

Medical Care and Medical Ethics at Guantánamo

A conference co-sponsored by The Constitution Project and Global Lawyers and Physicians

December 2, 2013

Post-conference summary

Note: Conference materials, participant bios, and videos of each panel discussion are available [here](#).

I. Conference objective

To identify, analyze and propose solutions to structural and other obstacles that impede physicians' ability to deliver quality ethical medical care to detainees at the Guantánamo Bay detention facility.

II. Subject matter presented and discussed

The case of Tarek El Sawah

Mr. El Sawah is an Egyptian who arrived in Guantánamo in May 2002. His in-processing weight has more than doubled to over 400 pounds during his 11 years at Guantánamo, putting him in the extreme obesity range (having a body mass index greater than 40). He now suffers with multiple medical complications related to his obesity, including: severe obstructive sleep apnea, probable coronary artery disease, diabetes, hypertension, fatty liver, dyslipidemia, and osteoarthritis. In addition, he has developed atrial fibrillation, an abnormal heart rhythm that increases risk of stroke and heart failure. He currently complains of shortness of breath and chest pain with minimal exertion, and can only sleep in an upright position due to breathing problems and nasal congestion. Testing and treatment for his complaints have been delayed for years, despite appropriate recommendations from the military's own physicians.

According to an affidavit provided to his attorneys, Mr. El Sawah arrived at his current weight at least in part at the hands of interrogators, who exploited Mr. El Sawah's significant psychological vulnerabilities and enticed him with excessive amounts of food in exchange for information, sometimes after periods of food deprivation. It is possible that his hyperphagia (and weight gain) has been induced or exacerbated by PTSD (although this has not been explored or treated). According to the same affidavit, Mr. El Sawah was reported to be tortured at Guantánamo and exhibited significant mental health symptoms. Because of his current medical co-morbidities, Mr. El Sawah had an increased risk of death from all causes.

Mr. El Sawah's health has been damaged by the prison system at Guantánamo – starting with presumed consequences of “enhanced interrogation” and conditions of confinement. Mr. El Sawah was not protected from extraordinary weight gain over a 10-year span which has resulted in multiple serious medical complications. As of the date of this conference, Mr. El Sawah has not received adequate assessment, diagnosis and treatment for his symptoms and chronic illnesses.

Mr. El Sawah is not facing any criminal charges. Three former Guantánamo commanders have written declarations affirming that he does not pose a significant danger to the security of the United States and should be released.

Post-Conference Summary

Discussant comments:

Mr El Sawah's care is a sobering example of the violation of obligations of physicians to incarcerated individuals in the domains of medical ethics, medical professionalism, and human rights law. Mr. El Sawah was not protected from the interrogators' use of food to exploit a mental disorder, which has resulted in harm. Obligations to provide medical care to prisoners under the International Convention on Economic, Social and Cultural Rights Article 12 (recognized by many as customary international law) and the Geneva Conventions Article 30 have not been met.

Standards in U.S. prison health care include the principle of necessity (is this treatment necessary – based on pain, outcome, and function?) and the principle of individual accommodation. It is the responsibility of the facility to make necessary individual accommodation based on need – including transfer out of the facility to receive care if necessary – and the responsibility of the physician to advocate for those accommodations. The detention center obligations (standards of U.S. prison health care) have not been met in the case of Mr. El Sawah.

Additional information about Mr. El Sawah, including his health status, is available [here](#), [here](#), and [here](#).

The case of Adnan Farhan Abd Al Latif Ala'Dini

Mr. Latif committed suicide on September 8, 2012, after a decade in captivity at Guantánamo. He 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 Mr. Latif “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 him in July 1995 of: “(l)oss of sight in the left eye as a result of eye nerve [illegible], and (l)oss of hearing in the ears.” A consulting neurologist at Guantánamo Naval Base evaluated Mr. Latif 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.” Mr. Latif reported traveling to Pakistan and Afghanistan in 2001 to get treatment for the symptoms and sequelae of the motor vehicle accident he suffered in 1994.

A district court judge granted Mr. Latif's *habeas corpus* case in 2010, but he 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. Mr. Latif would have been among the most difficult class of patients at any correctional facility or psychiatric hospital in the United States.

