The Ethical Application of Force-Feeding: a Closer Look at Medical Policy Involving the Treatment of Hunger-Striking POWs and Detainees

---

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

---

by
Jared L. Cohen
May 2016

Thesis Approvals:

Nora Jones, PhD, Thesis Advisor, Center for Bioethics, Urban Health, and Policy

ABSTRACT

Hunger strikes are used as a method of protest to call attention to grievances or political positions and galvanize support for a cause. Historical examples from pre-Christian Europe through Guantanamo Bay have demonstrated various motives, interventions, and outcomes to this unique form of protest. Starvation causes life-threatening damage to the body, and to intervene on an unwilling subject involves invasive medical procedures. As scholars have debated how to approach this medical-ethical dilemma, a tug-of-war exists between autonomy, beneficence, and social justice with regard to the rights of prisoners of war (POWs) and detainees. International documents, legislation, and case law demonstrate vast support for and place precedence on the prisoners right to make their own autonomous, informed medical decisions, and many in the international community lean towards abstaining from intervention on hunger strikes on the basis of patient autonomy. However, there are notable arguments both for and against force-feeding that have been well documented. Despite the vast international dialogue, there is a key component that seems to have been forgotten—the environment within which the prisoner or detainee resides is immersed with coercive and manipulative activity and interrogation on a regular basis. This environment may impede the ability for the POW or detainee to make an autonomous decision and then leads to the refusal of life-saving, medical intervention on the basis of a decision that is markedly coerced or manipulated. It is therefore noted that a different lens must be used to analyze hunger strike situations for this specific population.

Thank you to my family—my mother in particular—whose attention to detail and thoughtful wisdom has made my education from kindergarten through medical school, a successful endeavor.

ACKNOWLEDGMENT

I am extremely grateful to my professor, Dr. Nora Jones, for her creation of the Center for Bioethics, my duel degree M.D./MA program at Temple University, and her guidance throughout my medical education.

Legal Disclosure

The views, opinions, findings, and conclusions expressed in this thesis do not reflect the views or opinions of the United States Department of Defense or San Antonio Military Medical Center and its affiliates.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION

Throughout history, hunger strikes have been used as a method of protest. These powerful accounts of self-directed starvation have had profound effects reaching well beyond those who engage in them. Hunger strikes have been a way to call attention to grievances or political positions, and galvanize support for a cause. In today's global society, hunger strikes have provided an effective tactical strategy for those that have limited means or limited liberty to surmount a large-scale assault against their issue of protest.

Prisoners of war (POWs) and detainees are two groups with very particular and complex limitations on personal liberty. They have limited means to protest any concerns, and hunger strikes amongst this population are used as one of the only forms of protest that has the potential to be sustained, propagate local, national, and international discussion as well as lead to a desired outcome. However, western societies struggle to come to terms with an effective and ethically sound strategy to confront such forms of protest. Many legal documents, treaties, and medical associations have weighed in over the last century with various opinions, recommendations, and legal doctrine aiming to address the issue. However, no consensus exists, and current practice by many western-governing bodies varies drastically despite sharing similar ethical foundations.

One reason that States and various authorities have responded differently to hunger strikes relates to the unique challenges posed by the hunger-striking prisoner. In this situation, there is a clear dilemma. On one hand, the State is considered the caretaker for POWs and detainees, and they may favor force-feeding as a way to intervene to

preserve the striker's life due to their duty to care for them. Parenthetically, this viewpoint also preserves the State's interest in POWs and detainees as valuable assets in governmental affairs. However, on the other hand, there is the view that there is an individual right to self-determination that emanates from individual autonomy. Consistent with this argument, the force-feeding of POWs and detainees is rejected. Answering the question on the propriety of force-feeding during prolonged hunger strikes of POWs and detainees is driven by the approach chosen. Unfortunately, with no consensus existing on how to balance this conflict, State's responses to confront this quandary differ drastically even though they have similar ethical values.

Various authorities "answer" this situation differently as they appear to support specific pillars of bioethics while letting others slide. For example, the Netherlands and Germany deal with force-feeding of hunger strikers differently in their legislatures and court cases. Those in the Netherlands place more emphasis on an individual's right to self-determination and support autonomy while allowing the principles of beneficence or social justice to take a back seat.[17] This causes policy to lean away from intervention in hunger strikes. They emphasize the right to self-determination and refrain from intervention in hunger strikes—possibly at the expense of the prisoner's life and the expense of justice for the community. Contrary to this opinion, Germany emphasizes the interest of the State, justifying less emphasis on autonomous rights in the interest of supporting beneficence and social justice. This means that there is more support for force-feeding of hunger strikers to keep them alive despite uncomfortable feeding methods. The central point is that, for many reasons, throughout the world there have

been very different responses to hunger strikes of prisoners based on which principle takes precedence: autonomy, beneficence, or social justice.

This paper seeks to review policies and examples of approaches taken to resolve this conflict. Such a review of policy will aid in a discussions of an alternative viewpoint towards this dilemma that may, in-fact, pave a course of action that allows for all pillars of bioethics to be more effectively satisfied while both the goals of the State and rights of the imprisoned are thoughtfully met. Ultimately, the central focus of this paper specifically considers hunger strike management as it pertains to POWs and detainees.

CHAPTER 2: HISTORY OF HUNGER STRIKES

Hunger strikes have been described for centuries across various cultures. Hunger strike practices, for example, were described in ancient India as well as medieval Celtic societies. In ancient India, scripture relays that the brother of the exiled King of Rama used a fast "to coax him into returning." [19] In Ireland, before Christianity, the less powerful fasted against the powerful to redress perceived injustice or recover a debt. [27] The premise seemed to publically shame the wrongdoer into doing the right thing. Considered a remedy of last resort, the responsibility to end the hunger strike rested with the perceived wrongdoer. [27] If the perceived wrongdoer allowed the fasting party to die on his doorstep, he was considered at fault and responsible to the dead person's family "to bear the burden of his debt." [19]

