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Senate Judiciary Committee: Closing Guantánamo: The National Security, Fiscal, and Human Rights Implications

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Thank you for inviting me to share my experience with this subcommittee. It is a privilege, and I hope that my observations and impressions can assist your deliberations over the detention facilities at the Guantánamo Bay Naval Station.

I have publicly opposed torture and the involvement of military medical personnel in interrogations since 2005 when the *Washington Post* published my first opinion piece on the topic. I serve as an expert on torture and the treatment of detainees for Physicians for Human Rights. I am also a member of the group of retired generals and admirals convened by Human Rights First.

Professional Background

I am board certified by the American Board of Psychiatry and Neurology in General Psychiatry, as well as Child and Adolescent Psychiatry, and have extensive experience in clinical psychiatry, research, teaching, and administration. I retired from the United States Army at the rank of brigadier general and served in multiple positions of responsibility as a clinician and commander. I commanded medical activities, medical centers, and medical regions for most of the last 10 years of duty. During my career, I had served as an Assistant Inspector General for The Surgeon General of the Army and as the adjudicating authority for credentialing and privileging actions for numerous providers. My clinical practice has been broad and varied over the past 40 years and includes expert consultation to military attorneys and providing inpatient care, substance abuse and alcohol treatment, and community health services.

The Federal Courts and the Office of the Military Commissions have qualified me as a psychiatric and medical expert in numerous cases involving detainees at Guantánamo Bay Naval Station and accused terrorists. I have had multiple interviews with detainees at Guantánamo, advised attorneys on their respective cases, and spent cumulatively nearly three months at Guantánamo Bay Naval Station over the past 4 ½ years. I currently provide consultation and expert testimony regarding approximately seven current or former detainees. I have reviewed medical, intelligence, and military files of nearly 50 detainees and accused terrorists as a consultant to attorneys, Government authorities, and human rights organizations. The individuals have included high-value detainees, convicted belligerents, and others awaiting release and return to their homes. I have testified in cases of accused belligerents who were captured in the theater of operations and reviewed extensive records of their association with and assisting identified terrorist organizations. Moreover, I have been qualified as a

psychiatric and medical expert in the Military Courts Martial of a soldier convicted of involuntary manslaughter on the battlefield.

Since the onset of the hunger strike in Guantánamo in February 2013, I provided declarations to the District Court of the District of Columbia in support of the petitions of three detainees. I have evaluated other hunger strikers at Guantánamo including an individual who claims the status of the longest striker since 2006.

Much of my clinical practice and research involves patients with posttraumatic stress disorder (PTSD) and other sequelae of stress and war. These patients are: (1) service members with combat tours in Iraq and Afghanistan, and (2) detainees in Guantánamo and victims of torture, abuse, and cruel treatment. I established a nonprofit clinical research organization, The Center for Translational Medicine, in 2011 for testing promising treatments to help improve the healthcare for service members, veterans, and victims of trauma and abuse.

The treatment of hunger strikers at Guantánamo Bay Naval Station compromises the core ethical values of our medical profession. The American Medical Association has long endorsed the principle that every competent patient has the right to refuse medical intervention. The plain truth is that force-feeding violates that principle, and nothing claimed in the name of defending our country can justify cruel, inhuman, and degrading treatment of another man or woman. The detention facilities at Guantánamo diminish America's standing among our allies around the world by putting at question our true values.

Detainees Currently Suffer from Multiple Mental and Physical Illnesses

Snapshots from my caseload help complete the picture of who these men are and what their states of mind are. My experience, and that of many attorneys and clinicians who work with detainees, adds vital ground-level information in thinking about the conditions and operations at Guantánamo. The view from the front lines is as important as the thinking at the top levels of government. Basically, our experiences serve as “human intelligence” that is often so hard to get. I intend to present my observations and impressions in a way that can be used by leadership in their planning of continued operations and ultimately closing the detention facilities at Guantánamo Bay Naval Station.

Detailed information concerning the individuals I have examined at Guantánamo is restricted by the stipulations of the Protective Order issued by the Department of Defense (DoD) pertaining to the Military Commissions and by the United States District Court for the District of Columbia. Without breaching these orders, I can share some general observations and impressions based on the hundreds of hours I have spent with these men.

