

Psychiatry and Hunger Strikes

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Psychiatrists play an instrumental role in the evaluation of hunger strikers in correctional and detention facilities. This article focuses on the role that psychiatrists play in evaluating the capacity of an individual who is voluntarily fasting. It examines theoretical and legal definitions of hunger strikes, including the criteria applied in federal and state prisons, as well as in the detention center at the U.S. naval base at Guantánamo Bay. The article discusses the limitations of psychiatric involvement, including professional values on death and suicide, limited access to information, normative judgment, and the use of psychiatry for non-treatment government purposes. Despite these limitations, the article concludes that psychiatrists should play a critical role in hunger strikes, particularly in circumstances where hunger strikers have very limited rights and require ongoing mental health care.

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I. INTRODUCTION

From the hunger strikes of the English suffragettes in the early twentieth century to the public hunger strikes of Mohandas Gandhi in India, individuals have undertaken hunger strikes in both custodial and non-custodial settings as a means of conducting political protest and communicating distress.¹ Hunger strikes by detainees at the Guantánamo Bay Detention Camp at the U.S. naval base at Guantánamo Bay (“Guantánamo Bay”) are a contemporary example that has aroused increased scrutiny from the general public, medical and legal organizations, and human rights groups, both in the United States and internationally. As early as 2002, detainees protested alleged mistreatment of copies of the Koran by guards and interrogators by refusing to eat.²

These early hunger strikes at Guantánamo Bay were resolved after military officials released new guidelines on treatment of the Islamic holy book.³ Since 2002, however, allegations of isolative and inhumane detention conditions and abuse by guards resulted in multiple additional strikes by Guantánamo Bay detainees,⁴ notably in 2005,⁵ 2007,⁶ and 2009.⁷ Reports based on statements to a British newspaper by a U.S. military lawyer

1. See generally, SHARMAN A. RUSSELL, *HUNGER: AN UNNATURAL HISTORY* (2005).

2. Carol D. Leonnig, *More Join Guantánamo Hunger Strike*, WASH. POST, Sept. 13, 2005, at A3, available at http://www.washingtonpost.com/wp-dyn/content/article/2005/09/12/AR2005091201690_2.html.

3. *Id.*

4. Tim Reid, *One in Five Guantánamo Bay Detainees Is on Hunger Strike*, TIMES ONLINE, Jan. 15, 2009, http://www.timesonline.co.uk/tol/news/world/us_and_americas/article5518812.ece.

5. See, e.g., Mike Mount, *Hunger Strike at Guantánamo Grows*, CNN.com, Sept. 13, 2005, <http://cnn.com/2005/WORLD/americas/09/13/gitmo.strike>; Charlie Savage, *46 Guantánamo Detainees Join Hunger Strike*, BOSTON GLOBE, Dec. 30, 2005, at A2; Jane Sutton, *75 Prisoners Join in Hunger Strike at U.S. Base at Guantánamo Bay*, WASH. POST, May 30, 2006, at A7 (reporting that the recent hunger striking detainees join a few who have been refusing food since August 2005); Letta Taylor, “*People Will Definitely Die*”: *Guantánamo Inmates Resolute in Second Month of Hunger Strike*, NEWSDAY (Melville, N.Y.), Sept. 10, 2005, at A14.

6. Tim Golden, *Guantánamo Detainees Stage Hunger Strike*, N.Y. TIMES, Apr. 9, 2007, at A12, available at <http://www.nytimes.com/2007/04/09/us/09hunger.html>.

who represents one of the detainees indicate that nearly one in five detainees at Guantánamo Bay were on hunger strike as of early 2009, corresponding to an estimated forty-four to fifty of the 248 to 260 detainees held in Guantánamo at that time.⁸ In addition, some reports suggest that in early 2009 approximately thirty-three detainees were being force-fed through nasogastric tubes.⁹

Medical ethicists have pointed out the complex medical and ethical problems facing physicians who participate in the evaluation and force-feeding of detainees; they have thus cautioned against¹⁰ and heavily criticized¹¹ physician participation in force-feeding. However, little attention has been given to the critical role that psychiatrists play in the evaluation of fasting individuals, particularly since psychiatrists are commonly called upon to assess competence for medical and related decision making.¹²

This article focuses on the role that psychiatrists play in evaluating the competence of an individual who is voluntarily fasting. Inherent in defining a hunger strike are assumptions of legitimacy and mental capacity for decision making. Part II sets forth several theoretical and legal definitions of hunger strikes used by a variety of organizations, including criteria used in federal and state prisons as well as at Guantánamo Bay. This Part also articulates essential factors to consider in capacity evaluations of fasting individuals in order to illustrate why psychiatric evaluations cannot be done in a vacuum. In subsequent sections we explain the psychiatric model and show how psychiatrists are uniquely advantaged and simultaneously limited by their training and skill set when evaluating a hunger striker. We describe capacity evaluations and demonstrate that although psychiatrists may not be involved directly in the forced treatment of these individuals, they play an instrumental role in determining the legitimacy of the hunger striker's decision to fast and therefore may be seen as indirect agents of resulting force-feeding. Finally, we discuss several barriers to accurate capacity evaluations and the ethical dilemmas associated with psychiatric evaluations of fasting individuals. We assert that the psychiatric commu-

7. Reid, *supra* note 4, at A12; see also Mark Townsend & Paul Harris, *Top U.S. Lawyer Warns of Deaths at Guantánamo*, OBSERVER (London), Feb. 8, 2009, at 14, available at <http://www.guardian.co.uk/world/2009/feb/08/binyam-mohamed-torture-Guantánamo-bay>; Amnesty Int'l, *50 Guantánamo Detainees on Hunger Strike*, Feb. 10, 2009, http://www.amnesty.org.nz/archived_news/50_detainees_on_hunger_strike.

8. Tim Reid, *One in five Guantanamo Bay detainees is on hunger strike*, THE TIMES, Jan. 15, 2009, available at http://www.timesonline.co.uk/tol/news/world/us_and_americas/article5518812.ece.

9. Townsend & Harris, *supra* note 7, at 14.

10. George J. Annas, *Hunger Strikes at Guantánamo—Medical Ethics and Human Rights in a “Legal Black Hole”*, 355 N. ENGL. J. MED. 1377, 1377 (2006).

11. David J. Nicholl et al., *Forcefeeding and Restraint of Guantánamo Bay Hunger Strikers*, 367 LANCET 811, 811 (Mar. 11, 2006).

12. There is currently no article in the psychiatric literature on the role of psychiatrists in evaluating hunger strikers in Guantánamo, in contrast with the literature examining the participation of medical physicians in the force-feeding of hunger strikers. See, e.g., Annas, *supra* note 10; Nicholl, *supra* note 11.

nity should be aware of the moral implications of a psychiatric determination of capacity in hunger strikes, particularly in the case of Guantánamo Bay. Other models exist in response to hunger strikes—including ethical and rights-based models—and these should be considered alongside the psychiatric and medical model.

We conclude that early participation of psychiatrists and other mental health specialists in these situations is critical and necessary to the successful and ethical evaluation, intervention, and management of hunger strikes. Psychiatrists are vested with significant moral and political responsibility and should be aware of the potential limitations and implications of their assessments in these circumstances. We suggest the need for clearer guidelines from medical and psychiatric associations on the participation of psychiatrists and physicians in the evaluation of a hunger striker.

II. DEFINITION OF HUNGER STRIKES

How one defines hunger strikes raises ethical questions concerning legitimacy, rationale, and decision making capacity. This Part explores definitions of hunger strikes in order to highlight the complexities and moral implications that arise when psychiatrists are called to evaluate hunger strikers.

A. *International Red Cross Definition*

Hernán Reyes of the International Committee of the Red Cross defines a hunger strike as requiring three components: fasting, voluntariness, and a stated purpose.¹³ Reyes makes a distinction between two types of so-called, often self-labeled, hunger strikers in prison settings: “food refusers” and “real hunger strikers.”¹⁴ Within the food refuser group, he identifies two subgroups: (1) “reactive food refuser” and (2) “determined food refuser.” Reyes divides these subgroups based on level of intention toward death, source of motivation, and behavior. He argues that the reactive food refuser is a prisoner who “reacts to a given situation, most often in frustration or anger, and says he is ‘going on a hunger strike’ in protest.”¹⁵ He explains that the reactive food refuser “has not the slightest intention of fasting to death, or anywhere near death,” and is also a “noisy extrovert.”¹⁶ The determined food refuser “make[s] little if any noise” and is in “a hopeless

13. Hernán Reyes, *Medical and Ethical Aspects of Hunger Strikes in Custody and the Issue of Torture*, in 19 MALTREATMENT AND TORTURE, RESEARCH IN LEGAL MEDICINE (M. Oehmichen, ed., 1998), available at <http://www.icrc.org/Web/Eng/siteeng0.nsf/iwpList302/F18AA3CE47E5A98BC1256B66005D6E29>.

14. *Id.*

15. *Id.*

16. *Id.*

position.”¹⁷ These types of food refusers are not trying to exert external pressure by fasting but are expressing desperation or a cry for help.

Actual hunger strikers, according to Reyes, can be divided into “determined” and “not-so-determined” hunger strikers.¹⁸ He describes determined strikers as those who are willing and intend to fast to death. Reyes’s method of distinguishing between real and so-called hunger strikers is useful in extreme contexts where the prisoner is clearly attempting to frustrate security, is refusing food because he or she is depressed or hopeless rather than for a cause, or is clearly reluctant about actually fasting. However, Reyes’s categories are not helpful in situations where the hunger striker may have a mixture of attributes from each category and complex, multiple motivations. For example, many detainees in Guantánamo Bay are reported to be hopeless and desperate,¹⁹ but the same individuals are also hunger striking to protest alleged religious abuses by the U.S. government at Guantánamo Bay.²⁰ Furthermore, whether these individuals are noisy and extroverted should not be relevant to whether they are actual hunger strikers. Therefore, although Reyes attempts to legitimate the individual by labeling him or her an “actual hunger striker” with a real political cause or motivation while de-legitimizing others by labeling them “food refusers,” in reality, the line between categories is often blurred.

Reyes’s definition is also limited in that it misses several variables that we believe are critical and that will be discussed later in the context of our proposed definition of hunger strikes. Reyes alludes to several such variables such as the idea that reactive food refusers are more common in countries where basic rights of prisoners are respected and the idea that real hunger strikers often participate in a collective effort.²¹ We maintain, however, that it is advisable to assess each of these situational and evaluative factors separately rather than label individuals based on these subtypes.

Reyes’s distinction among these subtypes does, however, raise an important point: How one views an individual’s intention and commitment to stop eating helps determine whether or not one views the hunger strike as legitimate. Other definitions of hunger strikes also assume the specific purpose of the strike.²² Reyes’s and other purpose-focused definitions attempt to reserve the term “hunger striker” for those individuals whose fasting appears to more legitimate. The problem with this method of definition is that it becomes entangled in normative judgments about the purpose of the

17. *Id.*

18. *Id.*

19. Carol J. Williams, *Details on Detainee Suicides Emerging*, L.A. TIMES, June 12, 2006, at 1 [hereinafter *Details Emerging*] (paraphrasing psychiatrist Steven Xenakis, a retired Army Brigadier General) (reporting that detainees on hunger strikes appear to “signal[] feelings of hopelessness and fatalism”).

20. See Leonnig, *supra* note 2.

21. Reyes, *supra* note 13.

22. Michael K. Daines, *Hunger Strikes in Correctional Facilities*, in CORRECTIONAL PSYCHIATRY 8-1 (Ole Thienhaus & Melissa Piasecki eds., 2007) (defining a hunger strike as “the refusal of nutrition as a means of passive resistance”).

strike—whether the strike is an act of resistance simply for the sake of being oppositional or for protesting some condition. In practice, the situation is frequently either more uncertain or complex than his definition allows. Thus, in this paper, we depart from the Reyes typology and refer to hunger strikers as those individuals observed to be voluntarily fasting, even if their purpose is unclear.