More recently, in the early twentieth century, hunger striking began to take on a broader political significance. Suffrage advocates such as Alice Paul reflect this shift. Paul was a New Jersey Quaker who apprenticed with the British suffragettes.[31] She was force-fed while imprisoned in England in 1909 because she participated in a hunger strike. [22] At the end of the decade, the Chinese students in Tiananmen Square staged protests of the restrictive government, and hunger strikes were used many times leading up to and during the movement.[35] Other well-known strikes include Mahatma Gandhi's highly publicized fasts to protest British-occupied rule in India, actions that brought attention to a non-violent means for a revolution in the struggle for India's independence as well as other fasts to protest Hindu-Muslim violence. [30] It is estimated that between "1972 and 1982 there were at least 200 hunger strikes in 52 countries."[27] Very recently, hunger strikes were directed in many regional or local ways, too, such as to champion

educational reform in Chicago. In that situation, hunger strikers pressured the Chicago Public Schools to re-open Dyett High School in response to protestor's demand for an arts-focused neighborhood school for their children. [29]

On the backs of many successful hunger strikes performed by free citizens in support of a cause, there are other well-known prisoners, prisoners of war, and detainees who have also used hunger strikes as a means of protests either to show conviction to their cause or promote change in their treatment during incarceration, and it is one of the only ways for prisoners to make a statement that draws the attention of those outside of the prison walls. One especially well-reported example of a hunger strike in prison was Bobby Sands' 1981 hunger strike protest. Sands was a member of the Irish Republican Army (IRA) who was in jail for gun possession and, interestingly enough, while in jail, was actually elected to British Parliament. His hunger strike was not merely about the prison demands or requests for "political prisoner status" or even about other IRA issues, but it reflected the "great moral struggle between Irish justice and British oppression."[4] His hunger strike death, after 66 days without food or British government intervention, drew attention from the "media of the world" and "[Sands] was a hero, martyr."[27] It was reported that there were "seven hundred media people… to cover his funeral (with a) crowd of one hundred thousand marching…."[4] Sands became known as a man that "starved to death for justice" and he "was famous… for dying." Even ten years later, "thousands marched to commemorate the tenth anniversary of Bobby Sands' death."[4]

Subsequent to the Sands notoriety, there were a series of other less well-known hunger strikes regarding those deprived of their liberty including those in the Netherlands in 2002. Volkert van der Graaf, the convicted murderer of politician Pim Fortuyn,

underwent a hunger strike protesting his strict isolation. The strike was promptly reversed when the isolation was stopped.[7]

Another less well-known hunger strike occurred in Spain by Inaki de Juana Chaos, a member of the Basque separatist group. He was convicted of killing 25 people in 1987 and sentenced to 3,000 years in prison and underwent multiple hunger strikes during his incarceration. In August 2006, he began a hunger strike to protest his continued imprisonment. He was force-fed on day 44 of food deprivation and suspended his hunger strike after day 63.[6] He underwent another hunger strike from November 2006 until March 2007. It ended after 114 days and de Juana being moved from Madrid to a hospital that he requested in the Basque region.[30] He was later granted the freedom to serve the rest of his sentence on house arrest.[23] The Spanish Government decision to move de Juana to his house due to concerns over his health was criticized by conservative wings of the population who cited this as encouragement for future prisoner hunger strikes. Inaki de Juana Chaos was put back in prison later that year. On July 17, 2008, de Juana began his third hunger strike from prison and he was subsequently released from prison after serving a total of only 21 years on August 2, 2008.[2]

Contrary to the management in the Inaki de Juana ordeal, Tohuami Hamdaoui, a 41-year-old Moroccan, went on a hunger strike and the government chose not to intervene. He was convicted for robbery as well as sexually assaulting a 13-year-old girl. Tohuami Hamdoaoui underwent a hunger strike in February of 2011, and he became the first Spanish prisoner to die from starvation in July of 2011 after Spanish officials sought no intervention.[13]

Additional deaths by hunger strike occurred in Austria in 2007. Detainees awaiting deportation from the country went on hunger strike and were kept in detention. It was openly expressed by the individuals and reported in the international community that their lives were endangered. A 41-year-old Nigerian detainee awaiting deportation died after 41 days without food, and an 18-year-old asylum seeker from Gambia died after just 11 days. [33] These events sparked conversation from numerous human rights activists.

Additionally, a less well-known hunger strike situation occurred in Cuba in 2010, when Orlando Zapato Tamayo who was allegedly incarcerated due to his political views against the Castro regime died after 85 days of food deprivation. [16] While official reports state that his protest was due to not having a phone and TV in his prison cell and that he ate food brought in by his relatives on visits, the true events surrounding his strike are not clear.

Also, in April 2014, 290 Palestinian detainees in Israel underwent a hunger strike. Seventy of these hunger strikers required removal from incarceration and hospitalization. Hospitalization occurred after 24-28 days. The average length of hunger strike amongst this population was 63 days and the longest strike lasted 137 days. It is not clear if force-feeding was implemented, but living to 137 days without any nutrition would be a medical marvel.[18]

While each of the prior examples gained local attention, it was the controversy regarding the management of hunger strikes in Guantanamo that fostered increased national and international debate on this issue. This controversy was highlighted in 2005 when reports of a mass hunger strike amongst detainees from the U.S. led War on Terror

held at Guantanamo Naval Base in Cuba erupted. The issue of force-feeding as an intervention for those involved in hunger strikes was placed on an international stage. U.S. policy reportedly favored force-feeding these detainees at Guantanamo and this has promoted discord as it contrasts with some European models for detainees on hunger strikes. Somewhere between 76 and 200 detainees participated in a hunger strike. It is reported that at least eighty captives dropped below 100 pounds during the strike. [34] The first hunger strike was stopped on July 28, 2005 after prisoners were promised rights provided in the Geneva Conventions. However, strikes resumed later in the summer as prisoners allegedly did not approve of their treatment. In September of 2005, the New York Times reported that a third of the camp had taken to hunger strikes, and that at least 20 of them were being given intravenous fluids and being force-fed through nasal tubes. Major Weir, a spokesman at Guantanamo said, "We will not let them starve themselves to the point of causing harm to themselves."[21]

A review of various hunger strikes over the last century—beginning with the incarcerated women asserting a right to vote and through the on-going events at Guantanamo—shows that they share a common desire to protest, although not necessarily a desire to die. It is the management of these various protests that is at issue, and there is not a universally accepted resolution for the management of hunger strikes.