The detainees span a wide range of backgrounds, interests, and experiences. For context, the aging population at Guantánamo is vulnerable to developing debilitating neuropsychiatric disorders secondary to trauma and stress and suffering with dementia, serious depression, and increasing emotional instability. Senior officials at the Department of Defense (DoD) recognize that the detention facilities at Guantánamo are “turning into a nursing home.”¹

My current caseload includes a diverse cohort of detainees with various physical and mental illnesses. One man has suffered with chronic schizophrenia for decades and was certainly psychotic when apprehended and transferred to Guantánamo over 10 years ago. Another detainee has gained hundreds of pounds during his detention. He currently weighs over 450 pounds, 270 pounds more than when captured, and he suffers with multiple medical conditions. Another has been on a hunger strike since 2006. When documented, his weight has been as low as 91 pounds.

No detainee has ever threatened me or acted in a way that I felt physically endangered me. To put it plainly, I do not feel the apprehension or threat to personal safety that often arises when walking into an American prison despite the high fences, sniper wire, and guard towers surrounding the camps in Guantánamo.

None of these men fit the picture of the “worst of the worst.” They do not compare to prisoners I have seen in this country accused of serious felonies or murder. I have annotated in medical examinations, and surmised from reviewing records, that the severe psychological trauma stemming from their experience in U.S. custody has often not been diagnosed nor addressed by the medical staff and authorities and deprived the detainees of needed treatment. My observations and assessments are that keeping many detainees incarcerated at Guantánamo and subjecting hunger strikers to cruel and degrading force-feeding is counterproductive to our national interests and causes further harm.

On instruction from counsel I have also examined the medical records, client affidavits, attorney–client notes, and legal declarations of medical experts relating to nine Guantánamo detainees who had alleged torture during their detention.² Dr. Vincent Iacopino and I published an analysis of the medical records and evaluations of detainees. In these records it was clear that authorities failed to diagnose conditions and illnesses associated with trauma, abuse, and torture, including obvious posttraumatic stress disorder (PTSD) and postconcussion syndrome. Only the exceptional record documents a diagnosis of PTSD in detainees with known histories of torture and abusive and harsh interrogations.³

¹ Confidential and non-attribution.

² Iacopino V, Xenakis SN (2011) Neglect of Medical Evidence of Torture in Guantánamo Bay: A Case Series. *PLoS Med* 8(4): e1001027.doi:10.1371/journal.pmed.1001027).

³ Furthermore, the government has propagated the theory that time alone can purify the adverse effects of the torture and heal the mental state of the detainee. This assertion

It is accepted that the symptoms of posttraumatic stress disorder require professional treatment to abate, and there is no evidence that the detainees have received effective treatment for their conditions. Most complain of severe impairment including disrupted sleep, anxiety, poor concentration and thinking, and social isolation.

Statements in the media often leave the impression that all the detainees at Guantánamo are highly trained soldiers, eager to get back on the battlefield. As I have said, I have interviewed over a dozen detainees, reviewed the files of at least 50, and spent a cumulative three months at the Guantánamo Bay Naval Station detention center. In my professional opinion, the vast majority of these men do not fit this picture of the "worst of the worst." In terms of the behavior I have evaluated, many of these detainees pale in comparison to some of the violent prisoners accused of serious felonies or murder that I have seen and evaluated in this country. To be clear, if any detainee has committed a crime, I strongly believe that they should be charged, prosecuted, and if convicted, punished accordingly. The fact is, however, that most of these detainees have not even been charged with a crime. Moreover, the Department of Defense has evaluated many of their cases and cleared 86 for release.

Most Detainees Present Limited Risk of Recidivism

My personal evaluations, interviews, analysis of medical files, and reviews of other records including interrogations indicate that the evidence against the detainees, history of their apprehension, and current condition makes them unlikely threats to national security. Despite that observation, our Government has been unwilling to return them to their respective homelands because of considerations over the instability of the respective countries and potential threat to our military force. This judgment is highly speculative, as their illnesses, length of imprisonment, and cumulative stresses have weakened them and most likely deter them from the "fight."