B. World Medical Association Definition

The World Medical Association (WMA), unlike Reyes, does not require a specific purpose in its definition of hunger strikes. In the Declaration on Hunger Strikers, the WMA states that “[a] hunger striker is a mentally competent person who has indicated that he has decided to embark on a hunger strike and has refused to take food and/or fluids for a significant interval.”²³ Of note, this definition presupposes the mental capacity of the hunger striker (i.e. in order to qualify as a hunger striker, an individual must have had the capacity to make this decision at the time he or she decided to fast). The medical literature on hunger strikes does not consistently use this definition—it instead often refers to the individual who is voluntarily fasting as the “hunger striker” and then distinguishes between hunger strikers who are competent and incompetent.²⁴ In this paper, the term “hunger striker” does not assume that the fasting individual possesses decisional capacity. Thus, we will use the term hunger striker to include all those who are voluntarily fasting, irrespective of whether they have been evaluated for competency.

C. U.S. Federal Prison and Detention Definitions

The correctional setting is one area where the U.S. government has defined hunger strikes. The Federal Bureau of Prisons has issued detailed guidelines delineating hunger strikes and procedures for the force-feeding of inmates.²⁵ Prison officials are required to monitor the health and welfare of inmates and to ensure that all steps are taken to preserve life. These guidelines define hunger strikes as follows:

- (a) When he or she communicates that fact to staff and is observed by staff to be refraining from eating for a period of time, ordinarily in excess of 72 hours; or
- (b) When staff observe the inmate to be refraining from eating for a period in excess of 72 hours.²⁶

23. World Med. Ass'n, *Declaration on Hunger Strikers*, Nov. 1991, rev. Oct. 2006, available at <http://www.wma.net/en/30publications/10policies/h31/index.html> [hereinafter World Med. Ass'n, *Declaration*].

24. See, e.g., Bea Brockman, *Food Refusal in Prisoners: A Communication or a Method of Self-killing? The Role of the Psychiatrist and Resulting Ethical Challenges*, 25 J. OF MED. ETHICS 451, 453 (1999).

25. 28 C.F.R. §§ 549.60-549.66 (2009).

26. 28 C.F.R. § 549.61.

However, the staff does not have to wait for an observed hunger strike in order to refer an inmate for a medical evaluation. When the staff considers it “prudent,” a referral for medical evaluation may be made without waiting seventy-two hours.²⁷

The U.S. Immigration and Customs Enforcement (ICE) has also issued a standard for hunger strikes.²⁸ ICE defines a hunger strike as “[a] voluntary fast undertaken as a means of protest or manipulation. Whether or not a detainee actually declares that he or she is on a hunger strike, staff members are required to refer any detainee who is observed to not have eaten for 72 hours for medical evaluation and monitoring.”²⁹ Detainees at Guantánamo Bay have been evaluated under similar criteria. Officials at Guantánamo Bay state that a detainee is classified as being on hunger strike after going three consecutive days without eating.³⁰

Why have policymakers chosen a seventy-two hour period? The medical effects of hunger strikes help interpret this period of observed fasting. If the individual is well nourished when the hunger strike starts, then the risk of death from malnutrition occurs about six to eight weeks after starting a complete fast.³¹ If the individual is refusing both fluids and food, then deterioration is expected rapidly, with risk of death as early as seven to fourteen days.³² Deterioration of muscle strength and increased risk of infection can occur within three days of fasting.³³ Furthermore, many individuals who commence fasting do not start in a healthy condition, and medically compromised individuals can die as early as three weeks after the beginning of the fast.³⁴

D. *Assessment of Other Factors*

We argue that the complete assessment of a hunger strike should weigh several factors in addition to purpose and motivation. Instead of specifying

27. *Id.*

28. U.S. IMMIGRATION & CUSTOMS ENFORCEMENT, U.S. DEP’T OF HOMELAND SEC., OPERATIONS MANUAL ICE PERFORMANCE BASED NATIONAL DETENTION STANDARDS, ICE/DRO DETENTION STANDARD: HUNGER STRIKERS 1 (2008), available at http://www.ice.gov/doclib/PBNDS/pdf/hunger_strikes.pdf.

29. U.S. IMMIGRATION & CUSTOMS ENFORCEMENT, U.S. DEP’T OF HOMELAND SEC., OPERATIONS MANUAL ICE PERFORMANCE BASED NATIONAL DETENTION STANDARDS, ICE/DRO DETENTION STANDARD: DEFINITIONS 4 (2008), available at <http://www.ice.gov/doclib/PBNDS/pdf/definitions.pdf>.

30. *Sharp Rise in Number of Gitmo Detainees on Hunger Strike: US*, AGENCE FRANCE-PRESSE, Jan. 12, 2009, available at http://www.google.com/hostednews/afp/article/ALeqM5ioVHLbShKEGU_p90YF0W57_0eJYTA [hereinafter *Sharp Rise*].

31. OFFENDER HEALTH, DEP’T OF HEALTH (U.K.) & DR. MIKE STROUD, GUIDELINES FOR THE CLINICAL MANAGEMENT OF PEOPLE REFUSING FOOD IN DETENTION SETTINGS & PRISON 8 (2007), available at <http://www.medicaljustice.org.uk/images/stories/texts/hungerstrikeguidelines2007.pdf> [hereinafter GUIDELINES].

32. *Id.*

33. *Id.*

34. *Id.*

the purpose of the strike as a determining factor, we characterize hunger strikes according to situational, individual, and evaluator factors.

1. *Situational Factors*

Several situational factors should be considered when evaluating a hunger strike. The first factor is whether the strike is an individual or organized effort. The decision to embark on a hunger strike as an individual as opposed to participating in an organized hunger strike can give insight into the intent and motivation behind the hunger strike. Proceeding as a group may increase credibility because more people have decided to engage in the same behavior, and accurate reality-testing is more likely in a group than in a single person. On the other hand, the possibility of peer pressure is also an important consideration. Whatever the role of peer pressure, collective hunger strikes are more likely to be taken seriously both by those at whom the strike is directed and by the hunger strikers themselves.

The second situational factor considers the details of an individual's legal status, including citizenship, custodial status, physical location, and stage of any claim or criminal charge against the hunger striker. These distinctions can shed light on the available alternative avenues for individual expression (if any), the degree of protection of procedural rights, the amount of mental duress the hunger striker is experiencing, and the importance of what is at stake. Whether the striker has been charged, tried, or sentenced are all relevant factors that evaluators should consider.³⁵ A distinction should also be made between individuals in prison or jails and those in detention. The prison culture imposes different and separate stresses on the individual's mental health and behavior compared to other institutions.³⁶ Even among different types of prisons, there are different pressures to consider.³⁷ Detention may have unique stresses arising from indefinite length and limits on access to the outside. Individuals who are civilly committed to a mental institution and thus in custody of the state are also a separate category.

These factors are helpful to understand a striker's motivation and the degree to which his or her rights are protected. Additional insights may be gained by comparing the striker to precedents within the same population. The psychiatric assessment should consider whether similar hunger strikes have occurred in that detention setting, as well as any similarities among prior hunger strikes—that history can shed light on the level and kind of duress of a particular detention context.

35. Brockman, *supra* note 24, at 452.

36. James Knoll IV, *Impact of the Structure and Function of Corrections on Inmates' Mental Health*, in CORRECTIONAL PSYCHIATRY, *supra* note 22, at 2-1.

37. *Id.* at 2-9 - 2-12.

a. *The Case of Asylum Seekers*

This section examines the case of asylum seekers in order to illuminate complex issues of management and evaluation of hunger strikes in a detention setting. Hunger strikes by asylum seekers are a well-described phenomenon, but evaluations are often complicated by significant language and cultural barriers as well as the alleged existence of past persecution in an asylum seeker's native country.³⁸ Noncitizens who are not physically present within the United States, such as those detained at the border, have historically been afforded fewer procedural protections than either citizens or noncitizens within the country.³⁹ Despite the existence of procedural due process rights for asylum seekers on U.S. soil, asylum seekers nevertheless face significant challenges navigating the procedures of the ICE. Conflicting circuit court opinions suggest that there is significant dispute over the content of adequate procedural safeguards for asylum seekers.⁴⁰ The asylum review process is rigorous and can also be lengthy and burdensome.⁴¹ These pressures and procedures are associated with psychological stress for the asylum seeker, which may present in various ways. Symptoms of anxiety, depression, and post-traumatic stress disorder have been significantly correlated to the length of detention.⁴² Between 2003 and 2007, the average length of customs or asylum seeker detention increased from sixty-four to ninety-four days.⁴³ The uncertainty of the length of detention may exacerbate the asylum seeker's distress.⁴⁴ An understanding of hunger strikers in this context therefore requires consideration of the asylum

38. Brockman, *supra* note 24, at 452; see also Mary A. Kenny et al., *Legal and Ethical Implications of Medically Enforced Feeding of Detained Asylum Seekers on Hunger Strike*, 180 *MED. J. AUST.* 237 (2004); Derrick Silove et al., *Ethical Considerations in the Management of Asylum Seekers on Hunger Strike*, 276 *J. OF AMER. MED. ASS'N* 410 (1996).

39. The Fifth Amendment's protections do not extend to aliens outside the territorial boundaries. See *United States v. Verdugo-Urquidez*, 494 U.S. 259, 269 (1990); *Landon v. Plasencia*, 459 U.S. 21, 32 (1982); *Johnson v. Eisentrager*, 339 U.S. 763, 784 (1950). For the longstanding distinction between an alien who has effected an entry into the United States and one who has never entered, see *Leng May Ma v. Barber*, 357 U.S. 185, 188–190 (1958) (finding an alien “paroled” into the United States pending admissibility had not effected an “entry”); *Kaplan v. Tod*, 267 U.S. 228, 230 (1925) (holding that despite nine years’ presence in the United States, an “excluded” alien “was still in theory of law at the boundary line and had gained no foothold in the United States”). For an analysis of due process rights for citizens, noncitizens, and potential asylees, see generally Nimrod Pitsker, *Due Process for All: Applying Eldridge to Require Appointed Counsel for Asylum Seekers*, 95 *CALIF. L. REV.* 169 (2007).

40. Kendall Coffey, *The Due Process Right to Seek Asylum in the United States: The Immigration Dilemma and Constitutional Controversy*, 19 *YALE L. & POL'Y REV.* 303 (2001).

41. See 8 U.S.C. § 1158 (2006). See also TRANSACTIONAL RECORDS ACCESS CLEARINGHOUSE IMMIGRATION, ASYLUM LAW, ASYLUM SEEKERS AND REFUGEES: A PRIMER (2006), <http://trac.syr.edu/immigration/reports/161/>.

42. Allen S. Keller, et al., *Mental Health of Detained Asylum Seekers*, 362 *LANCET* 1721, 1721–23 (2003).

43. PHYSICIANS FOR HUMAN RIGHTS & BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE, FROM PERSECUTION TO PRISON: THE HEALTH CONSEQUENCES OF DETENTION FOR ASYLUM SEEKERS 14 (2003), available at <http://physiciansforhumanrights.org/library/documents/reports/report-perstoprison-2003.pdf>.