CHAPTER 3: PHYSICIAL CONSEQUENCES OF A HUNGER STRIKE AND MEDICAL INTERVENTION OPTIONS

The Stages of Starvation

A hunger strike causes life-threatening damage to the body. To answer the question of whether intervention should take place (and at what moment), an understanding of the course of a hunger strike is foundational. Understanding the process of starvation is complex, and medical management of the starving is not commonly taught in Western societies. In fact, the World Medical Association (WMA) has developed a course that includes starvation management because even physicians have little expertise or experience with treating starvation. It is entitled "Doctors working in prison: human rights and ethical dilemmas." The Dutch Johannes Wier Foundation also published a manual for physicians dealing with hunger strikes that clearly outlines the four phases in the hunger striking process, explaining a complex process in understandable portions.[33]

The first phase in the hunger striking process is the first week where the hunger strike is generally handled well by the human body. There are only a few risks provided sufficient fluid intake is obtained. The risks are largely associated with underlying medical conditions. If no other medical conditions are applicable, there can be "hunger pains," but they typically disappear in a few days. Blood sugar levels can initially drop, but will stabilize at a new, lower level with minimal effect on the hunger striker's overall physiology. Physical exercise is possible during this phase. Despite minimal risk in a

previously healthy subject, physiological changes begin after just a few days as the body shifts what it uses to make energy.[5]

The second phase is the remainder of that first month. During this time, the hunger striker experiences dramatic weight loss.[8] The hunger striker becomes increasingly weak and physical changes impede mobility. Fatigue occurs more quickly and muscle pain is felt during minor exertion. Apart from the weight loss and fatigue, other objective changes to the hunger striker's physiology are noticed. The resting heart rate slows to often less than 60 beats per minute (bradycardia), and the hunger striker is unable to maintain their blood pressure when one goes from a sitting to a standing position (orthostatic hypotension).[33] This can cause transient dizziness and occasional headaches. Because of decreased metabolism, the hunger striker's body temperature also drops. Even early in this first month of the hunger strike, the liver and intestines will atrophy. The heart and kidneys will show signs of atrophy towards the end of the month.[33]

The third phase occurs after the first month and is termed, "the sickness phase." The transition point from feeling "fatigued and not well" to feeling seriously ill and often bedridden occurs around the 40th day of the hunger strike. [17] This severe sense of weakness and illness can be complicated by loss of hearing, deteriorating eyesight, double-vision, severe nausea, and hemorrhage due to loss of proteins involved in forming blood clots. [33]

The final phase, which only lasts a few hours to days, is characterized by mood swings and confusion followed by a coma and death. Important decisions concerning medical intervention and treatment must be made well in advance of phase four. Once in

phase four, death is likely unavoidable and usually results from cardiovascular collapse, or a heart dysrhythmia, or upon several hours after going into a coma secondary to low blood sugar. [8] If only water is consumed, total lack of food is likely to cause death between 42 and 80 days. If vitamins, electrolytes, and adequate hydration are maintained, these phases are prolonged. Prisoners have survived for 6 months without food with the help of ample vitamin, electrolyte, and sugar supplementation. [8]

Recovery from a Hunger Strike

In the majority of hunger striking cases, the hunger strike stops before serious injury occurs. After the hunger striker stops, detailed medical attention is needed to replace lost vitamins (such as thiamine and B vitamins) and small portions of carefully selected foods should be added to avoid refeeding syndrome which can easily result in death. Refeeding syndrome is characterized by electrolyte depletion (low potassium, phosphorus, magnesium) and fluid retention caused by a sudden release of insulin due to the shift to carbohydrate metabolism after prolonged starvation. [8] Hospital monitoring needs to be continued for several days after eating has restarted as cardiac complications can occur. Hunger strikers are often not aware and not informed of the complex physiological and psychological processes that are at play when eating is resumed. The period of recovery can take substantially longer than the period of the actual hunger strike. For a hunger strike that lasts three weeks, it is anticipated for it to take 3 months to get the hunger striker back to his or her pre-strike state of health. [17]

Interventional Options

In addition to understanding the course of a hunger strikers condition, it is equally necessary to understand the options available for force-feeding in order to make an informed decision about the situation.

Nearly all people who partake in a hunger strike accept water. Without water, one would die within days, which would not allow enough time for their protest goals to be met. However, as the starved enter from phase two to phase three of the hunger strike, it is increasingly difficult to adequately hydrate oneself. Intravenous hydration is needed. This allows the hunger striker an extended timeline to pursue his or her demands. Electrolytes are commonly used in the hydration solution, as it is not safe to infuse pure H_2O. In addition, certain crucial vitamins (for example, thiamine) can be added to the solution as can sugar should the hunger striker allow it to be.

Additionally, complete nutrition can be provided through the IV line, which is termed medically as parenteral feeding. This is a medically derived substitute for "eating." This form of nutrition called peripheral parenteral nutrition or total parenteral nutrition provides a mixture of protein, carbohydrates, and fat that is vital for energy, tissue repair, and overall survival. However, feeding via this route is the most expensive route of alternative feeding and multiple complications can occur including life-threatening infections and electrolyte imbalances. One can only use this feeding mechanism for a short period of time (days to two weeks) before having to replace the IV catheter. Additionally, the most concentrated delivery of nutrition through the veins, which may be necessary to maintain life in a prolonged hunger strike, must be delivered

through one of the larger, central veins. Obtaining central venous access is an uncomfortable procedure that does pose risks including life-threatening hemorrhage, damage to surrounding structures, and risk of infection.

An alternative to the parenteral feeding methods is enteral feeding which involves nutrition being placed into the gastrointestinal tract via a tube. This nasogastric tube can be placed through the nose, down the back of the throat, to the esophagus, and into the stomach. The nasogastric tube is very uncomfortable by all accounts, but it can be tolerated while the subject is awake. Other tubes can be placed directly into the stomach or the small intestine, but these require surgery which is not an ideal option in this circumstance. Enteral feeding is preferred to parenteral feeding because it is more physiologic, poses less life threatening risks, and is substantially less expensive. However, the delivery mechanism needed for enteral feeding via the nasogastric tube imposes more overall discomfort for the subject than a standard intravenous line. Also, a nasogastric tube cannot remain in place indefinitely.

