency under the Department of Justice, updated its policy on hunger strikes in January 15, 2005. In their Program Statement, entitled *Hunger Strikes*, the purpose section obligates the prison administration to “preserve life” (51). The policy defines a hunger strike as a refusal of food of 72 hours with or without the inmate’s explicit declaration of engaging in one (51). This definition matches the corpsman’s description of missing nine consecutive meals by GTMO hunger strikers (48). *Hunger Strikes* cites the language of Title 28 Part 549 as the guiding source for outlining initial medical referrals, psychiatric evaluations, informed consent procedures, and involuntary feedings (51). Also, protesting inmates transfer to a single person cell, lose commissary privileges, and receive three meals a day (51). In comparison, in 2006, William Winkenwerder released a Department of Defense Instruction, entitled *Medical Support for Detainee Operations*, to outline the principles of managing hunger strikes. The procedures constitute close similarities with the Bureau of Prison mission to prevent death with involuntary treatment (52). Also, like the domestic policy, inmates undergo mental and health evaluations and receive thorough informed consent discussions (52). Of importance, the Instruction orders detention facilities, such as JTF-Guantanamo, that their hunger strike policies “shall be developed with consideration of procedures established by Title 28, Code of Federal Regulations, Part 549” (52). The American Civil Liberties Union, under the Freedom of Information Act (FOIA), obtained a specific command Standard Operating Procedure (SOP) from the Bagram Theater Internment Facility, in Afghanistan. The SOP outlines the same definitions and procedures as

Winkenwerder's instruction and adds certain medical criteria for the initiation of involuntary force feeding (53). Military physicians are instructed to consider enteral feeding when they observe signs of organ damage, fasting patients with pre-existing conditions, prolonged fasts of more than 21 days, weights less than 85% of ideal body weight, or reductions of 15% of original weights (53). Furthermore, similar to the U.S. Bureau of Prisons, the SOP outlines other alternatives such as intravenous hyperalimentation or placing a gastrostomy tube as last resorts (51, 53). Also, both institutions implement authorization checks on medical personnel through the requirement to have commanding officer or warden/court authorization, respectively (51, 53). None of these institutions' publications consider in writing the prevailing stance of the ethics community against involuntary treatment of competent individuals, thus, suggesting their heavy reliance on U.S. case law precedence (51, 53).

Outside of the United States, the international community demonstrated examples where case law upheld a prisoner's right to refuse treatment. The review of these cases implies that the medical legal system, by at least through court cases, has an impact on patients' rights. In 1995, the United Kingdom recognized patient autonomy in *Secretary of State for the Home Department v Robb* (54). Here, the High Court reasoned that since the prisoner undergoing the hunger strike was of "sound mind" and that he understood the consequences of his fast then the prison system did not possess the authority to force feed him (54); this ruling upheld British law and set the same medical standard amongst civilians and prisoners (37). Since the British ruling, there have been two prison deaths from hunger strikes in the United Kingdom involving Gary Bland and Barry Horne, in 1996 and 2001 respectively (55). Bland was a former murderer and Horne was an animal

rights activist (55). The fact that, since 1995, two UK hunger strike deaths occurred, suggests that few prisoners will culminate a fast with their personal demise. Subsequently, other global rulings supporting prisoners emerged. For example, in 2005, the Human Rights Court in Ukraine upheld the right to refuse nutrition; the Court rationalized that the prison system did not show compelling evidence of medical necessity to initiate feedings and cited Common Article 3 and the WMA's *Declaration of Tokyo* as standings towards ruling in favor of the prisoner (56). Unlike the majority of the U.S. cases, here, in the case of *Nevmerzhitsky v. Ukraine*, the court uses established bioethics in deciphering their opinion (56). Following in 2006, a United Nations Tribunal reviewed a case from the Netherlands involving a Serbian prisoner's hunger strike. In *Prosecutor v Vojislav Seselj*, the Tribunal ordered the Dutch government to pursue medical care of the detainee "to the extent that such services are not contrary to compelling internationally accepted standards of medical ethics or binding rules of international law" (57). Also, the Tribunal requested the Dutch to update their citations of medical ethics to include the updated *Declaration of Malta* of 2006 which irrevocably rules out force feeding (57). The international cases of *Nevmerzhitsky* and *Seselj* demonstrate that the international community has acknowledged a prisoner's medical autonomy recently.

Apart from international court cases, the United Nations independently reviewed the medical ethics of JTF-Guantanamo. In the Commission of Human Right's *Situation of Detainees at Guantanamo Bay*, the Commission concluded that the internment procedures were in violation of medical ethics and the "right to health" (58); also, of note, the review noted that the U.S. court cases failed to regard relevant mandates (59).

The Commission recommended that the United States stop force feeding competent detainees (58). Also, the Commission encouraged the reform of U.S. policy to conform to the United Nations' *Principles of Medical Ethics* in which it specifically prohibits the use of restraining procedures (58, 59). In 1998, the International Committee of the Red Cross (ICRC) posted their stance on force feeding aligning with the WMA's declarations (60). Here, the ICRC stresses that an open patient-physician relationship would allow for effective informed consent; furthermore, physicians should not subject prisoners to coercion (60). In an interview in *Harper's Magazine*, the ICRC was documented to disagree with the U.S. military's policy (61). The senior medical advisor, Dr. Paul Bouvier, spoke to the Assistant Secretary of Defense for Health Affairs and he relayed that the ICRC does not support the force feeding of prisoners (61).