44. *Id.* at 7.

seeker's legal status and claims, as well as resulting psychological stress, coping, and motivation.

b. The Case of Detainees at Guantánamo Bay

The procedural and substantive rights of those classified as “enemy combatants” and detained offshore at Guantánamo Bay have been an even more controversial area of litigation and dispute.⁴⁵ Court decisions have largely focused on issues of process, including whether courts have jurisdiction,⁴⁶ whether the appropriate branch of government made the policy determination,⁴⁷ and whether policy implementation procedures were proper.⁴⁸ For example, in *Hamdan v. Rumsfeld*, the Supreme Court held that the military commissions established by President Bush to try detainees were unconstitutional because the procedural and evidentiary rules prescribed by the President differed substantially from the rules set forth in the Manual for Courts-Martial and offered inadequate protections for the accused.⁴⁹

The Guantánamo Bay detainee cases highlight the importance of understanding the conditions of a hunger striker in custody in order to comprehend his or her motivation and intention as well as any realistic alternative to a hunger strike. Specifically, it is essential to consider whether the hunger strike occurs in a setting where inadequate procedural protections or even human rights violations and abuses are likely that leave the hunger striker with few or no other options for self-expression. But the evaluator of the hunger striker's mental status, who must put the hunger strikes into context, then faces a difficult and possibly insurmountable obstacle: How is one to assess the adequacy of procedural protections or the likelihood of human rights abuses? Should this assessment be based on investigations or opinions of the governing state, the international community, or NGOs such as Amnesty International? How much should one weigh the fact that a jurisdiction may be bound by certain international laws, including, but not limited to, the Geneva Conventions? There are few reliable indicators, as Guantánamo Bay demonstrates. The U.S. government has argued that that the detention center at Guantánamo Bay complies with the Geneva Conventions, but detainees and some investigators have reported abuses in violation of the Geneva Conventions.⁵⁰ Some experts and commentators

45. See generally Jenny S. Martinez, *Process and Substance in the “War on Terror,”* 108 COLUM. L. REV. 1013 (2008). See also Mark A. Drumbl, *Guantánamo, Rasul, and the Twilight of Law*, 53 DRAKE L. REV. 897 (2005); David A. Martin, *Offshore Detainees and the Role of Courts after Rasul v. Bush: The Underappreciated Virtues of Deferential Review*, 25 B.C. THIRD WORLD L.J. 125 (2005).

46. *Rumsfeld v. Padilla*, 542 U.S. 426, 446 (2004) (holding that the petition challenging detention as enemy combatant should have been filed in South Carolina rather than New York).

47. *Hamdan v. Rumsfeld*, 548 U.S. 557 (2006) (holding that the President must comply with statutes enacted by Congress in terms of procedures for military commissions).

48. *Hamdi v. Rumsfeld*, 542 U.S. 507, 533 (2004) (holding that prisoner was entitled to minimal procedural due process).

49. *Hamdan*, 548 U.S. at 622–23.

50. Charles Babington & Michael Abramowitz, *U.S. Shifts Policy on Geneva Conventions*, WASH. POST, July 12, 2006, at A1, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/>

have gone so far as to assert that one is likely to find torture in any administrative detention.⁵¹ Thus, the scope of this inquiry is clearly outside the realm of what a psychiatrist evaluating a hunger striker in the situation can accurately ascertain. Access to information in connection with such investigations may be extremely limited.⁵² In these cases, the evaluator is obligated to consider the likelihood of abuse in the detention setting, just as an evaluator is obligated to consider the impact and relevance of real or perceived emotional, sexual, or physical abuse in a person's psychiatric history.⁵³

c. The Case of Haitian Refugees at Guantánamo Bay

It is notable that hunger strikes have been used before as a form of protest at the U.S. Naval Base at Guantánamo Bay. From 1991 to 1993, the United States government ran a special detention camp, Camp Bulkely, at the Naval Base in Guantánamo Bay.⁵⁴ The camp detained 310 Haitian refugees with human immunodeficiency virus (HIV).⁵⁵ The U.S. Constitution did not apply to this particular refugee processing center and the aliens therefore had no claims to due process.⁵⁶ Yale Law School's Lowenstein Human Rights Clinic initiated a legal and grass-roots campaign to free the Haitian refugees at Guantánamo Bay, which resulted in a difficult and lengthy struggle with Bush administration lawyers.⁵⁷ As the legal battle began to appear less hopeful, even after the transition to the Clinton administration, the refugees began a hunger strike in what was interpreted to be an expression that they would "either close the camp or die."⁵⁸ As Michael Ratner, one of the lawyers who was part of the movement to release these refugees explains, the hunger strike's likely effect was a source of great debate: "while the strike could bring great media and public attention to the camp, some members of our legal team thought it could be counterproduc-

07/11/AR2006071100094.html; Peter Finn & Del Quentin Wilber, *Review Finds Detainees' Treatment Legal*, WASH. POST, Feb. 21, 2009, at A03, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/02/20/AR2009022002191.html>.

51. See, e.g., Jennifer Van Bergen & Douglas Valentine, *The Dangerous World of Indefinite Detentions: Vietnam to Abu Gbraib*, 37 CASE W. RES. J. INT'L L. 449, 449 (2006).

52. See David Luban, *Lawfare and Legal Ethics in Guantánamo*, 60 STAN. L. REV. 1981, 1989 (2008) (noting the extremely limited access that habeas lawyers have to detainees); *Camp Off Limits During Khadr Hearing: Guantánamo Prison Officials Don't Want Detainees to Feel Like They're 'On Display'*, KITCHENER RECORD, Jan. 10, 2006, at D9 (noting that hearings of the alleged abuses are not public at Guantánamo Bay).

53. See, e.g., Metin Basoglu, et al., *A Multivariate Contextual Analysis of Torture and Cruel, Inhuman, and Degrading Treatments: Implications for an Evidence-based Definition of Torture*, 79 AM. J. ORTHOPSYCHIATRY 135, 137 (2009); Eric Blaauw, et al., *Traumatic Life Events and Suicide Risk Among Jail Inmates: The Influence of Types of Events, Time Period and Significant Others*, 15 J. TRAUMATIC STRESS 9, 9 (2002).

54. See Michael Ratner, *How We Closed the Guantánamo HIV Camp: The Intersection of Politics and Litigation*, 11 HARV. HUM. RTS. J. 187, 187 (1998).

55. *Id.* at 187.

56. *Id.* at 192.

57. *Id.* See also, Harold H. Koh, *The Haitian Centers Council Case: Reflections on Refoulement and Haitian Centers Council*, 35 HARV. INT'L L.J. 1 (1994).

58. Ratner, *supra* note 54, at 208.

tive.”⁵⁹ However, Ratner asserts that “the hunger strike was the strategic turning point. It brought press, well-known personalities, and politicians to Guantánamo.”⁶⁰ Ratner recalls the impact of the hunger strike on the legal strategy:

Some of us were fearful that the strike would embarrass the Clinton administration and make it harder for our inside lobbying strategy to work. Others felt it would help put pressure on Clinton, and that it was, therefore, a positive development. In reality, it made little difference what any of us thought. The Haitians had been in the camp almost a year, and they were doing what they believed was necessary to gain their freedom. The hunger strike gave them a semblance of control over their situation and made the lawyers work harder. . . . The hunger strike turned out to be very successful, and it is an example of outside organizing around a legal proceeding, beyond the legal team’s grand plan.⁶¹

This example illustrates the importance of considering the larger cultural, religious, and political context within which hunger strikes often occur. In the Haitian refugee camp situation, the strikes resulted in political and legal changes that may not have otherwise occurred as quickly or at all. This case also helps to illuminate how hunger strikes have been used as a vehicle for protest and have in some instances, to a certain extent, resulted in more recognized legal rights for the hunger strikers. Most importantly, as Ratner implies, a hunger strike represented perhaps the only method by which the detained Haitian refugees could express their autonomy and humanity and be *heard*.

The organized hunger strike by Irish Republican Army (IRA) members in 1981 is another example of how important political conflicts can generate hunger strikes. Bobby Sands, an IRA officer, began a hunger strike to protest British treatment of IRA members as criminals rather than political prisoners.⁶² Sands fasted for sixty-nine days and, along with nine other strikers, died as a result of the hunger strike.⁶³ However, not all strikes are motivated by a need to protest political or cultural causes. For example, John Allen Muhammad, convicted of six murders in connection with sniper attacks in the Washington, D.C. area in 2002, began an individual hunger strike in 2005. A judge on the 6th Judicial Circuit Court of Maryland authorized the Department of Corrections to administer necessary nourishment, hydration, and medical care through nasogastric feeding and intrave-

59. *Id.*

60. *Id.*

61. *Id.* at 211.

62. DAVID BERESFORD, TEN MEN DEAD: THE STORY OF THE 1981 IRISH HUNGER STRIKE 7-104 (1987).

63. *Id.*

nous fluids, if necessary, to sustain his life.⁶⁴ Muhammad's strike ended after six days of fasting.⁶⁵ This hunger strike had very different characteristics than the Guantánamo Bay hunger strikes, as illustrated by several contextual factors. Specifically, Muhammad undertook an individual strike, which did not have clear political or cultural motivations. He was held on U.S. soil in a facility where procedural protections and rights have historically been respected and where he had alternative avenues for communicating his concerns and grievances. Having examined situational factors in a number of examples, we now explore different individual factors that help evaluate and distinguish hunger strikers.

2. *Individual Factors*

Factors specific to the hunger striker are critical to understanding the nature and intent of the hunger strike. A first important consideration is the hunger striker's age and whether the person is a minor or an adult. Some of the Guantánamo Bay hunger strikers have included minors such as Omar Khadr, who was captured by U.S. forces and brought to Guantánamo Bay in 2002 at age fifteen.⁶⁶ Khadr undertook a hunger strike in 2005 for reasons that are unclear; he has also been described as contemplating suicide.⁶⁷ Both the medical and legal communities presume that minors have less decision-making capacity than adults and may be more susceptible to external pressure from peers and adults. Other demographic factors, including race, ethnicity, religion, socioeconomic class, and the relationship that the individual has to these factors (for example whether ethnicity plays a central role to identity) are also important in evaluating the larger cultural and political context of a hunger strike.⁶⁸

The evaluator should identify any barriers that might compromise the hunger striker's decisional capabilities. For example, an examination of the person's psychiatric and medical history and current symptoms may reveal factors affecting a hunger striker's decision-making abilities and cognitive processes. One should assess whether there is preexisting mental illness or if this mental state was induced by state-imposed circumstances. Most commonly, hunger strikers do not have mental disorders.⁶⁹ However, some hunger strikers have had a prior mental illness, such as psychosis and paranoia, which can lead the person to stop eating for reasons that are not real-

64. *National Briefing, Mid-Atlantic: Maryland: Officials Allowed To Force-Feed Sniper*, N.Y. TIMES, Aug. 27, 2005, available at <http://query.nytimes.com/gst/fullpage.html?res=9404E7D91F3EF934A1575BC0A9639C8B63>.

65. *Id.*

66. See Matthew Happold, *Child Soldiers: Victims or Perpetrators?*, 29 U. LA VERNE L. REV. 56, 71 (2008) (discussing the case of Omar Khadr); Jeff Tietz, *The Unending Torture of Omar Khadr*, ROLLING STONE, Aug. 24, 2006, at 60–104 (reporting on juvenile detainee, Omar Khadr, who has contemplated suicide).

67. *Id.*

68. Silove, *supra* note 38, at 410–415.

69. Daines, *supra* note 22, at 8–1.

ity-based.⁷⁰ Other psychiatric illnesses, such as depression, post-traumatic stress disorder, and behaviors like suicidal gestures or self-injury must also be considered. Suicide is the leading cause of death in detention centers and the third leading cause of death in prisons.⁷¹ A range of self-injurious behavior and suicidal behaviors exist in correctional settings.⁷² It is therefore critical to distinguish between behaviors intended to kill oneself and behaviors undertaken to make a statement or protest. Although hunger strikes can eventually result in death due to the risk of infection and organ failure, the hunger striker may not have commenced a hunger strike with the intent of killing himself. For example, a politically motivated hunger striker may pursue a strike precisely with the goal of living under better conditions, even though he is willing to die for his cause.