The United Nations has "Special Rapporteurs" which are independent experts appointed by the Human Rights Council to examine and report back to the UN council on a specific human rights or country situation. They are not employed by the UN and are not paid for their work. One such investigation was conducted in 2012 on the practice of force-feeding of detainees at Guantanamo Bay. With regard to nasogastric tube feeds, the report graphically states:

> They [the prisoners] are being force-fed through the nose. The force-feeding happens in an abusive fashion as the tubes are rammed up their noses, then taken out again and rammed in again until they bleed. For

> a while, tubes were used that were thicker than a finger because the smaller tubes did not provide the detainees with enough food. The tubes caused the detainees to gag and often they would vomit blood. The force-feeding happens twice daily with the tubes inserted and removed every time. Not all of the detainees on hunger strike are in a hospital but a number of them are in their cells, where a nurse comes and inserts the tubes there. [25]

Beyond the graphic adjectives, this description is not drastically far from the description of insertion of a nasogastric tube in a controlled, hospital setting. It is an unpleasant experience for all parties involved. Hopefully, no ethical medical professional will try to be "abusive" or "ram" the tube up the nose, but light bleeding regularly occurs. Additionally, larger diameter tubes are needed for higher volume tube feeds, especially if the nutrition needs to be delivered in a short time frame. However, a hospitalized, cooperative patient would typically only need to undergo this procedure once as the tube can be left in place for days. Since the hunger-striking patient will certainly pull the tube when given a chance, the procedure was performed twice each day on the detainees at Guantanamo.

Additionally, it is important to recognize that performing any of these procedures on an unwilling patient drastically increases the risks associated with the procedure. The patient will need to be restrained either chemically with medication or with physical restraints for the procedure. The person would also need to be restrained for the duration of time that one wants the tube or IV line in, so he or she does not remove the feeding mechanism. This poses severe challenges to the medical providers both physically and emotionally, and this increased risk for error needs to be thoughtfully considered in any force-feeding decision.

CHAPTER 4: KEY DEFINITIONS

In order to present a careful review and discussion of policy regarding prisoners of war and detainee hunger strikes, it is important to carefully define terms that are commonly used in these policy statements. Definitions and key concepts will be presented from various influential organizations and commonly accepted premises within each definition or concept will be used in the discussion.

Table 1: Key Definitions

Autonomy "We have one concept and many conceptions of autonomy." [9]	"The capacity to act intentionally, with understanding, and without controlling influences." [3] "Autonomy means the patient has full rights to make decisions freely and without coercion regarding the method of treatment and to grant, or not, permission prior to the start of a treatment plan" (Israeli Medical Association).
Competence	Capacity of a person to act on his/her own behalf; the ability to understand information presented, to appreciate the consequences of acting, or not acting, on that information, and to discuss treatment choices. [1]
Coercion	"If and only if one person intentionally uses a credible and severe threat of harm or force to control another." [3] "Threat must displace the person's self-directed course of action." "Coercion renders even intentional and well-informed behavior non-autonomous." [3] "Coercion aims to manipulate the patient's decision by influences which undermine independent reasoning" [11]
Detainee	Used by governments to refer to individuals held in custody that it does not classify nor treat as a POW or as a suspect in criminal cases. "Any other person captured or otherwise detained by an armed force."[12] Legally, in certain western societies (U.S.), detainees are not granted the rights provided in international laws like the Geneva Convention although this has recently been debated.
Detention	Process when a state or private citizen lawfully holds a person by removing his/her freedom of liberty at that time. This can be due to pending criminal charges or to protect a person or property.
Doctor & Physician	Are used interchangeably nationally and internationally as a person who is licensed to provide medical care.
Force-feeding	Medical treatment where a patient who is unwilling to eat is compelled to ingest food. "All force feeding is artificial, but not all artificial feeding is forced." [17]
Health care provider	Definition extends to include doctors, physician assistants, nurses, and military field medics.
Hunger strike	"Refusal of food lasting longer than 72 hours" (World Medical Association).

Informed Consent Elements [3]	Threshold elements (Preconditions): 1) Competence (to understand and decide); 2) Voluntariness (free from coercion or manipulation) Information Elements: 1) Disclosure to material information; 2) Recommendation of a plan. 3) Understanding of disclosures and recommendations Consent Elements: 1) Decision in favor of a plan; 2) Authorization of the chosen plan (chosen plan can be to do nothing)
Manipulation	Information rendered in such a way that it alters a patient's understanding of a situation or makes him decide to act in a certain way. [17]
Persuasion	"A person must come to believe in something through the merit of reasons another person advances" [3] "Aims to enlist the patient's decision by providing information" [11]
Prisoner	A person who is deprived of their liberty and kept under involuntary restraint, confinement, or custody in connection with a suspected or proven criminal offense. [26]
Prisoner of War (POW)	A person captured or interned by a belligerent power during war… Include(s) guerrillas, civilians, or noncombatants associated with a military force. [10]

CHAPTER 5: INTERNATIONAL DOCUMENTS AND LAW IN RESPONSE TO HUNGER STRIKES

Although there are legal cases in the court systems of various countries, there are also many international human rights treaties that comment on the rights of prisoners and detainees. The United Nations, The Human Rights Committee of the International Covenant on Civil and Political Rights (ICCPR), The Geneva Convention, and the World Medical Association (WMA) are commonly referenced as authoritative.

The United Nations

There are numerous UN agreements that highlight preferred treatment of prisoners and detainees. Several of the UN agreements state stipulations that are relevant to the discussion of force-feeding.

The UN General Assembly adopted the "Resolution on Principles of Medical Ethics" in 1982. [36] Although the Resolution on Principles of Medical Ethics has no binding legal effect and is effectively "soft law," the document provides ethical guidelines for all healthcare personnel when treating "all persons who are deprived of their liberty" (not just prisoners). In Principle 2, it is stated that:

> It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading punishment. [36]

In Principle 4, it is specifically stated that health personnel may not be involved in interrogation of prisoners and detainees in a manner that may adversely affect their mental health. Lastly, principle 5 states:

> It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and it presents no hazard to his physical or mental health. [36]

The "Standard Minimum Rules for the Treatment of Prisoners" adopted by the UN in Geneva in 1955 provides a set of standards for the protection of the rights of prisoners and detainees. [37] The Standard Minimum Rules do not specifically address force-feeding. However, Rules 33 and 34 contain statements against the use of restraints. Rule 33 states that the use of handcuffs, chains, irons, and straitjackets may never be applied as punishment as well as stating that chains and irons may not be used as restraints. Rule 34 states that other instruments of restraint may not be used except to a) prevent escape during transfer, b) on medical grounds by direction of the medical officer, or c) by order of the director, if other methods of control fail in order to prevent a prisoner from injuring himself or others. The exception explained in Rule 34b can be used to justify the force that is necessary to feed a hunger-striking prisoner. 34c opens an argument that force may be used to prevent a prisoner from injuring himself, and a hunger strike is without a doubt injuring over the long term. However, in its strictest

interpretation, 34c likely referred to subjects who are actively suicidal. Suicide, while it may be an accepted outcome for those partaking in a hunger strike, is typically not the primary objective. [37]

A few years after the adoption of the Principles of Medical Ethics, the UN drafted the Convention against Torture. Article 2 of the Convention against Torture states, "No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability, or any other public emergency, may be invoked as a justification of torture."[38] It effectively bans torture under all circumstances but is general in its definition, which has made it difficult to invoke this Convention legally.