The overarching connection between the U.S. military and the justice department reached a stronger consensus when, in 2009, the United States District Court of the District of Columbia heard the first case involving hunger strikes in GTMO (62). Here, United States District Judge, Gladys Kessler, ruled in favor of the Government. In *Al-Adahi v Obama*, Mohammad Ali Abdullah Bawazir and others filed for an Emergency Motion for Injunction to stop the use of restraint chairs during enteral feeds; the plaintiffs urged that the application of restraint chairs equaled torture (62). Kessler denied the injunction and allowed military medical personnel to continue force feeds and use restraint chairs as they seemed necessary (62). Citing legal precedence, Kessler decided that the District Court did not have jurisdiction over aspects of detention operations in Guantanamo and, even if it held such right, she rationalized that prior U.S. cases such as *Turner* substantiated the practice of force feeding and the use of restraint chairs, when

necessary (62). The case of *Al-Adahi v Obama* conclusively links the unforeseen consequence of 1979-1997 case law: extending domestic doctrine into the treatment of prisoners of GWOT.

Amidst the criticism of the military's hunger strike practices, the groundwork began almost 30 years ago within the United States. Even though hunger strikes have been a form of protest throughout history, the jurisdiction of the 1980's and 1990's reflected American ideology that the preservation of life and the State's interests can upend a prisoner's right of privacy, in this case medical autonomy. Since the Global War on Terror began after September 11, 2001, the United States military could have formulated their mandates on published medical opinions and international laws. Furthermore, key foreign entities, such as the United Kingdom, enacted and upheld a patient's right to refuse nutrition regardless of a citizen's status. Therefore, the only legitimate backing for the United States Department of Defense lies in the United States legal system corroborated by the case law history of the State, District, and Supreme Courts. Another controversial military policy, such as "Don't Ask Don't Tell" (DADT), has been supported and rejected by the justice system using Supreme Court decisions on sodomy laws such as *Bowers v Hardwick* and *Lawrence v Texas* (63, 64). The DADT issue exemplifies another instance where domestic case law affects military policy, albeit in a non-medical context, and further underscores this relationship in regards to hunger strikes.

The unintended consequences of hunger strike case law on international detainees beg the question of how we could have arrived at a different current outcome. Perhaps, the U.S. court system, during its time, did not fully involve the bioethics community in

assessing each case of prisoner hunger strikes. At the very least, the court system could have referenced with more stature the published stances on hunger strikes. The Geneva Conventions, the *Declaration of Tokyo*, the *Declaration of Malta*, and the UN's *Principles of Medical Ethics* constitute some of these resources. Thus, if the court system ignored, or, at the most, perused medical ethics, then the authoritative weight of medical associations, global bodies, and international law comes into question.

Then, does the obstinate resistance of the U.S. military on hunger strikes suggest that medical ethics should consider a separate framework for military physicians? How can military physicians free themselves from breaching their moral compass of medical practice while fulfilling requirements of military necessity? A simplistic solution requires physicians to defer to the institution during mixed agency situations. In the case of national prisons, the United States has concluded that patient autonomy does not stand as an absolute right and that penitentiary order and discipline constitute lofty priorities. Military prisons share such priorities with the added responsibility of national security. JTF-Guantanamo performs interrogation operations on its detainees and, one may suggest, that death from successful fasts undermines this national goal. The Office of National Intelligence published several thwarted terrorist plots from information collected through detainee interrogations (65). Therefore, a possible solution forces the bioethics community to uphold, or at least recognize, the validity of an institution's agenda-- a prison's interest to keep competent, healthy inmates alive and the military's objective to keep America secure.

Alternatively, how does the chronicled effect of U.S. medical law history into foreign military policy illuminate the best way towards patient-centered reform? As a

broad and starting platform, undergraduate and graduate medical education should emphasize a thorough discussion of military medical ethics and mixed agency conflicts. This investment would place future well-versed civilian and military physicians to discuss and improve military medical ethics. In 1994, as an Army doctor, Brian Carter, conducted an intra-service survey to ascertain ethical concerns by Army physicians deployed in Desert Storm (66). Sizable groups of respondents disagreed with certain tenets of detainee care outlined by the Geneva Conventions (66). In 2007, motivated by the ethics of GWOT, J. Wesley Boyd and fellow peers surveyed about 5,000 medical students from various institutions and demonstrated that the majority of respondents received less than one hour of ethics instruction in military medicine and few students were familiar with mandates of the Geneva Conventions (67). These objective studies and sobering findings call for further exploration of military medical ethics throughout the training pipeline.

Externally, many commentators and human rights organizations believe that the United States military should involve independent bioethicists and policy planners in constructing medical guidelines surrounding mixed agency issues (10, 18, 28, 68, 69); clearly, this approach demands consideration and the Department of Defense credits referencing the civilian medical world for input (29, 70). Yet, this approach has failed to a degree, since amidst the rhetoric, current policy still condones force feeding with the backing of domestic health law. Here, then, one must conclude that effective action for reform would originate from harder authoritative sources. Congressional legislation from either the state or federal levels would begin to change the national landscape of upholding a competent prisoner's right to refuse medical treatment. Therefore, health

law, human rights, and ethics activists should target their concerted efforts to all branches of government. A pressing voice would initiate greater discussion within public officials and the American people. If the United States desires to advance the field of medical ethics and, ultimately, one of the mixed agency scenarios of military physicians, then a change in domestic policy should be reanalyzed and reformed. With this goal of change, the State, physicians, and the general public would have to restrain their pride and view all prisoners as *patients first*. This prolonged misperception of prisoners serves as the initial barrier in reform as reflected in *The King's Threshold* by W. B. Yeats during Ireland's early 20th century hunger strikes:

He has chosen death:

Refusing to eat or drink, that he may bring

Disgrace upon me; for there is a custom,

An old and foolish custom, that if a man

Be wronged, or think that he is wronged, and starve

Upon another's threshold till he die,

The common people, for all time to come,

Will raise a heavy cry against that threshold,

Even though it be the King's. (71)

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