Other medical and neurological factors, such as delirium, can affect a hunger striker's mental state. Delirium can be caused by a range of different medical reasons, including fasting and malnutrition.⁷³ The acuity of the striker's medical or neurological condition and the likelihood of its deterioration are also important in assessing the urgency of the evaluation. In more extreme situations, the striker may become comatose as a result of a hunger strike. In these cases, one is forced to operate with limited data on the person's motivations.

In situations where a hunger striker's mental status is compromised, even when the individual can speak with the evaluator, collateral sources and a careful examination of past behavior and associations shed light on the possible intent and motivation of the hunger striker. For example, past preferences, choices, and coping strategies may clarify how the hunger striking behavior is related to individual psychology. Often, however, even after assessing these individual factors, it may still be difficult to determine whether one is acting out of sheer resistance of authority, as an act of expression, or as a protest against specific conditions. It may be a combination of multiple motivations that, for various reasons, cannot be readily assessed (e.g., limited data, unwillingness of the striker to communicate). The striker may not even fully understand his or her motivations or purpose. The psychiatric model, which is introduced in Part IV, creates a framework within which individual factors can be organized and analyzed in order to determine the competency of an individual.

70. See Brockman, *supra* note 24, at 452 (describing an African asylum seeker who believed that people were trying to poison him and who also was found later to have a record of mental illness in his native country).

71. Ole J. Thienhaus, *Suicide Risk Management in the Correctional Setting*, in CORRECTIONAL PSYCHIATRY, *supra* note 22, at 6-1 - 6-10.

72. Henry Schmidt III & Andre Ivanoff, *Behavioral Prescriptions for Treating Self-Injurious and Suicidal Behaviors*, in CORRECTIONAL PSYCHIATRY, *supra* note 22, at 7-1.

73. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS IV §293.0 83-84 (4th ed. 2000) (defining delirium as "an acute confusional state characterized by a disturbance in consciousness and change in cognition . . . characterized by a reduced clarity of awareness of the environment with impairment in the ability to focus, sustain, or shift attention").

3. Evaluator Factors

The identity of the evaluator may also create differences in terms of his or her obligations and approach to the hunger striker. A psychiatrist⁷⁴ plays a different role than a medical doctor⁷⁵ in the evaluation, although there are areas of overlap. In theory, either could be trained to screen for medical and psychiatric conditions and symptoms in the hunger striker. Yet the psychiatrist, unlike the general medical physician, is rarely, if ever, called upon to force feed a hunger striking individual in state custody.⁷⁶ Even so, the psychiatrist may nonetheless, either consciously or unconsciously, tend to act in the interest of the state rather than provide an objective assessment of the hunger striker's mental status. For example, a correctional psychiatrist may struggle with objectivity, especially regarding questions that may require an understanding of the prison culture and institutional operations. A psychiatrist may also have multiple roles relative to the government and the hunger striker. He or she may be called upon as an independent evaluator, as an expert by the individual's attorney, or as a state-employed actor. If the psychiatrist is state-employed, then he or she must have heightened awareness of the possibility that he or she is acting on behalf of state interests and is at risk of compromised objectivity. In these situations, the psychiatrist should act with caution to avoid being used as an instrument of the state. The psychologist should also consider other factors, including his or her cultural and political background. These become especially important when communication with the hunger striker may be limited by language and cultural barriers. In the next Part, we explore how these factors are treated within three different approaches to hunger strikes.

III. EXISTING MODELS

Several different models have emerged to assist in analyzing and crafting a response to hunger strikes. We address these models in the context of hunger strikes in detention centers and prisons, with specific reference to the hunger strikes at Guantánamo Bay. This Part presents the three major models: the medical model, the rights model, and the ethics model. We emphasize the need for a fourth psychiatric model in order to address and recognize the problems of mental health for detainees, particularly those on hunger strike. However, the complex ethical situation presented by hunger strikes necessitates including ethical and rights-based considerations as an

74. Brockman, *supra* note 24.

75. Annas, *supra* note 10; World Med. Ass'n, *Declaration*, *supra* note 23. See Neyyire Y. Oguz & Steven Miles, *The Physician and Prison Hunger Strikes: Reflecting on the Experience in Turkey*, 31 J. MED. ETHICS 169 (2005), for a description of the experience of a physician working with a hunger-striking prisoner in a Turkish prison. See Jonathan H. Marks, *Doctors as Pawns? Law and Medical Ethics at Guantánamo Bay*, 37 SETON HALL L. REV. 711 (2007), for a discussion of medical doctors' participation in force-feeding.

76. As experienced in R. Brendel's clinical practice.

important component of any psychiatric analysis. We assert that these three models should be integrated to address hunger strikes at Guantánamo Bay.

A. *Medical Model*

The medical model approaches the hunger striker as a patient.⁷⁷ The physician is faced with the task of completing the appropriate medical evaluation and diagnostic tests, recommending monitoring, and potentially recommending treatment interventions.⁷⁸ Formulating a standard of care for the medical management of hunger strikers is an ongoing effort, and non-governmental organizations have begun to release clinical guidelines toward this end.⁷⁹

Along with the clinical care recommendations, however, the physician must weigh the patient's autonomy and determine whether he or she has the requisite mental capacity to make the decision to refuse food. Formal capacity assessments are commonly performed by psychiatrists but can be done by any physician. While capacity assessment is under the larger umbrella of the medical model, it is also central to the psychiatric model, and in Part IV we will discuss it further in the context of a larger psychiatric model.

Organizations that issue standards for health care delivery in prisons have been silent on the specific issue of hunger strikes in prisons.⁸⁰ The U.S. Bureau of Prisons has issued guidelines on the clinical evaluation and management of hunger strikes, including the requirement of obtaining a psychological or psychiatric evaluation of the hunger striker.⁸¹ The medical model alone, absent psychiatric or psychological input, does not provide an adequate framework for balancing the competing imperatives of delivering appropriate medical care and respecting patient autonomy.

B. *Rights Model*

The rights model emphasizes the multiple rights implicated when an individual decides to initiate a hunger strike, continue the strike, and refuse treatment. It should be noted that no federal court has recognized a pris-

77. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* ix-x (1984) (discussing the medical model and the physician-patient relationship).

78. See GUIDELINES, *supra* note 31 (a clinical guide for management of people who refuse food in detention).

79. *Id.*

80. Tracey M. Ohm, Note, *What They Can Do About It: Prison Administrators' Authority to Force-Feed Hunger-Striking Inmates*, 23 WASH. U. J.L. & POL'Y 151, 161-63 (2007) (discussing the split in decisions by modern state courts on the issue of force feeding for hunger strikes).

81. Once the staff observes a hunger strike or suspects one, the staff can order an evaluation which requires one to: 1) measure and record height and weight; 2) take and record vital signs; 3) perform a urinalysis; 4) conduct a psychological and/or psychiatric evaluation; 5) conduct a general medical evaluation; 6) obtain radiographs as clinically indicated; 7) perform laboratory studies as clinically indicated. 28 C.F.R. § 549.63(a) (2009).

oner's right to hunger strike.⁸² The Federal Bureau of Prisons guidelines require that prison officials ensure that all procedures are taken to "preserve life."⁸³ The majority of state court decisions have held that the state's interest in the preservation of life, combined with penal and institutional interests, outweigh the autonomy-based right to hunger strike.⁸⁴ However, at least one court determined that the state does not have the right to frustrate a hunger striker and based its decision on the striker's autonomy.⁸⁵ Courts have noted that a hunger strike could constitute protected speech under the First Amendment if the strike is intended to express a message about prison.⁸⁶ However, as a matter of constitutional law, prisoners who hunger strike may still be force-fed and hydrated, even if the strike is a form of protected protest.⁸⁷

Legal arguments and rationales supporting the right to hunger strike have generally been grounded in the right to privacy and procedural due process.⁸⁸ These rights form the basis of the right to refuse treatment, specifically force-feeding. The Supreme Court has explicitly held that individuals have the right to refuse medical treatment in the form of life-sustaining nutrition and hydration in *Cruzan v. Director, Missouri Department of Health*.⁸⁹ In relevant case law, the courts weigh several state interests against the right to refuse force-feeding: preservation of life, prevention of suicide, and, in cases of prisoners and detainees, effective prison administration and security.⁹⁰ Officials at Guantánamo Bay have used many of these

82. Mara Silver, *Testing Cruzan: Prisoners and the Constitutional Question of Self-Starvation*, 58 STAN. L. REV. 631, 638 (2005).

83. 28 C.F.R. § 549.60 (2009).

84. Ohm, *supra* note 80, at 158.

85. *Zant v. Prevatte*, 286 S.E.2d 715, 716-17 (Ga. 1982) ("The State can incarcerate one who has violated the law and, in certain circumstances, even take his life. But it has no right to destroy a person's will by frustrating his attempt to die if necessary to make a point.").

86. *Stefanoff v. Hays County*, 154 F.3d 523, 527 (5th Cir. 1998) (holding that the First Amendment is not implicated when prisoner is denied credit for good behavior after a hunger strike).

87. See, e.g., Joel K. Greenbert, *Hunger Striking Prisoners: The Constitutionality of Force-Feeding*, 51 FORDHAM L. REV. 747 (1983); D. Sneed & Harry W. Stonecipher, *Prisoners Fasting as Symbolic Speech: The Ultimate Speech Action*, 32 HOW. L.J. 549 (1989).

88. See, e.g., Steven C. Bennett, Note, *The Privacy and Procedural Due Process Rights of Hunger Striking Prisoners*, 58 N.Y.U. L. REV. 1157 (1983); Stephanie Clavan Powell, *Forced Feeding of a Prisoner on a Hunger Strike: A Violation of an Inmate's Right to Privacy*, 61 N.C. L. REV. 714 (1983).

89. 497 U.S. 261 (1990). Nancy Cruzan remained in a persistent vegetative state after a car accident. Her parents sought the withdrawal of all artificial feeding and hydration. The state supreme court held that, for surrogate decisions, state law required clear and convincing evidence of the person's desire for treatment withdrawal. The Court held that a competent individual had the right to refuse lifesaving treatment but that the state could require clear and convincing evidence of the patient's wishes. *Id.* at 284.

90. See Silver, *supra* note 82, at 642-43; see also *Thor v. Super. Ct.*, 855 P.2d 375, 383-88 (Cal. 1993) (weighing preservation of life, prevention of suicide, maintaining the ethical integrity of the medical profession, protecting third parties, and order and security of a penal institution); *Singletary v. Costello*, 665 So. 2d 1099, 1105-08 (Fla. Dist. Ct. App. 1996) (noting preservation of life, prevention of suicide, protection of innocent third parties, maintenance of the ethical integrity of the medical profession, and maintaining an orderly and secure penal institution); *Zant*, 286 S.E.2d at 716 (Ga. 1982) (noting the "duty to protect the health of those who are incarcerated in the state penal system,"

state interests to defend the force-feeding of detainees, including the preservation of life and security.⁹¹ Similarly, the Pentagon has viewed hunger strikes as a tactic in “asymmetric warfare,”⁹² suggesting that it considers such actions by detainees to be a security concern.