The Human Rights Committee of the International Covenant on Civil and Political Rights

The Human Rights Committee is a collection of independent experts that monitor implementation of the "International Covenant on Civil and Political Rights" (ICCPR) by its States Parties. The ICCPR is a multilateral treaty adopted by the United Nations General Assembly on December 16, 1966. The Human Rights Committee states, "persons deprived of their liberty must not be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignitary of such persons must be guaranteed under the same conditions as for that of free persons…. By arresting and detaining individuals [State Parties] take the responsibility to care for their life." [15] In response to the death of detainees from hunger strikes awaiting deportation from Austria in 2007, the Human Rights Committee stated, "The State party should ensure adequate medical supervision and treatment of detainees awaiting deportation who

are on hunger strike." [15] This general call for medical supervision and treatment is nonspecific and sheds little light on solutions for that specific scenario.

The Geneva Convention of 1949

The Geneva Convention of 1949 differs from the above policy statements as it has played a significant role in legal application. It is also binding for those States that ratified its terms. The Geneva Convention forms an important framework of international humanitarian law, as it is specific for the subset of human rights applicable in times of armed conflict.

Specifically, of recent history, Article 3 of the Geneva Convention has been at the center of discussion of US policy of force-feeding hunger strikers at Guantanamo Bay. The third Geneva Convention of 1949 requires the humane treatment of prisoners of war. However, the wording in Article 4 seemingly protects a wider breathe of individuals than just enemy combatants. Article 4 states, "Persons protected by the [Geneva] Convention are those who, at a given moment and in any manner whatsoever, find themselves, in case of a conflict or occupation, in the hands of a Party to the conflict or Occupying Power of which they are not nationals." [39] Article 3 requires that all prisoners should be "treated humanely" and without "cruel treatment and torture and outrages upon personal dignity, in particular, humiliating and degrading treatment."[39] Since 2006, a number of detainees at the US Naval Base at Guantanamo Bay, Cuba were force-fed while on hunger strikes, and lawyers, physicians, and human rights organizations have protested this act on the basis that Article 3 of the Geneva Convention was violated.

The World Medical Association

The World Medical Association (WMA) is an international organization representing physicians. It was established shortly after the Nuremberg trials in 1947. The WMA aims to promote the highest possible standards of ethical behavior and care by physicians at all times. The WMA receives funding from 95 national medical associations. The WMA has issued ethical guidelines that specifically deal with the topic of prisoners and detainees on hunger strike. In fact, the WMA is the only global organization that has published such policy. There are two WMA documents that relate to this issue—The Declarations of Tokyo and the Declaration of Malta. To be clear, these documents are not legally binding on States, but they contain guidelines for doctors involved in the treatment of hunger strikers. Despite their lack of binding effect, they are considered, by many, as authoritative for the management of prisoners and detainees on hunger strikes from an ethical standpoint.

In 1975, the 29th General Assembly of the WMA adopted the Declaration of Tokyo. This 29th General Assembly sought to develop a framework for difficult situations in which physicians are asked or forced to participate. The Declaration of Tokyo states:

> While physicians have an obligation to diagnose and treat victims of torture, they are ethically prohibited from conducting any evaluation, or providing information or treatment, that may facilitate the future or further conduct of torture. Such actions constitute physician participation in torture, which is not only unethical, but also facilitates the acceptance of such procedures, and ultimately destroys patients' trust in the medical profession. [40]

Furthermore, Article 5 of the Declaration states:

> 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 essential elements are competency and informed consent. [40]

The Declaration of Malta, written in 1991 (revised in 1992 and 2006), is almost entirely about hunger strikes as opposed to the Declaration of Tokyo, which is more general. The Declaration of Malta addresses difficult situations and the ethical dilemmas that arise, as stated in its Preamble, when "[g]enuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians."[17] Applicable to all persons who are deprived of liberty (i.e., prisoners and detainees), in the Declaration of Malta, principles are specifically "formulated for physicians involved in the management of hunger strikes."[17] In summary, the principles reflect that a doctor is under a duty to act ethically (Principle 1). In this regard, the physician seeks to prevent coercion or mistreatment and object if it occurs. Next, the physician must respect a hunger striker's autonomy (Principle 2). Under this Principle, appreciating a striker's true wishes is essential as when a striker makes an informed and voluntary decision, an informed refusal, and this decision must be respected. In this situation, force-feeding contrary to a voluntary, informed refusal of food is unjustifiable. This approach relates to the principle of "beneficence" (Principle 3), and suggests "an assessment of the best interests of the patient must be balanced between seeking the best

outcome and consideration of the patient's own view, values and preferences." [17] Also, identified is the issue of a physician's dual loyalties to the employing authority and the hunger striker (Principle 4). According to this principle, the physician's primary responsibility is with the patient, the striker. [17] This Principle is bolstered by the statement that physicians must remain objective and not allow third party influences (Principle 5). No matter what outside pressure, the physician's medical ethics establish that the physician-patient relationship in this circumstance is primary just like in the outside world.

Further, in the Declaration, there are guidelines for management of hunger strikers relating to force-feeding. Specifically, it is stated that artificial feeding is allowed when strikers agree to it and also when incompetent individuals have left no unpressured advanced instructions refusing it (Article 20, Guidelines), but "forcible feeding is never ethically acceptable" (Article 21, Guidelines) as it is inhuman and degrading. [17] This means that physicians should "never be used to break hunger strikes through… force-feeding." [17] All of this also means that a hunger striker's informed decision to stop eating must be respected by the physician if it is truly voluntary.