Many detainees suffer illnesses and consequences of injuries that would disqualify them from recruitment or continuing service in the American military. How dangerous are they to our soldiers and marines, particularly as our forces

ignores the continuous adverse and oppressive climate of the conditions of confinement. An accepted clinical finding of patients with post-traumatic stress disorder is that the effects of the traumatizing events or symptoms can appear at any time in the individual's life and even unpredictably in otherwise innocuous circumstances. The constellation of triggers and associations to trauma vary significantly across individuals and do not correlate discretely to time elapsed or type of trigger. I have observed recurrent symptoms with the disabling nature in most detainees will undergo the court proceedings of the Military Commissions. The government has contended that bringing in a "clean team" that does not perpetrate torture and abuse is sufficient to abate the history of anxiety and fear from prior interrogations and events of confinement.

have withdrawn from Iraq and are leaving Afghanistan? Does the remote possibility that they may commit a random act of violence classify them as a strategic or military threat that we can effectively justify indefinite detention? Should we subject them to conditions that revive memories of prior torture and abuse and further damage their health? Does the risk of prosecuting or transferring these detainees outweigh the risk of keeping Guantánamo open? I don't believe so. The restrictive and oppressive conditions at Guantánamo undermine our strategic goals of promoting peace and security initiatives where we can.

The government has published data on the recidivism and future dangerousness of detainees who have been released from Guantánamo. This data is anecdotal, uneven, and lacks detail to be reliable. The data do not explain the extremely low rate of recidivism and dangerousness since 2009. The criteria are too general and ambiguous. The data fail the fundamental tests of scientific validity and utility in deciding the dispositions of these men. Moreover, forensic psychiatrists accept that future dangerousness cannot be reliably predicted.

My professional judgment is that the risk of recidivism by current detainees is much lower than the rate of recidivism of those who have committed violent felonies in the American criminal justice system.⁴ Even the Defense Department's flawed recidivism data reflect a lower rate of recidivism than our criminal justice system. There is, however, a very real threat that events at the Guantánamo Bay Naval Station detention facility will continue to undermine our moral authority and international standing.

The story of Adnan Farhan Abd Al Latif Ala'Dini who committed suicide on September 8, 2012, is instructive. I provided a declaration⁵ in support of his petition for writ of habeas corpus in June 2010. The facts as documented in the decision of the Court on August 16, 2010⁶ are that Latif "...suffered a closed head injury following a motor vehicle accident in 1994. The records from the Islamic Hospital, Amman, Jordan, dated August 21, 1994, indicate that a radiologic test revealed 'a broken skull but no brain injury.' The attending physician notes that Petitioner 'was suffering from aches and a headache.' The Medical Committee of the Military Medical Insurance Department of the Ministry of Defense, Republic of Yemen, assigned diagnoses to Petitioner in July 1995 of: (l)oss of sight in the left eye as a result of eye nerve [illegible], and (l)oss of

⁴ <http://www.bjs.gov/content/reentry/recidivism.cfm>
<http://www.bjs.gov/index.cfm?ty=tp&tid=17>
<http://www.bjs.gov/content/pub/pdf/rpr94.pdf>

⁵ Declaration of Stephen N. Xenakis, M.D. Adnan Farhan Abdul Latif v. Barack Obama. District Court of the District of Columbia, June 6, 2010.

⁶ United States District Court, District of Columbia. Mahmoad ABDAH, et al., Petitioners, v. Barack H. OBAMA, et al, Respondents., Civil Action No. 04-1254 (HHK). Aug. 16, 2010.

hearing in the ears. A consulting neurologist at Guantánamo Naval Base evaluated Petitioner on August 18, 2006. The neurologist documented findings of ...mild deficits in memory and concentration, and upper motor neuron findings involving the left upper extremity that could be residuals of a closed head injury; ... (m)ultiple records of psychiatric interviews and assessments of (Latif) annotate findings consistent with emotional instability and cognitive impairment. Latif reports traveling to Pakistan and Afghanistan in 2001 to get treatment for the symptoms and sequelae of the motor vehicle accident he suffered in 1994.”

I opined that ... “(t)he severity of the closed head injury; impairments in cognition, motor functioning, vision, and hearing; and subjective symptoms of headache and emotional instability are all consistent with postconcussion syndrome.⁷ With reasonable medical certainty, (Latif)’s claim that he suffered with significant symptoms and sequelae of his closed head injury in 2001 and was seeking medical treatment is credible.” The Court ruled that “(t)he evidence upon which respondents primarily rely, [Redacted] is not sufficiently reliable to support a finding by a preponderance of the evidence that Latif was recruited by an Al Qaeda member or trained and fought with the Taliban.”

Nonetheless, Latif was not released from Guantánamo after an appeal by the Government. He continued to manifest serious emotional instability and neuropsychiatric symptoms that caused significant management problems for the detention authorities. He went on occasional hunger strikes and splashed the guards with feces and urine. A lengthy investigation of his death, recently released, documents the challenges in treating him and circumstances leading up to his suicide.⁸ The decision to hold a brain injured and emotionally unstable man in Guantánamo defies rationality, particularly in light of the cost of operating the facility and the adverse publicity following his death.