C. Ethics Model

Professionals, policymakers, philosophers, and other academics have attempted to approach hunger strikes through the lens of theoretical and applied ethics. Professional organizations and academics in both medicine and law have convened to consider whether and how physicians⁹³ and lawyers⁹⁴ should participate in the management of hunger strikes at Guantánamo Bay. At times, lawyers have been one of the few groups of individuals, other than the military and government officials, permitted to enter Guantánamo Bay.⁹⁵ For this reason, some lawyers have argued that they have heightened responsibility for, and ethical duties to, the detainees.⁹⁶

The role of the physician in force-feeding is ethically problematic.⁹⁷ Courts and physicians have tended to view the role of physicians in treating hunger strikers as an affirmative ethical duty. For example, in decisions to

and preservation of human life); *In re Caulk*, 480 A.2d 93, 96 (N.H. 1984) (considering “the preservation of internal order and discipline and the maintenance of institutional security” and “preservation of human life and the prevention of suicide”); *Von Holden v. Chapman*, 450 N.Y.S.2d 623, 625-27 (N.Y. App. Div. 1982) (weighing preventions of suicide, preservation of life, and prison security and administration); *Commw. v. Kallinger*, 580 A.2d 887 (Pa. Commw. Ct. 1990) (considering preservation of life, prevention of suicide, and enforcement of “prison security, order, and discipline”); *Laurie v. Senecal*, 666 A.2d 806, 808 (R.I. 1995) (considering preservation of life and prevention of suicide); *McNabb v. Dep’t of Corr.*, 112 P.3d 592, 594-95 (Wash. Ct. App. 2005) (considering “preserving life and preventing suicide” and “internal order and discipline, as well as maintaining institutional security”); *State ex rel. White v. Narick*, 292 S.E.2d 54, 57 (W. Va. 1982) (considering a test from *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977): preservation of life, prevention of suicide, “protection of interests of innocent third parties,” and “maintenance of physicians’ ethical integrity”).

91. *Guantánamo Suicides “Acts of War”*, BBC News, June 11, 2006, <http://news.bbc.co.uk/2/hi/americas/5068606.stm> [hereinafter *Guantánamo Suicides*].

92. *See id.* (quoting an unnamed Pentagon official).

93. For accounts on physician participation, see generally Annas, *supra* note 10; Jonathan H. Marks, *Doctors as Pawns? Law and Medical Ethics at Guantánamo Bay*, 37 SETON HALL L. REV. 711 (2007); and Leonard S. Rubenstein, *First, Do No Harm: Health Professionals and Guantánamo*, 37 SETON HALL L. REV. 733 (2007).

94. *See* David Luban, *Lawfare and Legal Ethics in Guantánamo*, 60 STAN. L. REV. 1981, 1998 (2008) (discussing how lawyers have shed light on hunger strikes, among other happenings, at Guantánamo Bay).

95. *See id.* (discussing how the presence of lawyers in Guantánamo is essential to the generation of information to the outside world); *see also id.* at 2025 (quoting a lawyer who remarks that isolation is one of Guantánamo’s guiding principles).

96. *See id.* at 2025 (explaining that lawyers keep returning to Guantánamo Bay as a matter of principle, despite efforts by Guantánamo Bay officials to drive them away).

97. *See* Annas, *supra* note 10; *see also* Press Release, ACLU, *ACLU Calls For End To Inhumane Force-Feeding Of Guantánamo Prisoners* (Jan. 9, 2009), available at <http://aclu.org/intlhumanrights/nationalsecurity/38277prs20090109.html>.

enforce involuntary medical treatment, courts have pointed to the protection of the ethical integrity of the medical profession.⁹⁸ In contrast, medical organizations themselves hesitate to endorse forced treatment as readily. The World Medical Association, to which the American Medical Association is a signatory member, issued guidelines about physician participation in force-feeding, prohibiting the force-feeding of prisoners on a hunger strike.⁹⁹ This position highlights the underlying tension between preservation of life and respect for individual autonomy.¹⁰⁰ However, professional psychiatric and psychology organizations, including the American Psychiatric Association, have so far remained silent on their role in dealing with prisoners or detainees on hunger strike, despite their clear stance against psychiatrist involvement in torture and parts of the interrogation process of detainees at Guantánamo.¹⁰¹

The next Part examines the psychiatric model of capacity evaluations and explores possible reasons why the psychiatric community has not adopted a positioned response to hunger strikes in Guantánamo Bay.

IV. THE PSYCHIATRIC MODEL

The psychiatric perspective is both a subset of the medical model and a separate model of its own. The psychiatric framework has so far been overlooked in the literature on hunger strikes, particularly in relation to the strikes at Guantánamo.¹⁰² We begin by explaining the role of the psychiatrist in determining the capacity of an individual who is voluntarily fasting. We argue that psychiatrists should be involved as early as possible, prior to the emergence of a crisis point. Early and ongoing provision of mental health care is critical to both the assessment and treatment of individuals during detention or imprisonment, as well as to addressing the longitudinal mental health care needs of these individuals if and when they are released. However, while psychiatrists are uniquely trained and positioned to be able to evaluate the mental capacity of the hunger striker, they should, at the

98. See cases cited *supra* note 90. See, e.g., *Comm'r of Corr. v. Myers* 399 N.E.2d 452, 454 (Mass. 1979) (quoting expert witness testifying that “medical ethics [requires that] everything possible be done to [treat] the defendant”).

99. World Med. Ass'n, *Declaration*, *supra* note 23.

100. Rebecca W. Brendel, Commentary, 50 *PSYCHOSOMATICS* 193, 193-194 (2009).

101. For a discussion of the adoption of position statements by the American Psychiatric Association and the American Psychological Association, prohibiting their members from participating in torture and forbidding, in part, involvement in interrogations, see A.L. Halpern, et al., “*Enhanced*” *Interrogation of Detainees: Do Psychologists and Psychiatrists Participate?*, 3 *PHIL. ETHICS & HUMAN. MED.* 21 (2008).

102. There is currently no article in the psychiatric, ethical, or legal literature on the role of psychiatrists in evaluating hunger strikers in Guantánamo, in contrast with the medical literature found for medical physicians in their participation of force-feeding of hunger strikers. For examples of such medical literature, see Annas, *supra* note 10 and Nicholl, *supra* note 11.

same time, be aware of both the limitations of their role and the ethical valence of their participation.

Hunger strikes at Guantánamo Bay occur in the context of what appears to be widespread psychiatric symptomatology, including depression, individual and mass suicide attempts, self-injurious behavior (more than 350 acts of self harm in 2003 alone),¹⁰³ completed suicides,¹⁰⁴ and post-traumatic stress disorder from alleged physical and emotional abuse.¹⁰⁵ It has been reported that as many as one-fifth to one-third of Guantánamo Bay detainees are prescribed anti-depressants.¹⁰⁶ The problem is that although a large percentage of the detainees may be on anti-depressants, the detainees might not necessarily have actually been diagnosed with depression. Nevertheless, the high level of distress, regardless of what diagnosis one might make, is clear. A 2006 joint report submitted by five independent human rights experts from the United Nations Human Rights Council (formerly the Commission on Human Rights) reported that the mistreatment of detainees has had profound and long-term mental effects on many detainees, adding that conditions of confinement are a causal factor.¹⁰⁷ Some of the most serious cases involving suicide attempts have involved minors.¹⁰⁸ One of the four reported completed suicides at Guantánamo Bay was a detainee who was under the age of eighteen when U.S. forces transferred him to Guantánamo Bay.¹⁰⁹

A. *The Role of the Psychiatrist in the Evaluation of Hunger Strikes*

Psychiatrists may have multiple roles within correctional and detention facilities. They may provide general mental health care delivery to individuals in prisons and detention centers, but they may also be asked to provide assessments of inmates or detainees in the context of security interest or

103. U.N. Econ. & Soc. Council [ECOSOC], Comm'n on Human Rights, *Situation of Detainees at Guantánamo Bay*, ¶ 82 U.N. Doc. E/CN.4/2006/120 (Feb. 27, 2006) (prepared by Leila Zerrougui, Leandro Despouy, Manfred Nowak, Asma Jahangir, & Paul Hunt) [hereinafter *Situation of Detainees*], available at http://www.globalsecurity.org/security/library/report/2006/guantanamo-detainees-report_un_060216.htm; see also Josh White, *Three Detainees Commit Suicide at Guantánamo*, WASH. POST, June 11, 2006, at A01 (noting at least twenty-five detainees have attempted suicide and many have made multiple attempts); Williams, *Details Emerging*, *supra* note 19 (noting events after the first three suicides and indicating military officials admitted hundreds have attempted suicide).

104. See *Guantánamo Suicides*, *supra* note 91; see also James Risen & Tim Golden, *3 Prisoners Commit Suicide at Guantánamo*, N.Y. TIMES, June 11, 2006, at A1.

105. See *Guantánamo Suicides*, *supra* note 91.

106. JAMES YEE, FOR GOD AND COUNTRY: FAITH AND PATRIOTISM UNDER FIRE 100 (2005) (estimating that one third of detainees was on anti-depressants); see also Paul Koring, *Tough Questions for U.S. Candidates: What to Do with Guantánamo?*, GLOBE & MAIL (Canada), June 18, 2007, at A1 (suggesting that at least one in five detainees take anti-depressants); David Rose, *How We Survived Jail Hell*, OBSERVER (London), Mar. 14, 2004, available at <http://www.guardian.co.uk/uk/2004/mar/14/terrorism.afghanistan>.

107. *Situation of Detainees*, *supra* note 103.

108. See Jennifer Brown, *This Guantánamo Nightmare Has Gone on Long Enough*, TOWNSVILLE BULL., Jan. 2, 2007, at 15.

109. *Id.*

institutional needs, such as classification or housing. In terms of hunger strikes, psychiatrists may be asked to perform a psychiatric evaluation and capacity determination when a detainee or inmate is presumed to be on a hunger strike. Informed consent has become the paradigm for medical intervention; without this consent, any medical intervention is unethical and may subject the physician to liability for battery, barring some other overriding justification.¹¹⁰ If a person does not consent, psychiatrists may be called upon to perform a capacity assessment to determine whether or not the patient has the mental capacity to decide to accept or refuse treatment. In the clinical setting, if the individual in question is found to have capacity to make that specific treatment decision, then the decision must stand. In clinical terms, a patient may accept or refuse treatment if he or she possesses the decisional capacity to do so; in legal terms, a competent individual may accept or refuse any treatment, even life sustaining treatment for a reversible illness.¹¹¹ In practice, the slow judicial process means that legal determinations of competency take time. Therefore, in most cases requiring immediate attention, clinicians are left to make determinations about an individual's capacity to make medical decisions, and these decisions go to court relatively rarely.¹¹²

Prison and detention systems should be encouraged not to wait until after an individual is determined to be on a hunger strike to get a mental health professional evaluation. Most guidelines in prison and detention centers encourage the staff to use their discretion in obtaining an evaluation.¹¹³ Psychiatrists should be involved early for several reasons. First, the individual in question is more likely to be able to communicate early on—mental state is more likely to be influenced by the physical and medical sequelae of the hunger strike if the evaluation occurs later. Second, earlier engagement with the individual may help establish a therapeutic alliance so that the individual can communicate his or her wishes and motivations to the psychiatrist through open and repeated discussions over a longer period of time.

B. Justification of Psychiatric Involvement

Any physician may make a determination of decisional capacity, but psychiatrists are most often consulted to perform these evaluations in hospi-

110. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 48–84 (1984) (tracing the development of informed consent doctrine); see also Peter H. Schuck, *Rethinking Informed Consent*, 103 *YALE L.J.* 899, 924 n.109 (1994) (stating that the origin of informed consent is in the common law doctrine of battery).

111. Ned H. Cassem & Rebecca W. Brendel, *End of Life Issues: Principles of Care and Ethics*, in *MASSACHUSETTS GENERAL HOSPITAL HANDBOOK OF GENERAL HOSPITAL PSYCHIATRY* 365–387 (Theodore A. Stern et al. eds., 5th ed. 2004) [hereinafter *MGH PSYCHIATRY HANDBOOK*].

112. Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 *NEW ENG. J. MED.* 1834, 1834 (2007).