CHAPTER 6: ARUGMENTS FOR AND AGAINST FORCE FEEDING OF PRISONERS AND DETAINEES

Before further discussion on this topic, it is important to recognize many popular arguments for and against the force-feeding of prisoners. Clearly, when there is a hunger strike there are both pro and con arguments regarding whether to force- feed. The arguments against force-feeding imply that hunger strikers should be allowed to begin and continue their hunger strikes without intervention. However, the arguments in favor of force-feeding intervention of hunger strikers suggest that other parties' interests or the prisoner's /detainee's best interests justify intervention to sustain life. Interestingly, these issues are balanced differently throughout the world.

Arguments against Force-Feeding Prisoners and Detainees

1. Right to Self-Determination

The most cited argument in the debate against force-feeding is its violation to the hunger striker's right to self-determination. This relates to humanity's view that one has personal autonomy, and this right includes self-determination to require a patient's informed consent before medical treatment. Based on this argument, force-feeding POWs and detainees on hunger strikes is rejected.

2. Goes against Medical Ethics

The medical ethical controversy on forced-feeding concerns the protection of patient's rights. The argument is that the use of force-feeding has clear medical risks, and it goes against the Hippocratic Oath.[28]

3. Torture, Inhumane, Degrading or Punishment

This argument suggests that the invasive nature (especially when there is a non-cooperative striker) is torture, inhumane, degrading, and punishment.

4. Breach of Freedom of Expression

Hunger striking is a way to voice an opinion or argument by POWs and detainees and is used to present ideas or positions to the outside world from within the prison or detention center. If forced-feeding is allowed, the hunger striker's ability to send a message is disabled.

5. Non-Violent Protest

In principle, hunger strikers do not physically hurt or directly damage others with their actions, only themselves. This is not a criminal act. Also, in the modern western world, authorities do not get involved when civilians stage hunger strikes. For example, there was no government intervention with Gandhi's non-violent hunger strikes or the Chicago school system strikes. The argument is that prisoners and detainees should be treated in the same way. Parenthetically, some arguments have been made that prisoners and detainees would engage in more violent actions if precluded from hunger strikes.

6. Miscellaneous

Some also argue that a non-invasive hunger strike is better than interventions such as force–feeding because it would save resources and costs expended on the intervention. Also, victims or interested parties may feel relieved if a prisoner or detainee dies as a result of a self-inflicted hunger strike and might not prefer any intervention to keep the person alive.

Arguments for Force-Feeding Prisoners and Detainees

1. Duty to Protect Health

States have the responsibility to take care of prisoners and detainees and preserve life. The view is that this overrides any of the prisoner and detainee rights.

2. Stops Manipulation

Since hunger strikes are viewed as manipulative efforts and even a form of blackmail, they put a great deal of pressure on the authorities. The hunger striker has the potential to put the State or authorities in a subordinate or difficult position regarding prisoner and detainee demands. Further, this may create sympathy and/or support for the prisoner or detainee causes. To reduce this situation, force-feeding muffles the power of the hunger striker to gain issue control, and the hunger striker's ability to control and manipulate is completely reduced.

3. Preserving Order and Security

Hunger strikes have the potential to cause disruption and turmoil both inside and outside the prison or detention center. This is particularly evidenced when there are mass hunger strikes. Prolonged strikes lead to deaths and that may lead to riots or discord outside the prisons or detention centers as well as inside. It is argued that strikes, even individual strikes, should be ended to preserve internal order and security within and can be justification for force-feeding. Force-feeding is a tool to gain control and suppress resistance.

4. Justice and Gaining Evidence

Hunger strikers may die if there is not intervention such as force-feeding and then would not be available to give evidence or stand trial so that justice may be served. With force-feeding, there is evidence preservation for trials with the POW or detainee present, but if the strikers die this opportunity is lost permanently. Dying from a hunger strike not only is a loss of evidence and a loss of a party to face the judicial system, but the prisoner/detainee avoids punishment if there is a criminal conviction. Punishment for these types of crimes not only serves as a form of justice, but the punishments are also in place to prevent or deter similar crimes from occurring in the future. Making the prisoner or detainee available to face potential punishment is a popular social justice argument favoring force-feeding.

5. Suicide

There are many arguments regarding a duty to preserve the life of prisoners and detainees. For this reason, it is the state's duty to prevent suicides. This argument justifies intervention in hunger strikes by force-feeding because hunger strikes might be viewed as a form of suicide. (The opposite argument is that this may be flawed thinking because the traditional aim of suicide is death, and the primary aim of hunger striking is not death but issue resolution.)

6. Prevent Martyrdom

History reveals that important political figures have used hunger strikes to launch a political point. Suffering for the cause and a death from a hunger strike may create an image of a martyr. Force-feeding prevents hunger strikers from becoming martyrs and glorifying themselves for their causes.

7. Other Interested Parties

This argument suggests that the interests of dependents (such as children, the elderly, handicapped, etc.) are important. The argument suggests that recognition for those who would be harmed by the hunger strike death and suggests that force-feeding is sometimes needed to protect these people

CHAPTER 6: DISCUSSION

Differences between Inmates in Prison and POWs/Detainees

As one approaches the issue of force-feeding hunger striking prisoners, a clear distinction needs to be drawn between inmates in the prison system and prisoners of war or detainees. Both 'common knowledge' and legal doctrine lump prison inmates with POWs and detainees, a conflation which does all parties a disservice. While both groups have many similarities in terms of liberties lost and the necessity for the state to provide services, there are vital differences between the two groups. It is these distinctions that provide the cornerstones for developing a thoughtful strategy for the management of POWS/Detainees involved in hunger strikes and how they should not be treated identically to imprisoned citizens. (For simplicity sake, the word "detainee" for the duration of this discussion will be utilized to comprise all subsets of POWs, detainees, enemy combatant, etc. While there are differences amongst each defined category, the overarching principle of how these groups should be treated on this issue is consistent throughout this discussion).

In western society, inmates in a given prison are convicted of their crimes in a court of law, their liberties are stripped, but they are typically housed within their home country. Inmates in a western societal prison system have a defined term of confinement, are free from direct torture, are able to write letters, have phone calls, and even receive gifts and in person visits from family and friends. They often have jobs or roles in contributing to the functioning of the prison community and have opportunities to

improve their daily life and interact with others if they exemplify decent behavior. Inmates of prisons in western society are provided basic health care, and, with the exclusion of their right to liberty, many prisoners live at a level that, while not desirable to many, still well surpass the global average. They have prepared meals, opportunities for reading, entertainment, exercise, and personal hygiene. Moreover, inmates of a prison system have a daily routine that is consistent and relatively predictable.