Another detainee who has been on a prolonged hunger strike has developed gastroparesis (paralysis of the stomach), irritable bowel syndrome (IBS), and evidence of chronic malnutrition. His medical condition is precarious, and he manifests symptoms that could eventually lead to his death. He is not receiving optimal medical and psychiatric treatment and requires a comprehensive medical behavioral plan. Because of his status as a chronic hunger striker, he requires a careful and thorough assessment, including many hours of psychiatric interviewing. The medical staff lacks sufficient information to judge his competence or mental capacity, and there is no data to ascertain his cognitive functioning. He has refused to meet with military psychiatrists out of distrust from prior experience with military medical personnel and a history of prior abuse. There has not been an adequate assessment of the intention of his statements

⁷ Diagnostic and Statistical Manual of Mental Disorders (DSM–IV); Neurol Clin. 1992 Nov;10(4):815-47, attached as Attachment D; and J. Trauma 2007 Jan;62(1):80-88, attached as Attachment E.

⁸ AR 15-6 Investigation, Report on the Facts and Circumstances Surrounding the 8 September 2012 Death of Detainee Adnan Farhan Abd Latif, 8 November 2012.

and beliefs. The conditions of prolonged confinement without reasonable hope of being returned to his home aggravate his illness and contribute to endangering his health. Furthermore, medical staff are subordinated to the guards who maintain the primary relationship with him. This arrangement violates the principles of good medical and psychiatric practice that are essential in the management of complicated cases such as his.

As I mentioned, one detainee now weighs over 450 pounds. He weighed 180 pounds at the time of his capture. He is now morbidly obese and exhibits symptoms consistent with a multitude of medical complications, including diabetes, hypertension, obstructive sleep apnea, cardiovascular disease, and depression. He is at significant increased risk of mortality without treatment, and treatment will be costly. Three former Guantánamo commanders have provided his lawyers with declarations affirming their belief that this detainee does not pose a significant threat to the security of the United States and his continued law of war detention is not necessary. His home country has repeatedly submitted requests to the Department of State and the Department of Defense that he be allowed to return home. Nonetheless, he remains detained, in a severely depressed state, waiting to die in Guantánamo.

I intend for these case vignettes to add vital context to the realities of the environment and climate at the detention facilities. My observations and impressions shift the strategic view of Guantánamo from the overriding mission of security operations to rehabilitation and transition of individuals who should return to their homeland. We should assist them to establish constructive lives in their communities.

Seasoned military leaders appreciate that effective and strong command requires good policies at the top and accurate data from the front lines. These stories elicited from detainees and observations by outside lawyers and physicians complete the picture of who these people are and what their lives are like. They add to the facts that we need to achieve our strategic goals and military mission.

The Hunger Strike and the Consequences of Abuse and Torture

The current hunger strike at Guantánamo dates to February. Since that time, the authorities have classified almost 100 detainees as hunger strikers. The authorities relocated the hunger strikers from the communal cellblocks to individual cells in March. According to Standard Operating Procedures (SOP) at Guantánamo, detainees who missed 9 consecutive meals were subjected to forcible feeding by nasogastric tubes starting in February. By June, at least 45 detainees were being force-fed. The authorities conducted multiple forced cell extractions (FCE) and reinstated intrusive search procedures causing further distress and aggravation. Since Ramadan, some detainees have returned to the communal cellblocks and are not officially classified as hunger strikers.

The genesis of this recent hunger strike has multiple sources. At the core, however, is a general feeling of desperation and hopelessness the detainees endure as a result of their indefinite detention. Even those who have never been charged and have been cleared for release by the Department of Defense have lost all hope of ever being released from Guantanamo.

Attorneys and journalists covering the hunger strikes trace its genesis to Latif's suicide, which is documented in an AR 15-6 investigation conducted by the military. The detainees express deep aggravation at JTF-GTMO reinstating search procedures from 2006 that followed Latif's suicide and investigation. The detainees feel offended by procedures reinstated by the guard staff that includes frisking groin areas, rifling through Korans, and invading the privacy of living areas. They feel appalled at being treated like convicted criminals, even though many had been cleared for release and had never been charged or convicted of crimes that justified imprisonment.