113. See e.g., *GUIDELINES*, *supra* note 31.

rals¹¹⁴ and other clinical settings.¹¹⁵ Psychiatrists are well-suited to this task, as psychiatry is the branch of medicine responsible for understanding alterations in mental status, perceptions and misperceptions of reality, rationality, and irrationality. Psychiatrists possess both the expertise to rule out psychiatric illnesses that directly affect an individual's decision making capacity and to more broadly assess an individual's mental state, reasoning, and judgment in light of his or her cultural, religious, and spiritual beliefs. Psychiatrists are trained to screen for preexisting or current mental illnesses that could cloud the person's decision to embark on a hunger strike. Furthermore, the psychiatrist can make sure that the individual understands the full risks and benefits of the decision to hunger strike. If the psychiatrist is concerned that the individual has not understood the risks and benefits of food refusal, the psychiatrist can arrange for a medical physician to explain the medical consequences of fasting and can also make sure that the individual is accurately informed of the likely (and generally limited) scope of the benefits of pursuing a hunger strike, including the reality of how the system may or may not respond to a hunger strike.

C. Capacity Evaluation of Hunger Strikers

Over the past thirty to forty years, a practical framework for the assessment of decisional capacity for medical decisions has emerged.¹¹⁶ For a person to possess decisional capacity, four conditions must be met.¹¹⁷ First, the person must be able to express a consistent preference. Second, the individual must understand the facts surrounding the decisions being made. Third, the person must be able to express an appreciation of how the facts pertain to him or her, including the risks and benefits of action versus non-action. Lastly, the individual must be able to rationally manipulate data in the decision making process. The rational manipulation requirement is assessed in view of the person's life and circumstances, including previous behavior, guiding principles such as religion and culture, and past choices.¹¹⁸ As applied to the hunger striker, under the first condition, the individual expresses a consistent preference by refusing food. The second condition requires that the striker understand the medical risks of fasting as well as other consequences such as how the authorities will respond to a hunger strike. The striker should be able to understand the benefits of the

114. See Ronald Schouten & Rebecca W. Brendel, *Legal Aspects of Consultation*, in MGH PSYCHIATRY HANDBOOK, *supra* note 111, at 349-64.

115. See Rebecca W. Brendel & Ronald Schouten, *Legal Concerns in Psychosomatic Medicine*, 30 PSYCHIATRIC CLINICS OF N. AM. 663, 663 (2007).

116. See generally Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW ENG. J. MED. 1635 (1988); Alan Meisel et al., *Toward a Model of Legal Doctrine of Informed Consent*, 134 AM. J. PSYCHIATRY 285 (1977); Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977).

117. See Appelbaum & Grisso, *supra* note 116.

118. Appelbaum, *supra* note 112, at 1835-37.

hunger strike, for example that the strike affects the power differential, protests certain treatment, and/or is a demand for material goods. The striker needs to demonstrate a carefully reasoned process that has weighed all possible outcomes, including the likelihood of success. The hunger striker should be aware that he may ultimately die from fasting but also communicate that he or she is not trying to commit suicide per se (i.e., the goal of the hunger strike is not death but some other gain). If a person satisfies these criteria, the decision to hunger strike is competent. Where the person is found to lack capacity, the courts can decide that the individual should be force-fed. However, even where the person may have capacity, courts may still decide that the individual should be force-fed for other reasons, including state interests.

V. LIMITATIONS OF THE PSYCHIATRIC MODEL

The psychiatric model has several limitations, particularly when considered in isolation from the rights and ethical models. These weaknesses have been highlighted by the challenges of the post-9/11 climate, as the medical and psychiatric communities have faced the challenge of delineating their roles in contexts of detention, hunger strikes, enhanced interrogation, and alleged torture. One example of the difficulty in delineating a psychologist's role is the question of how or whether physicians and psychologists ought to participate in the interrogation of detainees.¹¹⁹

Professional societies in medicine and mental health fields specifically considered the ethical dimensions of psychologist and psychiatrist roles in military interrogations in 2004.¹²⁰ The American Psychological Association (APA)¹²¹ and the American Medical Association (AMA)¹²² positions were both premised on the ethical analysis that psychologists and physicians have professional obligations to both the individual subject of interrogation and to third parties like the government and the public. Both

119. For allegations that the American Psychological Association did not adequately discourage psychologists from participating in enhanced interrogation techniques, see Posting of Ghislaine Boulanger, to ACLU Blog of Rights, American Psychological Association Sees No Evil, <http://blog.aclu.org/2009/06/16/american-psychological-association-sees-no-evil/> (June 16, 2009, 14:39 EST).

120. See, e.g., Stephen Behnke, *Ethics and Interrogations: Comparing and Contrasting the American Psychological, American Medical and American Psychiatric Association Positions*, MONITOR ON PSYCHOLOGY, July/Aug. 2006, at 66.

121. The American Psychological Association issued the Report of the Task Force on Psychological Ethics and National Security (PENS report) in June 2005. AMERICAN PSYCHOLOGICAL ASSOCIATION, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY (2005), available at <http://www.apa.org/releases/PENSTaskForceReportFinal.pdf>.

122. The American Medical Association (AMA) released a report very similar to the PENS report and later adopted this position in its code of medical ethics. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AMA, PHYSICIAN PARTICIPATION IN INTERROGATION (2006), available at <http://www.ama-assn.org/ama1/pub/upload/mm/code-medical-ethics/2068a.pdf>; Council on Ethical & Judicial Affairs, AMA, *Opinion 2.068 – Physician Participation in Interrogation*, in CODE OF MEDICAL ETHICS (2008).

associations allowed psychologists and physicians to consult to interrogations if the interrogation was not coercive and the role of consultant was separate from that of a health care provider.¹²³ The APA did not specifically raise the issue of third party obligations, but it prohibited psychiatrists from “participat[ing] directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere.”¹²⁴ Although this position did not explicitly acknowledge any obligation to the government or public, the APA specifically did not include detainees in the group of interrogation subjects that are vulnerable or at risk,¹²⁵ a position that provoked heavy criticism from human rights groups, several medical communities, and the APA’s own members for not adequately responding to concerns that psychologists were aiding the government in enhanced interrogation.¹²⁶ Supporting these concerns, the president of the APA later stated that a military psychiatrist following orders “wouldn’t get into trouble” for participating in interrogations.¹²⁷ Thus, the general rule taken from all three positions is that military psychologists, physicians, and psychiatrists who are following orders and acting as consultants rather than health care providers may avoid discipline from their professional associations for taking part in interrogations, as long as the interrogations are not coercive or abusive.

The case of physician and psychologist participation in interrogations exemplifies how divided positions by psychiatric and medical professional organizations can be influenced by government actors. This example highlights the challenges that face efforts to regulate and form guidelines for the involvement of psychiatrists and physicians in hunger strikes and force-feedings.

123. Behnke, *supra* note 120, at 66. Note, however, that the chair of the AMA council on ethical and judicial affairs clarified that the AMA position should not be interpreted to allow physicians to participate in developing rapport-building or other strategies for individual detainees. Mark Moran, *AMA Interrogation Policy Similar to APA’s Position*, 41 PSYCHIATRIC NEWS 1, 1 (2006).

124. Press Release, Am. Psychiatric Ass’n, *APA Passes Position Statement Barring Psychiatric Participation in Interrogation of Detainees* (May 22, 2006), available at <http://www.psych.org/MainMenu/Newsroom/NewsReleases/2006NewsReleases/06-36positionstatementoninterrogation.aspx>.

125. Kenneth S. Pope & Thomas G. Gutheil, *The Interrogation of Detainees: How Doctors’ and Psychologists’ Ethical Policies Differ*, 338 BRITISH MED. J. 1178, 1178 (2009). For information on the development of the American Psychological Association position, see E-mails from the Listserv of the American Psychological Association’s Presidential Task Force on Psychological Ethics and National Security: Apr. 22, 2005-June 26, 2006, http://s3.amazonaws.com/propublica/assets/docs/pens_listserv.pdf (last visited Jan. 6, 2009).

126. The World Medical Association (WMA) revised its Declaration of Tokyo to assert that “the physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.” World Med. Ass’n, *Declaration*, *supra* note 23.

127. Behnke, *supra* note 120, at 67.

A. *Psychiatrist as Health Care Provider or Consultant*

One of the fundamental problems with the psychiatric model is that it does not address the context of the relationship between the psychiatrist and the hunger striker, particularly when the encounter is taken out of the hospital and other therapeutic contexts. As the case of detainee interrogation illustrated, professional associations permit involvement as long as the participation does not combine duties as consultant and health care provider. This distinction assumes that these professional roles can be separated without jeopardizing one's overall ethical duties as a psychiatrist or physician.

The distinction between these different roles has been criticized as a false dichotomy created in order to ethically excuse participation in nonclinical contexts. For example, former American Psychiatric Association president and law professor Alan Stone controversially pointed out the ethical implications of forensic psychiatrists who testified in court or performed court evaluations, arguing that forensic psychiatrists faced conflicting identities as experts and physicians.¹²⁸ This critique of the ethics of forensic psychiatry has since elicited several responses among forensic psychiatrists.¹²⁹ One response argued that forensic psychiatry's guiding principle is one of truth rather than beneficence.¹³⁰ The argument asserted that the forensic psychiatrist serves justice and not the well-being of the patient, unlike the clinical psychiatrist.¹³¹

Similarly, one might argue that the role of the psychiatrist in evaluating a hunger striker is not tied to the same values of beneficence or non-maleficence that predominate in the clinical context. However, the absence of a clinical relationship does not mean that ethical standards of the profession should not apply. Even if psychiatrists are asked by the government to be a consultant and not a health care provider, psychiatric values and ethics should still serve as guiding ethical principles to the evaluation of the hunger striker. Justice can be one of those principles, but, as the following sections will illustrate, the psychiatrist is ill-equipped to evaluate and serve justice and, as in the case of Guantánamo Bay, actually may be violating the principle of justice through professional actions. The ethics of psychiatrist participation in the evaluation of hunger strikes will continue to be controversial among professional associations and human rights groups. Professional associations have thus far avoided this question at least in part because of their perception that psychiatrist involvement in evaluations is

128. Alan A. Stone, *The Ethics of Forensic Psychiatry: A View From the Ivory Tower*, in *LAW, PSYCHIATRY, AND MORALITY* 57 (1984).

129. For an overview of the history of developments in the area of ethics of forensic psychiatry, see Glenn H. Miller, *Alan Stone and the Ethics of Forensic Psychiatry: An Overview*, 36 *J. AM. ACAD. PSYCHIATRY L.* 191 (2008).

130. See, e.g., Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 *INT'L J.L. & PSYCHIATRY* 249 (1990).

131. *Id.*

only indirect (i.e., that the role of the psychiatrist does not lead to direct force-feeding of hunger strikers). The next section argues that even indirect participation is a strong enough reason for associations to articulate a position on the matter.

B. *The Problem of Indirect Participation*

Capacity evaluations of hunger strikers have wider consequences in the detainee and prisoner context than in other clinical contexts because these evaluations by psychiatrists may lead to indirect participation in a process that may lead to force-feeding. Does the fact that participation in hunger strikes is indirect relieve psychiatrists from addressing the ethical dimensions of their involvement? We argue that it does not. A psychiatrist may be removed from the ultimate decision to force-feed but must still be aware of the role that he or she may play as an instrument of the state; the capacity determination and understanding of the hunger strikers' motivation established by the psychologist may be used by courts to justify force-feeding. This concern is particularly heightened where the force-feeding itself may be performed in a way that has been found to violate human rights or be tantamount to torture.