A lengthy investigation of his death documents the challenges in treating Mr. Latif and circumstances leading up to his suicide. He stated unequivocally 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. 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 leadership at Guantánamo failed to assign staff experienced with individuals at risk for self-harm and suffering with serious emotional disturbances. The medical and psychiatric issues were

Post-Conference Summary

subordinated to policies for maintaining good order and discipline. These policies and procedures deprived medical and psychiatric personnel from standard and appropriate options for managing an individual with serious medical and psychiatric illnesses and providing optimal treatment for his condition.

Discussant comments:

Given his diagnosis, Mr. Latif presented an especially complex and challenging case for health professionals at Guantánamo, and would have as well for any institution in the United States. Institutional problems, cultural forces and more specific failures (e.g., not following proper procedures for suicide risk assessment / management, med pass, searches and constant observation/line of sight) contributed to Mr. Latif's suicide.

Multiple individual failures to follow protocol contributed to Mr. Latif's suicide. If only one of these procedures were properly followed, the outcome could have been avoided. This suggests that the environment at Guantánamo is one where both Joint Detention Group and Joint Medical Group staff were not comfortable questioning a failure to follow proper procedures or to double-check a suspected breach of protocol.

Mr. Latif had a documented history of hoarding medications in the past and threatening suicide by overdose. In addition to the overall failures to follow the med pass procedures that led to his ability to hoard and eventually overdose on medications, this indicates that Mr. Latif should have been especially scrutinized for such behavior (i.e., even if there was no outlined med pass procedure, the BHU staff should have been aware of Mr. Latif's hoarding history, and therefore would have had all the more reason to closely observe his medication administration).

Prisons are difficult environments in which to practice medicine – they are isolated and unnatural and can cause medical professionals to identify with the guard force / security mindset. Medical professionals feel pressure to “stay in their lane.” Those problems are exacerbated at Guantánamo.

Medical staff must have autonomy to deliver appropriate care within a correctional setting, but do not have such autonomy at Guantánamo. Systemic issues – in particular rapid rotation of medical staff in and out of Guantánamo – make it virtually impossible for medical professionals to effectively advocate for change, even for those inclined to do so. In a correctional setting, good health care results in good security and vice versa. The opposite is also true: bad health care is bad for security.

Mr. Latif should not have been put in 23 hour lockdown confinement, nor should anyone with serious mental illness. There are other ways to manage that difficult population – some examples can be found in correctional settings. These include alternate isolation settings for those with serious mental illness, as well as allowing an inmate the opportunity to complete a mental health program as part of a deal to reduce their isolation sentence.

In regard to Mr. Latif being given disciplinary isolation time for throwing feces on the staff, the psychiatrist noted that he was appropriate for transfer because of his actions being “volitional.” However, even if the volitional nature of his act was not in dispute, this does not indicate if his mental state made him appropriate for transfer at that time (i.e., arguably no one with serious mental illness should be put in isolation, but certainly if unstable, he would not have been appropriate for such a transfer).

Post-Conference Summary

It is important to increase the professional autonomy of the medical branch and to have an effective support system available to medical professionals when they object. It is also the affirmative responsibility of physicians to comment on and lobby for adequate conditions of confinement.

There must be some mechanism to implement appropriate changes in the medical and mental health care of detainees. This may require an outside consulting body to be able to review without bias the system in place, as well as have the authority to execute proposed changes. It is notable that investigations from two prior deaths at Guantánamo (February and May of 2011) included many recommendations that were synonymous with those listed in the report on Mr. Latif's death. This, in itself, shows that well over a year after those investigations, such recommendations had not been implemented.

To date Mr. Latif's autopsy has still not been released. Additional information about Mr. Latif and his death is available [here](#), [here](#), and [here](#).

Hunger strikes at Guantánamo

Detainees at Guantánamo have used hunger strikes to protest their confinement since shortly after the camp opened, in February of 2002. The largest wave of hunger strikes began in the summer of 2005 – by September, 131 detainees were refusing food. An increasing number of them were force-fed.