The claims of attorneys and journalists regarding the basis for the hunger strike and profound despair of the detainees are justified. The recent testimony of the Commander of United States Southern Command affirms that policies and procedures changed in response to Latif's suicide. The Joint Detention Group Commander decided that he had to reinstate procedures for guards to search through Korans for contraband and manually frisk the groin area of detainees before visits outside a housing camp or meeting with non-JTF-GTMO personnel. The guard staff decided to return to single cell operations and disrupt the communal living arrangement of most of the detainees.

The conditions of confinement revive memories of harsh interrogations and abusive treatment and constitute a credible threat of a return to abusive treatment. This environment is coercive and perpetuates the harsh and abusive treatment experienced by most detainees when apprehended. My assessment of the environment and conditions was expressed in the declaration that I submitted in February 2010 to Judge Thomas F. Hogan of the District Court of the District of Columbia:

The threats and use of coercion by Petitioner's interrogators were constant during the relevant time period. As detailed in Petitioner's classified testimony about the conditions of confinement, which the Court finds to be credible, United States forces were involved in both Afghanistan prisons where he was held. He believed the United States government orchestrated the harsh interrogation techniques to which he was subject. It thus should come as no surprise that during Petitioner's first Guantánamo interrogation, which was conducted by a United States official on the day Petitioner arrived at Guantánamo, he was gripped by the same fear that infected his Afghanistan confessions. His Guantánamo interrogators did little to assuage that fear. According to the reliable evidence in the record, multiple Guantánamo interrogators on multiple

occasions threatened Petitioner when he attempted to retract statements that he now claims were false confessions. Therefore, from Petitioner's perspective, his interrogators and custodians did not change in any material way during the period in question.

The high number of forced cell extractions (FCEs) during the current hunger strike reinforces fears and impressions that conditions at Guantánamo will not change and that detainees cannot reasonably expect to be released. The detainees regard the environment and command climate at the camps as disrupting any constructive dialogue and possibility of a decent and humane relationship with the authorities.

Over the years, I have conducted innumerable reviews of suicides and homicides looking for evidence of shortfalls and errors in clinical care. My review of Latif's AR 15-6 identifies many other factors and lapses in procedures that provide more compelling causes for his death than the failure to search his groin area or rifling through his Koran. The AR 15-6 investigation documented Latif's unequivocal statement that he intended to commit suicide, if returned to the single cell where he died. He had a history of traumatic brain injury and emotional instability that placed him at high risk for self-harm and suicide. My opinion, as a clinician and experienced reviewer, is that his suicide should be attributed to gaps in clinical care and routine procedures for closely monitoring an individual at high risk for harming himself or others. The change in procedures for searching detainees and transferring them from communal living deflects reasonable efforts to get to the bottom of the problem in safeguarding the detainees and protecting the guard force. Furthermore, there is no mention of a reported incident that preceded the hunger strike: a guard wounding a detainee in the neck with a rubber bullet while he and others were congregating in the communal area. The detainees attribute their embarking on the hunger strike to the cumulative stress of the search procedures, violations of the Koran, invasion of privacy, and assault.

The changes in procedures reportedly so offended the detainees that they felt they could only express their deep dissatisfaction by engaging in a hunger strike. Relocating the detainees to the individual cells from the communal blocks reenacts the trauma of the isolation and sensory deprivation experienced with cruel and abusive interrogation. The forced cell extractions, forcible feeding, and isolation in single cells significantly aggravates their neuropsychiatric symptoms and medical illnesses.

Force-feeding of Detainees

The policy by the authorities at JTF-GTMO to force-feed detainees by nasogastric tube (NGT) illustrates the gaps in understanding the mentality of the detainees, appreciating the stresses imposed on them, and the prerequisites for maintaining a constructive working relationship between guards and detainees. Furthermore, force-feeding completely undermines the physician-patient relationship by destroying the trust that is essential for all clinical treatment,

including medical issues unrelated to force-feeding. It inappropriately engages physicians in the use of force against detainees.

The World Medical Association (WMA) has published two ethics declarations describing the duties of physicians with regard to prisoners on hunger strikes. They are the Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (“Declaration of Tokyo”) and the Declaration of Malta on Hunger Strikers (“Declaration of Malta”). The Declaration of Tokyo, dating from 1975, states that

Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.

The use of the word “artificially” was somewhat imprecise, but has been interpreted by many organizations, including the American Medical Association, to prohibit force-feeding.⁹

The Declaration of Malta, originally adopted in 1991 and substantially revised in 2006 establishes both ethical standards and appropriate clinical responses to hunger strikes. It lays out a humane and clinically effective response to hunger strikes and establishes that force-feeding is unacceptable. It illustrates the false choice between saving lives and force-feeding.