The life of a detainee is drastically different. These prisoners are stripped from any form of life that they once knew. They are often housed in below average conditions, often placed in solitary confinement, and as a primary purpose of the detention, the detainee is put through vigorous interrogation. [24] They are imprisoned without a trial or conviction, the term of stay is unknown, and they do not have contact with family or friends. In fact, family and friends often assume that the detainee has been killed. While basic healthcare should be provided in accordance with international law, many other basic necessities that are given to regular prisoners are not provided to detainees. Additionally, large pieces of the society and the culture that the detainee previously experienced are instantly stripped from them once they enter captivity. The detainee's prior way of life is furthermore often intentionally kept away from them for the purpose of manipulating and coercing the detainees to divulge information. [24] A primary aspect of a detainee's detention is related to intense interrogation efforts. [24] Nearly all facets of the detainee's detention experience are meticulously constructed, often at the suggestion of trained psychologists, to provide an element of coercion to bend the subject for the purposes of those in control, with a keen emphasis on gaining information that the subject would not ordinarily divulge.

Accounts of Detainees Demonstrate Coercion is Universal to Detention

Over the years there have been many personal accounts regarding detainee detention experience. John McCain describes this from an American perspective in his personal account of his five-year captivity as a POW in North Vietnam. After his capture, he was told that he would not receive medical attention until he gave military information. [24] At the time of capture he refused to give "anything except my name, rank, serial number and date of birth," but he soon realized that they wanted military information before considering taking him to the hospital. [24] In fact, he offered to give military information in exchange for being taken to a hospital. [24]

Detainees in Abu Ghraib have accounts that demonstrate similar realities in their detention experience. These detainees were reportedly managed with "excessive isolation." [14] The "roughing up of prisoners was sometimes spur-of-the-moment" and, as one marine reported, "I wasn't trying to get information. I was just… playing mind control."[14] In fact, interrogation techniques at Guantanamo could "include…sleep deprivation, exposure to extremes of cold and heat, and placing prisoners in "stress positions." [14] There was a "worrying deterioration in the psychological health of a large number of the detainees" because of the uncertainty of their fate and situation. [14] The "interviews" or "interrogations" are a significant part of their detention, and the stay for these "enemy combatants" "could be indefinite, as teams of CIA, FBI, and military interrogators sought to pry intelligence out of them." [14] There were multiple tactics to "extract information" from these detainees. Other philosophies at Guantanamo, for

example, included F.B.I. officials stating that, “Our goal is to get information.” [14] From these accounts, it is clear that the “interview” or “interrogation” process includes coercion and manipulation that is inherently embedded in the daily environment of the detainee.

The Impact of Interrogation and an Environment Driven by Coercion and Manipulation During Detention

The environment within which the detainee resides in detention creates a unique situation. The detainees are interrogated as a cornerstone of their detention. The interrogations are inherently coercive and manipulative, regardless of the fact that the techniques for the interrogation are varied. Often this interrogation induces the feeling of dehumanization and the captors evoke this emotion intentionally. This is created within an environment designed of coercion and manipulation.

One syllogism is that all detainees experience interrogation. These interrogations, although varying in style, are meant to coerce and manipulate to secure information from the captured party and are created within an environment intended to coerce and manipulate the individual. Therefore all detainees are subjected to direct coercion and manipulation.

Autonomy and Informed Consent:

The principle of autonomy is related to a person’s independence and right to make decisions about what happens to their own body. To do this a person must be capable of rational thought and not be coerced or manipulated into (or out of) a decision. As the

Israeli Medical Association states, “Autonomy means the patient has full rights to make decisions freely and without coercion regarding the method of treatment and to grant, or not, permission prior to the start of a treatment plan.”

Informed consent requires that the patient is not only informed about a condition or treatment but understands the potential risks and benefits and agrees to them. Here also a patient must be capable of rational thought and not be coerced or manipulated into a decision. As explained previously, an informed consent (or informed refusal) needs to be completely voluntary. [3]

The Interrogation Process as well as the Detention Environment Imposed on Detainees Precludes Autonomy and Informed Consent

The considered thesis shows that it is a universal truth that detainees are subjected to interrogation and other embedded coercive and manipulative activity in their living environment while detained. This action eliminates the ability of detainees to generate a truly autonomous decision and makes it impossible to offer informed consent (or informed refusal) that is free from coercion and manipulation.

The daily coercion and manipulation clearly affects the detainee’s outlook on many aspects of life, including their own. If it were not for the environment with which the detainee dwells temporarily over the course of detention, the interrogation that is inherently coercive or manipulative would not exist. The concept that the detainee can control his medical decision making solely on the basis of being competent seems short sighted, and, in the case of a hunger strike, could lead to unnecessary loss of life on what is always an environment of inherent coercion and manipulation.

The Interrogation Process as well as the Detention Environment Imposed on Detainees Precludes Autonomy and Informed Consent

This element of interrogation, which is intended to be coercive and manipulative, coupled with unavoidable coercion and manipulation throughout the detention environment is well-known. However, although this provides a pivotal part of the detainee's life, it seems to be forgotten amongst current doctrine relating to hunger strikes. This realization is important because the current case law, legislation, and doctrines fail to consider the elements of uncontroverted coercion and manipulation of detainees. Therefore, it may be misguided in conclusions regarding the management of detainees that are hunger strikers.

The premise that all detainees live in a coercive and manipulative environment status shifts the situation relative to autonomy and informed consent for detainees. This has wide implications applicable to the management of a hunger strike for them. If the decision to refuse life saving medical supplementation of nutrition is believed to be coerced, intervention in any hunger strike situation to save a life would be legitimized. Accordingly, any rule allowing competent prisoners to make decisions on their medical treatment would not blindly apply to the detainee class of prisoner as this class inherently lives in a coercive and manipulative temporary life structure. This class of prisoner, the detainee, has an element of distinction due to frequent interrogation and the inherent coercion and manipulation throughout the detainees living environment. These facts change everything because no longer can their decision be considered truly autonomous and protected with informed consent (informed refusal).