The fact that a psychiatrist does not directly order or enforce force-feeding does not mean that he or she need not consider the consequences of a capacity determination on both the situation and the hunger striker. A capacity evaluation is used to understand the individual's rationale and decision making process. In this situation, the motivation behind a hunger strike has critical implications on whether a court will recognize a prisoner's right to refuse unwanted medical treatment. Courts have held that the purpose of the strike is important to understanding whether to allow force-feeding in order to avoid manipulative hunger strikes in prisons, especially when such hunger strikes pose a security risk.¹³² In other words, courts are more likely to condone force-feeding and limit autonomy in situations where the person is seen as disruptive and interested in personal material or secondary gain. The majority of cases allow force-feeding based on a determination that state and prison interests outweigh the right to hunger strike.¹³³

A psychiatrist must also consider that his or her capacity evaluation may result in force-feeding, which some institutions have deemed to be torture. U.S. military authorities report that force-feedings begin after a detainee

132. Silver, *supra* note 82, at 655-57; see also Ohm, *supra* note 82.

133. In order to determine whether a policy is reasonably related to legitimate penological interests, the Court has looked to four factors: (1) a "valid rational connection" between the regulation and the governmental interest put forth to justify it; (2) an "alternative means of exercising the right" available to the prisoner; (3) the "impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally"; and (4) the "absence [or presence] of ready alternatives" for prison administrators. *Turner v. Safley*, 482 U.S. 78, 89-90 (1987).

either has gone three weeks without a meal, has fallen below eighty-five percent of his ideal body weight, or if a doctor has recommended it as a medical necessity to preserve an inmate's life.¹³⁴ The question of whether force-feeding is torture remains controversial. Five U.N. Special Rapporteurs who investigated the condition of detainees at Guantánamo Bay considered violent force-feeding of detainees on hunger strike to be torture, following a similar precedent in the European Court of Human Rights,¹³⁵ and they concluded that force-feeding and drugging inmates violated the right to health because informed consent is "essential, [as it is a] 'logical corollary' [of] the right to refuse treatment."¹³⁶

The psychiatrist is caught between reluctance to allow someone to die by suicide and reluctance to participate in a process that may lead to actions tantamount to prolonging torture. The lack of clear professional guidelines leaves the psychiatrist without guidance on how to approach hunger strikes at Guantánamo Bay or elsewhere. Psychiatrists in these roles cannot operate with only the guiding ethical principle of serving justice, particularly when they may indirectly participate in the de-legitimization of a hunger strike by force-feeding. Thus, psychiatrists should be aware of the possibility that their evaluation and skills will be misused.¹³⁷ The following sections address further important limitations of the psychiatric model.

C. *Subverted Use of Psychiatry for Non-treatment Government Purposes*

Psychiatrist participation in the evaluation of hunger strikers raises the problem of dual loyalty.¹³⁸ Psychiatrists who perform capacity evaluations of hunger strikers must weigh their identity and priority as a health care professional against their obligation to the state as a third party. Determinations of capacity to maintain a hunger strike or to resist force-feeding have important consequences both in indirectly leading to force-feeding and, more broadly, in the legitimization or de-legitimization of hunger strikers and their protest. U.S. officials have responded to the scrutiny over hunger strikes in Guantánamo Bay in many ways, including casting doubt on the determination or commitment of the individuals by claiming, among other things, that the detainees are actually surreptitiously eating.¹³⁹ Such responses, while they may be true, serve to undermine the hunger

134. *Sharp Rise*, *supra* note 30.

135. *Nevmerzhiysky v Ukraine*, App. No. 54825/00 (Eur. Ct. H.R., Apr. 5, 2005).

136. *Situation of Detainees*, *supra* note 103.

137. *See generally*, INTERNATIONAL DUAL LOYALTY WORKING GROUP, DUAL LOYALTY & HUMAN RIGHTS IN HEALTH PROFESSIONAL PRACTICE (2003), available at <http://physiciansforhumanrights.org/library/documents/reports/report-2002-duelloyalty.pdf> (discussing guidelines for health care professionals) [hereinafter DUAL LOYALTY].

138. *Id.* (defining dual loyalty as "clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state").

139. Ben Fox, *Guantánamo Hunger Strikers Stay Defiant*, ASSOCIATED PRESS, July 20, 2007, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/07/20/AR2007072001426.html>.

striker's goals of creating negative publicity, calling attention to the conditions that they are protesting, and expressing their autonomy through one of the only means available under their restrictive conditions of confinement.

Psychiatrists and other mental health professionals should refrain from supporting the interests of the state when that support violates the individual detainee's human rights.¹⁴⁰ In situations where it is unclear how the psychiatrist's involvement may directly or indirectly lead to human rights abuses, psychiatrists should be cautious with their recommendations and evaluations. Professionals should be aware of the possibility that their evaluation may be co-opted to serve state interests in preserving order and discipline or maintaining security. One fundamental professional value in psychiatry that is most likely to be co-opted to serve state interest is the professional stance on death and suicide.

D. Professional Values on Death and Suicide

In psychiatry there is an underlying presumption against allowing an otherwise medically healthy patient to choose death.¹⁴¹ At the extreme, one might argue that psychiatrists ascribe pathology to what could be a fully informed, rational, and autonomous decision.¹⁴² On the other hand, the prevention of suicide is a longstanding professional value of Western psychiatry and society more generally.¹⁴³ This value is also legally supported in U.S. society; some states impose legal obligations on psychiatrists to prevent suicide by civilly committing or hospitalizing patients who are at risk of harm to themselves.¹⁴⁴

Psychiatrists also harbor reservations about those who voluntarily engage in a path that risks or hastens death. Psychiatrists believe in a strong relationship between mental illness and suicide because studies of suicidal patients have shown that most people who commit suicide have a mental abnormality.¹⁴⁵ This relationship holds true even in situations where there are other potential reasons for the desire to hasten death. Studies of terminally ill patients have shown that the key difference between patients who

140. For guidelines by a human rights organization on dual loyalty, see DUAL LOYALTY, *supra* note 137, at 51.

141. Thomas Szasz, *Case Against Suicide Prevention*, in STEPHEN GREEN & SIDNEY BLOCH, AN ANTHOLOGY OF PSYCHIATRIC ETHICS 196 (2006) (arguing against the traditionally held Western psychiatry professional value that suicide should be prevented).

142. *Id.*

143. *Id.*

144. *See, e.g.*, MASS. GEN. LAWS ch.123, §§ 12(a)-12(b) (2000) (stating that a psychiatrist may involuntarily detain, hospitalize, or treat a patient who is suicidal to prevent that patient from succeeding in committing suicide).

145. *See, e.g.*, Markus M. Henriksson et al., *Mental Disorders and Comorbidity in Suicide*, 150 AM. J. PSYCHIATRY 935, 935 (1993); *see also* Rebecca W. Brendel et al., *Care at the End of Life*, in MASSACHUSETTS GENERAL HOSPITAL COMPREHENSIVE CLINICAL PSYCHIATRY 821 (Theodore A. Stern et al. eds., 2008).

wish to hasten death and those who do not is the presence of depression.¹⁴⁶ Additionally, sick patients who are depressed make more restrictive advance directives about what care they would want if they became unable to express their own wishes.¹⁴⁷ When the depression is treated, these same patients changed their expressed wishes to include more treatment and life prolonging care.¹⁴⁸

Therefore, the medico-psychiatric model is at odds with the notion of allowing individuals who wish to die to make that decision, even where they are competent. First, psychiatrists generally presume that a patient who wishes to die or takes steps to shorten his life, until proven otherwise, is suffering from depression or some other type of mental illness. Second, psychiatrists presume that any patient who refuses an intervention that could prevent death or prolong life is suicidal, unless otherwise proven. Third, psychiatrists feel a sense of responsibility to dissuade and prevent individuals from choosing a path that risks death when other options are available. One psychiatric prison director captured this dilemma well when he testified: “[I]t would be devastating to the staff and the staff morale if they had to allow someone to cease living, virtually by their own hand, while under [prison] care.”¹⁴⁹ Witnessing an otherwise healthy person choose a path that could lead to death, regardless of the motivation or purpose, conflicts with deeply ingrained professional values in Western psychiatry not to allow someone to choose death. These values make it difficult for a psychiatrist to be part of a process that would allow the hunger striker to choose to fast to death, regardless of the competency of the striker’s decision-making process.

These underlying presumptions may potentially lead psychiatrists to reduce a hunger strike to a suicidal act or a sign of mental illness, when in fact it could be neither. A hunger strike alone does not create a presumption of mental illness or suicidality under these alleged circumstances.¹⁵⁰ In fact, most hunger strikes are not associated with mental illness.¹⁵¹ When hunger strikes are motivated by religious reasons or to protest abuse, as is the case at Guantánamo Bay, the psychiatric view is problematic. Applying these presumptions of mental illness and suicidality to the lack of capacity

146. Harvey M. Chochinov, *Management of Grief in the Cancer Setting*, in *PSYCHIATRIC ASPECTS OF SYMPTOM MANAGEMENT IN CANCER PATIENTS* 231 (W. Brietbart & J.C. Holland eds., 1993); see also Rebecca W. Brendel et al., *Suicide Assessment*, in *MASSACHUSETTS GENERAL HOSPITAL COMPREHENSIVE CLINICAL PSYCHIATRY* 821 (Theodore A. Stern et al. eds., 2008).

147. See, e.g., Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, 347 *NEW ENG. J. MED.* 582, 586 (2002); see also Linda Ganzini et al., *The Effect of Depression Treatment on Elderly Patients’ Preferences for Life-Sustaining Medical Therapy*, 151 *AM. J. PSYCHIATRY* 1631, 1631 (1994).

148. *Id.*

149. *Commw. v. Kallinger*, 580 A.2d 887, 892 (Pa. Commw. Ct. 1990) (quoting Dr. Jack Wolford).

150. See Reyes, *supra* note 13.

151. See Daines, *supra* note 22.

in hunger strikers can become misguided in cases where the rights of those detained or incarcerated may not be protected or respected. Hunger strikes can be the last resort for the confined individual to protest and demand the end of his detention. The case of torture is the paradigm case of the hunger strike as the last option to assert one's rights and dignity. If the power differential between the torturer and the tortured leads the victim's own body and mind to betray himself or herself, then taking control of the body through a hunger strike leads to a shift in the power differential. For anyone to intervene—directly or indirectly—to end the hunger strike by force feeding would be to have a hand in prolonging torture. In this situation, a hunger strike is not chosen for the purpose of hastening death. Rather, the hunger strike is paradoxically undertaken to pursue a better life, even if the cost is death.

Even where a person may be mentally ill, it is not clear how one should consider the fact that the government may have contributed to the person's disorder. For example, in Guantánamo Bay, prisoners allege that abuses by government actors have led them to suffer from post-traumatic stress disorder or other permanent psychological disabilities.¹⁵² This is a far different scenario than a mental illness such as psychosis—for example, a detainee falsely believes he or she is being poisoned and thus refuses to eat—where the decisional capacity of the detainee is brought into question because of an inability to understand the factual circumstances. Consider the statement made by psychiatrist Steven Xenakis, a retired Army Brigadier General, that those who participated in hunger strikes “signaled feelings of hopelessness and fatalism.”¹⁵³ Does the fact that the detainee does not want to live under the conditions imposed upon him by the U.S. government and that may lead him to despair—or even clinical depression—make him lack capacity to decide to hunger strike in protest?

Psychiatrists are not entirely unfamiliar with the task of distinguishing mental illness in evaluations of complex patients who desire death and may be allowed to end their lives. Psychiatrists are called upon to make the distinction between depression and justified desire to hasten death in other circumstances, such as Oregon's Death With Dignity Act, which provides for psychiatric evaluation of patients to rule out mental illness prior to receiving a prescription for a lethal dose of medication to end their lives.¹⁵⁴ However, the circumstances of the terminally ill patient choosing to die are distinct from the otherwise healthy hunger striker and do not provide a close enough comparison.

152. See, e.g., Jaclyn Belczyk, *Military Judge Rules Guantanamo Detainee's Lawyers May Not Tour CIA Black sites*, Aug. 25, 2009, JURIST, <http://jurist.law.pitt.edu/paperchase/2009/08/military-judge-rules-guantanamo.php>.