The physician’s role includes evaluating the detainee’s medical and psychological condition, discussing consequences of fasting and options for taking some nutrients, monitoring the detainee’s caloric intake, blood pressure, weight-loss, and other medical consequences of fasting. The physician advises, counsels, listens, and assists the prisoner in clarifying goals, desires, and decisions. To perform this role, there must be a true doctor-patient relationship based on trust. As the Declaration of Malta states:

Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimizes harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.

To establish trust, the physician must be clinically independent of the authorities. The Declaration of Malta states that doctors should “not allow third parties to

⁹ Lazarus, Jeremy A. Letter to Secretary of Defense Chuck Hagel, April 25, 2013.

influence their clinical medical judgment” nor “allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.” If they cannot fulfil this role, or a detainee does not trust the physician, a physician who can establish independence and trust must be brought it.

The first step in medical evaluation is determining mental capacity. The “assumption of capacity” is the overriding principle of capacity assessment. This states that a person is deemed to have capacity unless it is proved that they have an impairment or disturbance of mental functioning (such as an intellectual disability, dementia, other cognitive impairment, acquired brain injury or mental illness) and this impairment is sufficient to affect their capacity to make a particular decision, in this case food refusal.

Assessment involves two stages: (1) an assessment of mental impairment and (2) a mental capacity assessment.

In particularly complex cases (and the current hunger strike in Guantánamo falls into this category), a physician should call on a psychiatrist to provide an objective opinion. That opinion should be minimally influenced, as possible, by the environmental, political, and administrative issues affecting the mental state of the hunger strikers. Such an evaluation should also exclude other bases for food refusal such as mental illness (e.g. schizophrenia, suicidal depression, or anorexia). Hunger strikes rarely demonstrate suicidal intention. Rather, the prevailing opinion of experts in this field is that hunger strikes are undertaken by persons who do not wish to die, but are prepared to risk death in the hope that their demands are met. Case by case evaluation, however, remains critical. The procedure, information gathered during a capacity assessment, and the basis for the decision should all be carefully documented.

If the conclusion is that mental illness is causally linked to the food refusal, the physician may be obliged to override the patient’s decision. On the other hand, it may be determined that an individual suffers from a particular mental impairment but nevertheless retains mental capacity to make decisions regarding his or her own treatment. The WMA guidelines (attached) address such complex situations. *“If a physician is unable for reasons of conscience to abide by a hunger striker’s refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker’s refusal.”*

A lack of capacity cannot be assumed on the basis of cultural or religious beliefs, age, appearance or conditions of confinement.

It is noteworthy that the March 2013 Standard Operating Procedures at Guantánamo (released by the media) do not stipulate acting on capacity assessments. Instead the protocol says that a behavioral health unit will assess mental and psychological status, but does not say what is done with that information. We can infer that the absence stems from a policy of force-feeding all detainees who refuse food. That policy undermines good clinical practice as well as disrespecting the choices of competent detainees.

The Guantánamo hunger strike protocols make no provision for effective counseling beyond initial advice on the consequences of refusing nutrition. There are no procedures for advance directives. Effective medical counseling involves not only providing information on the medical consequences of fasting, but helping the detainee understand his options, including taking some nutrients; helping with decision-making in the event that medical complications occur after fasting, including setting out advance directives for treating life-threatening conditions.

The guidelines for hunger strikes at JTF-GTMO authorize forcible feeding after a detainee has missed 9 meals, long before a hunger strike becomes life threatening. The assertion of the Department of Defense is that it must force-feed to save lives, but these guidelines derail appropriate clinical evaluations and counseling and are not necessary to save lives. They set up a contest of wills between detainees and prison authorities.

The Declaration of Malta demands respect for the hunger striker's decisions. It explicitly addresses principles of medical beneficence and respect for patient autonomy. It explains that the obligation of beneficence "includes respecting individuals' wishes as well as promoting their welfare" and does not justify "prolonging life at all costs, irrespective of other values." The physician's obligation to avoid harm "means not only minimizing damage to health but also to not forcing treatment upon competent people nor coercing them to stop fasting." In other words, should the conclusion of the assessment be that the patient has the mental capacity to refuse food, the physician is bound by medical ethics and international and U.S. law to refrain from enteral feeding

Thus, the Declaration of Malta states that "*[f]orcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.*"

In short, the World Medical Association has determined that force-feeding through the use of restraints is not only an ethical violation but contravenes Common Article 3 of the Geneva Conventions. The International Committee of the Red Cross has taken the same position.