CHAPTER 7: CONCLUSION

The current legislation, case law and other local, national or international doctrines of management regarding hunger strikes are well reported. Many learned authorities have argued valuable and meaningful positions. However, the literature fails to consider a critical aspect that distinguishes detainee situations from all others. It is the universal interrogation of detainees and relentless environment of coercion and manipulation that distinguishes the detainee from that of others. This element requires that the detainee class of prisoner be evaluated differently than other prisoners for the management of hunger strikes.

The described environment that the detainee dwells is an environment that precludes autonomy and informed consent for life saving medical decisions. It is argued that, for this reason, during hunger strikes, detainees' actions may not be considered truly autonomous and/or with informed consent free from coercion or manipulation which creates a situation where there should be separate considerations for the management of their care. Force-feeding should be seen as a legitimate solution, when performed in ways that minimize invasive discomfort, if death of a detainee is the only other predictable outcome of the hunger strike. The potential of life, even that of your current enemy, is too valuable to let go on the basis of a medical decision that is not freely chosen.

BIBLIOGRAPHY

1. Appelbaum, PS. "Clinical Practice. Assessment of Patients' Competence to Consent to Treatment." *New England Journal of Medicine* 357, no. 18 (2007).

2. BBC News. "Spain Frees Notorious ETA Killer." (2008).

3. Beauchamp, T. L. and J. F. Childress, eds. *Principles of Biomedical Ethics*. New York: Oxford University Press, 1983.

4. Bell, Bowyer. *The Secret Army: The IRA* New Brunswick: Transaction Publishers, 1997.

5. Cahill, GF. "Starvation in Man." *New England Journal of Medicine* 282, no. 12 (1970).

6. Catan, Thomas. "Shackled and Emaciated Eta Killer Pleads for Peace from His Deathbed." *The Times,* 2007.

7. CNN. "Fortuyn Accused Ends Hunger Strike." 2002.

8. Crosby, SS, CM Apovian, and MA Grodin. "Hunger Strikes, Force-Feeding, and Physician's Responsibilities." *Jama* 298, no. 5 (2007).

9. Dworkin, G., ed. *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press, 1988.

10. Encyclopedia Britannica. "Prisoner of War (POW); International Law." In *Encyclopedia Britannica*, 2016.

11. Gillet, G. R. "Informed Consent and Moral Integrity." *Journal of Medical Ethics* 15, no. 3 (1989).

12. Globalsecurity. "Detainee Definition." . Accessed 04/14, 2016. http://www.globalsecurity.org/military/library/policy/army/fm/3-07-22/glossary.htm.

13. Hallett, Nicole. "Inmate Dies After Hunger Strike." *EuroWeekly News,*2011.

14. Hersh, Seymour. *Chain of Command*. New York: Harper Collins, 2004.

15. Human Rights Committee*. International Covenant on Civil and Political. Rights*. Austria, 2007.

16. Israel, Estaban. "Prisoner Deat a Setback in Cuba-U.S. Relations." *Reuters,*16 April 2012.

17. Jacobs, Pauline. *Force-Feeding of Prisoners and Detainees on Hunger Strike*

Intersentia, 2012.

18. Karni, Tami. "Hunger STriking Inmates and Detainees, and Medical Ethics." *Israeli Medical Association Journal* 17, (2015).

19. Kohari, Alizah. "Hunger Strikers: What can they Achieve?" *BBC News Magazine* (2011).

20. Landzelius, Kyra. "Hunger Strikes." *Encyclopedia of Food and Culture* (2003).

21. Lewis, Neil A. "Guantanamo Prisoners Go on Hunger Strike." *New York Times,*September 18, 2005.

22. Lunardi, Christine. *Alice Paul Equality for Women*. Boulder: Westview Press, 2013.

23. Lunes, Actualizado. "El PP Pide a Los 'Sensatos' Que Acudan a La Marcha Por El 'Caso De Juana'." *Elmundo,*2007.

24. McCain, John. "John McCain, Prisoner of War: A First Person Account." *U.S. News & World Report* (2008).

25. Mendez, Juan E. and Stephanie Seig. "Statement of the United Nations Special Rapporteur on Torture at the Expert Meeting on the Situation of Detainees Held at the

U.S. Naval Base at Guantanamo Bay."

26. Merriam Webster. "Prisoner Definition." In *Merriam Webster Dictionary*, 2016.

27. O'Malley, Padraig. *Biting at the Grave: The Irish Hunger Strikes and Political Despair*. Boston: Beacon Press, 1990.

28. Pavur, Claude. "The Hippocratic Oath in Latin with English Translation." *Academia* (2015).

29. Perez, Juan. "Dyett High School Hunger Strike Ends." *Chicago Tribune,*2015.

30. Stephey, M. J. "A Brief History of Hunger Strikes." *Time* (2009).

31. Walton, Mary. *A Woman's Crusade; Alice Paul and the Battle for the Ballot*. New York, NY: Palgrave MacMillan, 2010.

32. Welsh, James and Hernan Reyes. "Doctors Working in Prison: Human Rights and Ethical Dilemmas." https://nettkurs.legeforeningen.no/course/view.php?id=39&section=5.

33. Wier, Johannes. "International Federation of Health and Human Rights Organisations." . http://www.ifhhro.org/about-us/members-a-observers/18-about-

us/members-a-observers/28-the-johannes-wier-foundation-for-health-and-human-rights.

34. Worthington, Andy. "Guantanomo's Hidden History; Shocking Statistics of Starvation." *Center for the Study of Human Rights in the Americas* (2009).

35. Zhoa, Dihghin. *Power of Tiananmen*. Chicago: University of Chicago Press, 2001.

36. United Nations General Assembly, "Resolution of Principles of Medical Ethics." 1982. http://www.un.org/documents/ga/res/37/a37r194.htm

37. United Nations. "Standard Minimum Rules for the Treatment of Prisoners." May 13, 1977. https://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf

38. United Nations. "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" December 10, 1984. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx

39. International Committee for the Red Cross. "Geneva Convention." August 12, 1949. https://www.icrc.org/eng/assets/files/publications/icrc-002-0173.pdf

40. World Medical Association. “Declaration of Tokyo.” October, 1975.

http://www.wma.net/en/30publications/10policies/c18/

41. World Medical Association. “Declaration of Malta.” September, 1972.

http://www.wma.net/en/30publications/10policies/h31/