153. *Details Emerging*, *supra* note 19.

154. Oregon Death with Dignity Act, OR. REV. STAT., §§ 127.800-127.995 (1994).

Psychiatrists should note that their views on suicide and acts of self-harm amongst detainees are distinct from how the state and military have viewed such acts. Assistant Secretary of Defense for Health Affairs, William Winkenwerder, Jr., M.D., has stated that the government's "intentions are good" and that they are "seeking to preserve life,"¹⁵⁵ but the Pentagon has labeled suicide and hunger strikes as tactics in "asymmetric warfare."¹⁵⁶ Although psychiatrists are faced with professional values and biases that bias them toward a judgment of non-capacity in cases where one chooses death, psychiatrists cannot use the prevention of suicide alone to determine a lack of capacity.

E. The Problem of Access to Information

The psychiatrist who evaluates a fasting individual also faces the more general problem of access to information that is necessary to make an accurate capacity evaluation. This is particularly true in Guantánamo Bay. First, psychiatrists are not in a position to assess fully the conditions of detention, particularly on the question of abuse or torture. This limitation of fact can make it difficult to determine motivation and rationale. Simply put, how is the psychiatrist to evaluate the accuracy of a detainee's perception of his or her conditions of confinement without collateral data? Second, psychiatrists' access to information about the motivations, intent, and mental state of the individual may be impeded in other ways: by the hunger strikers themselves, who may not want to engage in the discussion with the evaluator, and by cultural, political, and language barriers. Psychiatrists may encounter a fundamental lack of any underlying therapeutic alliance with the individual. The individual may be unwilling to discuss his or her motivations openly and honestly with an evaluator whom he or she may perceive to be working for the government. Furthermore, sources that could provide collateral information about that person's mental state, history, and beliefs could be limited or difficult to access.

This leads us to the next question: For the purposes of a capacity evaluation, is it sufficient for the individual hunger striker to believe and allege that his rights have been violated and that this violation is the reason for his protest? After all, the capacity evaluation is about the mental capacity in the decision making process and does not necessarily depend on whether what that person believes is true or false. For example, in the case of the Jehovah's Witness who declines a life-saving blood transfusion, it is not necessary to answer the actual question of whether or not one will be admitted to heaven if one receives a blood transfusion. In that case, the psychiatrist needs only to assess the person's beliefs and whether he or she makes a

155. Luke Mitchell, *God Mode*, HARPER'S MAG., Aug. 2006, at 10, available at <http://www.harpers.org/archive/2006/08/0081137>.

156. *Guantánamo Suicides*, *supra* note 91.

decision consistent with this religious belief to refuse treatment, even if he or she is willing to risk certain death. The psychiatrist cannot deem a lack of capacity based on his own personal judgment that refusing treatment is not justified. Compare this with a second case in which a person declines a life-saving blood transfusion because he believes that doctors are trying to kill him by injecting him with poison. In the second case, the accuracy of the person's belief is relevant to the determination of whether the person is able to assess reality.

Similarly, the question of whether a detainee actually has been abused or tortured in detention is relevant for two issues: reality testing and justification for the hunger strike. Compare a detainee in Guantánamo Bay with a prisoner in U.S. federal or state prisons.¹⁵⁷ We will assume for this hypothetical that there is less probability of abuse or torture in federal or state prisons compared to Guantánamo Bay.¹⁵⁸ We are less likely to find capacity in the state prison hunger striker who claims he or she has been tortured; we are more likely to conclude that either the hunger striker has impaired reality testing (failing the second prong of the evaluation) or is using the hunger strike for less justified motives (e.g., to be manipulative or resistant rather than to protest). In the Guantánamo Bay scenario, we will assume that it is very difficult for the psychiatrist to know whether abuses have occurred. In this situation, the hunger striker may be factually accurate and have a sound rationale for striking, but the psychiatrist cannot reliably know if the individual has intact reality testing. As a result, the evaluator cannot reliably determine a lack of capacity. In this case, the evaluator may be persuaded to come down on the side of caution, based on the aforementioned medical-psychiatric model assumptions—siding on preservation of life, presumption of suicidality and mental illness. This decision would be an artifact of professional and cultural values rather than what a capacity evaluation sets out to assess: the person's mental state and decision making capacity. This decision also has the potential to propagate human rights violations.

This example highlights the distinction between capacity and justification and the importance of information for making a complete capacity determination. In cases where psychiatrists simply do not have enough information to make an accurate assessment of the capacity of the hunger striker, the evaluation should reflect the limited data and should state the

157. For overviews of comparisons of quality of private and public sector prisons in the U.S., see Scott D. Camp et al., Fed. Bureau of Prisons, *Quality of Prison Operations in the U.S. Federal Sector: A Comparison with a Private Prison*, 4 PUNISHMENT & SOC'Y 27 (2002), and Douglas McKinzie, Harsh Punishment in the Federal and State Prison Systems (2009) (unpublished manuscript), available at http://www.allacademic.com/meta/p_mla_apa_research_citation/3/6/1/0/0/pages361009/p361009-1.php.

158. For a summary of abuses and government investigations of abuse in Guantánamo Bay, see LAUREL E. FLETCHER ET AL., UNIV. OF CAL., BERKELEY, GUANTÁNAMO AND ITS AFTERMATH: U.S. DETENTION AND INTERROGATION PRACTICES AND THEIR IMPACT ON FORMER DETAINEES (2008), available at <http://hrc.berkeley.edu/pdfs/Gtmo-Aftermath.pdf>.

uncertainty in making a capacity determination. An uncertain capacity determination does not prevent the state from proceeding with force-feeding, but at least it would prevent the government from using psychiatry to declare an individual as lacking capacity when such a determination is actually unclear.

Within the two-part capacity test, psychiatrists are trained to understand reality testing, but they do not have the appropriate standing or training to determine the justification value of a strike. Psychiatrists are not in the business of determining whether an act is justified or not—this is the province of the courts, legislatures, and public policy makers. The question of justification involves weighing state interests against the hunger striker's motivations. Capacity does not require that the hunger strike be conducted for a higher purpose. In cases where prisoners have been found to have capacity, courts should then determine the validity of the justification, weigh individual and state interests, and intervene in hunger strikes where state interests prevail over individual interests.

F. *The Problem of Normative Judgment*

The Guantánamo Bay scenario above also raises the problem of normative judgment and its relationship to capacity evaluations. The capacity evaluation model assumes the evaluator's pure neutrality,¹⁵⁹ that is, that the psychiatrist can maintain an apolitical stance, integrate a cultural and religious sensitivity, and transcend his or her own personal beliefs and biases when assessing the individual's decision.¹⁶⁰ Can psychiatrists act with pure neutrality, particularly in controversial situations such as Guantánamo Bay? Aside from clear cases of mental illness and suicidality, it is almost impossible for psychiatrists to extricate normative judgments from politically and culturally complex capacity evaluations. Political beliefs ultimately affect the threshold of whether the psychiatrist believes there may or may not be valid reasons for the hunger striker's protest. Psychiatrists with varying political beliefs may have different thresholds for accurate reality testing and may attribute different motives and decision-making processes for detainees. In other words, when politics is involved, the line between justification and capacity becomes blurred. This is a problem that the psychiatrist cannot resolve by himself. This leads us to the last and perhaps most pressing limitation of the psychiatric model: the lack of clear professional guidelines.

159. The concept of "therapeutic neutrality" stems from psychoanalytic literature, recommending that psychiatrists should not take sides in the patient's intrapsychic conflicts. BENJAMIN JAMES SADDOCK & VIRGINIA ALCOTT SADDOCK, *SYNOPSIS OF PSYCHIATRY* 242 (10th ed. 2007) (describing neutrality in the psychiatric evaluation).

160. Robert H. Humphries, *Therapeutic Neutrality Reconsidered*, 21 *J. RELIGION & HEALTH* 124, 124 (1982) (examining the problem of implicit negative biases even when the psychiatrist's "conscious goal is to maintain strict neutrality").

G. *Lack of Clear Professional Guidelines*

In addressing these thorny ethical and practical issues identified above, the most problematic issue of all is that there are no clear guidelines for psychiatrists as to what constitutes an ethical and professionally sound evaluation of and approach to hunger strikers. Psychiatrists and other mental health specialists are left to confront these difficult questions on their own. One reason the psychiatric community lacks position statements or consensus on this matter may be the traditional professional resistance to allowing hunger strikers to refuse treatment and risk death. Another concern is a decision to respect autonomy and allow hunger strikes without interventions could be interpreted as a decision not to help. For example, when seventeen prisoners went on a hunger strike in Australia in 1998 to protest a ban on contact visits and to demand exercise equipment, the Australian government used a draconian approach. The Queensland Prisoners Minister opined that the prisoners could starve, stating "I don't care if they starve. I don't care about them, they're the bottom of the barrel."¹⁶¹ A systematically draconian approach could lead to neglect of the hunger striker's medical, psychiatric, and emotional condition. Finally, the psychiatric community may reason that it does not need guidelines because psychiatric participation is limited to capacity evaluation of hunger strikes and thus has only an indirect relationship with force-feeding. However, we have argued that the excuse of indirect participation is insufficient where the consequences include an impact on the legitimacy of the hunger strike, the potential for human rights violations, and background allegations of torture.

VI. CONCLUSION

When a psychiatrist applies a capacity assessment to individuals who are clearly enmeshed in a political and cultural context that may be at least one impetus for their voluntary fasting, the psychiatrist is forced to assess these political and cultural contexts in order to understand the patient's rationale and behaviors. It is not possible to assess capacity for the decision to hunger strike in a vacuum, particularly in situations as charged as Guantánamo Bay. This article identifies several limitations to a narrowly applied psychiatric model. It recognizes that psychiatrists may be reluctant to let someone who is otherwise healthy choose to die, as the sources of this internal resistance are deeply rooted in the professional principles of the psychiatric community. However, such limitations do not mean that the use of psychiatrists should be abandoned. Instead, psychiatrists, especially those who are not state actors, have unique professional expertise to both assess and determine hunger strikers' reasoning and decision-making process in a context,

161. Scott Emerson & Christopher Niesche, *Vicious, Callous Prisoners Welcome to Starve - Minister*, AUSTRALIAN, Apr. 8, 1998, at 3.

to expand the psychiatrist model to include this context, and to address individuals' mental health care needs to promote the physical, mental, and emotional well-being of the hunger striker.

Capacity evaluations in the clinical and correctional setting are also opportunities to educate the individual about his circumstances. The encounter can be used to listen to the concerns of the individual and to allow the person to feel that he or she has been heard, even if the psychiatrist is unable to change the hunger striker's circumstances. Similarly, the evaluating psychiatrist may use the encounter with the hunger striker to observe and understand the mental distress of the individual who has chosen to express himself through a hunger strike. Along with close medical monitoring and a thorough informed consent process, we therefore recommend earlier and more consistent mental health care for hunger strikers and other detainees in Guantánamo Bay and all detention and correctional settings.

Other possible solutions to the challenges of evaluating hunger strikers may include guardianship or substituted judgment. Guardianship attempts to preserve more of the hunger striker's autonomy by finding a person who will make decisions to the extent that he or she believes the hunger striker would have wanted if he or she could have communicated his or her decision while having capacity. However, this does not necessarily resolve the issues that we have discussed, particularly in light of the limited access to information about the individual and likely limited access to family members or those who might best know the striker's intentions, goals, and motivations. Another alternative would be the use of the court and a judge as decision maker, which is what is currently used to determine competency, but such decisions still generally rely heavily on capacity evaluations performed by psychiatrists.

The announcement of the planned closure of Guantánamo Bay does not mark the end of the need to consider seriously the current and future mental health needs of the detainees. Hunger strikes are only one marker of the detainees' level of mental distress—a clear sign that mental health needs of the detainees will continue well beyond their detention.