The American Medical Association (AMA) has been a member of the WMA since its inception after World War II. In 2005, 2009, and most recently on 25 April 2013, through Dr. Jeremy Lazarus, then President of the AMA, the AMA reiterated its opposition to force-feeding at Guantánamo. He wrote to Secretary of Defense Chuck Hagel detailing the AMA's position on force-feeding. "Every competent patient has the right to refuse medical intervention, including life-sustaining interventions." The AMA position means that when a physician performs, orders, supervises or monitors enteral feeding on a person who has

refused such treatment, and has the mental capacity to refuse, this constitutes a violation of medical professional ethics.

Every aspect of Guantánamo's policy of force-feeding contravenes these standards. Physicians are not independent, and are instructed to follow a protocol for enteral feeding that overrides medical professionalism. They do not counsel detainees about their options, much less help them prepare advance directives. According to the protocol, they participate in the coercive process, including being expected to order physical restraints for force-feeding. Nurses similarly are ethically compromised. Nurses are not allowed to act on a detainee's request to see a doctor or to change the content of the food used or the rate of flow -- only to make a note in a chart.

Indeed, there is an inherent conflict of interest in having the Senior Medical Officer (SMO) and/or primary medical provider serve as the decision maker with regard to nutritional and tube feeding choices for the hunger strikers. Any trust that the provider has established with the patient is at risk, and any desirable influence that the provider may have over the patient's decision making may be lost. Additionally, consulting physicians, both military and private, have observed that this responsibility has proven acutely stressful for the individuals filling the SMO position, likely as a result of the interference with a sound relationship with the patient.

The infringement on medical and nursing professionalism at Guantánamo is deliberate. The new Standard Operating Protocol states that responding to hunger strikes "requires a partnership between the [Joint Medical Group] medical staff and the Joint Detention Group (JDG) security force." That is an inappropriate role for physicians and nurses: they are expected to be independent and serve patients, not security forces.

Further, the process of force-feeding at Guantánamo is painful, degrading and inhumane. My experience as a physician is that the process is intolerable for many. The humiliating nature goes beyond the nasogastric tubes and restraints.

Reliable reporting indicates that the authorities conduct multiple Forced Cell Extractions that traumatize and potentially injure detainees. The forcible feeding at Guantánamo appears designed to end the protests and not to save lives. The Department of Defense's March 2013 protocol on force-feeding analogized changes in responding to hunger strikers to adjustments made in battlefield tactics. The changes include rescission of policies allowing detainees to choose the rate of flow of nutrients and taste of food and denying communal activities to hunger strikers.

It appears that, during the past week to 10 days, some hunger strikers have abandoned their hunger strikes. This may prove that the punitive, cruel, and inhumane politics are working – but that hardly makes the policies and procedures legitimate, ethical, effective, or legal.

Experiences In Other Countries

Two major allies, the United Kingdom and Israel, address hunger strikes alleged to be associated with terrorism, and both prohibit force-feeding. The UK prohibits forcible feeding by law. It is instructive that Israel has written the sanctity of life into law, but it has not forcibly fed thousands of Palestinian prisoners on hunger strikes. A court case in 1996 permitted force-feeding, but the Israeli Medical Association demands adherence to the Declaration of Malta and uses ethics committees to aid physicians attending to hunger strikers. If detainees do not trust prison physicians, outside physicians are called. Although the response of Israeli prison authorities to hunger strikes could be improved, they have not engaged in force-feeding and, to my knowledge, no prisoners have died since procedures under the Declaration of Malta were adopted.

Leadership

A complex operation such as Guantánamo requires experienced and steady leadership. An axiom of good military leadership is that the command at the top sets the climate and is responsible for “what is done and not done.” Recent testimony by senior leaders at hearings before the Military Commissions convey details of policies and procedures that have an adverse effect on the overall operation of the facility and contribute to obvious problems.

Standard policies for assigning senior leaders and personnel stipulate tour lengths of a year or less.

Few senior leaders have backgrounds in operating complex detention facilities. These leaders enact policies and procedures that further harm the detainees and perpetuate a climate of abuse and maltreatment. Over the past 10 years, the senior commander has been a rear admiral— in the combat arms or combat support - with experience commanding fighting units. The commanders are assigned to JTF-GTMO for a year and rely on “learning on the job.” The testimony of a former Commander of JTF-Guantánamo at the recent Military Commissions reflects the facility’s overwhelming emphasis on safety, security, and intelligence gathering and analysis. Basic ethical and legal standards for the attorney-client relationship, rehabilitation of detainees, and medical treatment are subordinated in favor of policies for maintaining order and discipline. As the hunger strike indicates, current policies and procedures further abuse detainees and undermine even faint attempts to prepare them for transition to their homes and rehabilitation.

Furthermore, the testimony of the current Joint Group Detention Commander at the Military Commissions hearings revealed that he “...had never run a prison.” When asked if he had ever run a detention facility housing people awaiting the death penalty, he again answered “(n)o.” He had only operated detention facilities housing American prisoners, and indicated no experience with Muslim

detainees or men of other ethnic backgrounds. This commander is responsible for the changes in policies and procedures following Latif's suicide and preceding the current hunger strike. I am not impugning his professionalism or competence as an Army officer, but questioning the wisdom of DoD in assigning a comparatively inexperienced officer to run the 'most notorious prison on the planet.'

The circumstances surrounding the suicide by Adnan Latif and subsequent hunger strike illustrate the problems with effective leadership at Guantánamo. The leadership failed to assign staff experienced with individuals at risk for self-harm and suffering with serious emotional disturbances. The medical and psychiatric issues were subordinated to policies for maintaining good order and discipline. Primary responsibility for management rests with the guard staff and not the medical staff. These policies and procedures deprive medical and psychiatric personnel from standard and appropriate options for managing individuals with serious medical and psychiatric illnesses and providing optimal treatment for their conditions.

Recommendations

Force-feeding at Guantánamo must end. It is unethical, an affront to human dignity, and a form of cruel, inhuman, and degrading treatment in violation of our Geneva Convention obligations. It simulates the conditions of torture and abuse that many detainees had already suffered. Further, the claim that force-feeding at Guantánamo is essential to save lives is false and not corroborated by clinical experience. The experience with hundreds of hunger strikers in other countries over the past decades shows that engaging early in an appropriate doctor – patient relationship obviates the decision to forcibly feed to save life. The procedures outlined by the World Medical Association, and endorsed by the American Medical Association, are effective, ethical, and life-saving.

The decision to end force-feeding is an important starting point to reforming policy, guarding against coercion of detainees, and ending indefinite detention.

My recommendations include:

First, the underlying issues that contributed to the hunger strike must be addressed. These include expeditious release from Guantánamo of those detainees already cleared for release to ending the harsh conditions of confinement that have been put into place this year.

Second, detainees should not be punished for engaging in hunger strikes. Placing hunger strikers in isolation or in "dry cells," subjecting them to violence in transferring them from place to place, denying them access to communal areas or other detainees, and all other coercive measures should end and be prohibited in the future.

Third, all directives, orders and protocols that provide, explicitly or implicitly, that health professionals act as adjuncts of security officials must be rescinded. There is no such thing as an effective partnership between security officials and medical care providers in addressing the medical needs of detainees. Doctors and nurses need to act as treating clinicians, with professional independence and in accordance with ethical obligations of doing no harm and meeting individual needs. There are difficult challenges in providing health care services in any prison, but adherence to professional ethics should not be one of them. Further, mechanisms need to be put into place to reinforce professional independence and provide for support of doctors and nurses who find their independence or other ethical responsibilities tested. This includes leadership at the highest levels of the military in affirming these values.

Fourth, the aging detainees require more complicated and sophisticated medical care. Chronic hunger strikers often become medically compromised, nutritionally depleted, and suffer from physiological and psychological harms that impose special challenges on clinicians. In general, the detainees do not trust physicians and nurses who have been part of the force-feeding apparatus. The regular rotation of clinical staff impedes continuity of care, diagnosis, and treatment. It places dedicated and professional military clinicians in untenable circumstances of providing suboptimal treatment to an increasingly ill population. It is not fair to the doctors, nurses, or detainees. If the closure of the detention facility is not achievable, then independent medical evaluations, followed by appropriate treatment and counseling, are invaluable.

In taking these steps, the Department of Defense has many resources to aid in formulating and implementing new policies. I am confident that medical associations, both in the United States and in countries such as the United Kingdom or Israel, would be willing to lend expertise. The International Committee of the Red Cross (ICRC) has extensive experience in advising prison authorities in responding to hunger strikes. Physicians like me who have had experience with detainees at Guantánamo would, I am quite sure, be willing to contribute their expertise and insights.

Thank you, again, for the privilege of speaking to you.