In December of 2005, a forensic psychiatrist and three consultants from the Federal Bureau of Prisons (BOP) visited Guantánamo and made recommendations for changing the hunger strike protocol, including recommending the use of a “restraint chair”. By the end of December 2005, only four or five detainees were still on hunger strike.

Beginning in the fall of 2005, detainees' lawyers filed motions asking federal courts to stop the force-feeding, which they claimed was carried out in a punitive, brutal fashion. The Defense Department disagreed, denying that force-feeding was intended to punish detainees.

The current hunger strike – a protest rooted in detainee hopelessness and the introduction of new restrictive search and other policies – peaked in July at 106 participating detainees. The standard operating procedure (SOP) governing management of the hunger strike required medical professionals to engage in unethical conduct, including force-feeding, which was routinely accompanied by forcible cell extractions. By early November, the number of hunger strikers had fallen to 11 but was again on the rise according to the latest information provided by the military. On December 2, 15 detainees were hunger striking, all of whom were approved for force-feeding.

(Immediately following the 12/2 conference it came to the organizers' attention that the military has apparently revised the 2013 hunger strike SOP recently but is refusing to make it public. The military has also decided to stop providing information to the public about the number of detainees engaged in hunger strikes).

Force-feeding violates both the World Medical Association's 1975 [Declaration of Tokyo](#) (Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment), and its subsequent [Declaration of Malta](#) on Hunger Strikes (adopted in 1991 and revised in 2006). The Declaration of Malta notes that physicians must ensure that

Post-Conference Summary

prisoners are competent and their refusal of nourishment is voluntary, and does not result from peer pressure, but concludes that “forcible feeding is never ethically acceptable.” Regarding end-of-life issues, the Declaration of Malta states: “Consideration needs to be given to any advance instructions made by the hunger striker. Advance refusals of treatment demand respect if they reflect the voluntary wish of the individual when competent. ... It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will.”

Though problematic in their own right, [Bureau of Prisons \(BOP\) guidelines](#) for force-feeding include several safeguards that are not in place at Guantánamo, and the guidelines make no mention of restraints. Prison guidelines require the warden to notify a sentencing judge of involuntary feeding, with an explanation of the background of and reasons for involuntary feeding, as well as videotaping of force-feeding. BOP requires that “treatment is to be given in accordance with accepted medical practice” – that includes an individualized assessment of the patient’s situation and individualized counseling of the detainee.

The BOP’s written policy on the use of restraints also conflicts with the restraint-chair protocol at Guantánamo. In federal prisons, restraints can be used “to gain control of an inmate who appears to be dangerous because the inmate is assaulting another individual, destroying government property, attempting suicide, inflicting injury upon himself or herself, or displaying signs of imminent violence.” The use of four-point restraints must be authorized by the prison warden if he finds that they are the “only means available to obtain and maintain control over an inmate,” and he cannot delegate this decision. In general, restraints are to be used “only when other effective means of control have failed or are impractical,” and are to be removed when an inmate exhibits self-control. The regulations make no provision for routine or categorical use in cases, regardless of an individual inmate’s behavior, or the use of restraints in force-feeding.

Discussant comments:

Several participants shared the experiences and views of organized medicine, both inside and outside the United States, on the issue of hunger strikes and force-feeding.

The AMA has expressed its position on force-feeding and related medical issues repeatedly throughout the last decade. Whenever a detainee refuses food it poses an ethical dilemma for the physician treating him. It creates a conflict between the detainee’s autonomy and the physician’s duty to heal. Among the policies of the AMA that bear on this dilemma are:

- According to Principle I of the AMA [Principles of Medical Ethics](#), physicians must dedicate themselves to providing medical care “with compassion and respect for human dignity and rights.”
- The AMA *Code of Medical Ethics* provides that informed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent.
- The physician has an ethical obligation to respect the patient as decision-maker. Accordingly, patients may accept or refuse any recommended medical treatment. The physician need not fully understand, or agree with, the patient’s decision, but must honor it.
- The AMA has clear policy on the appropriate use of restraints in medical care: they should only be used in accordance with appropriate clinical indications and not for punishment or convenience.

Post-Conference Summary

- The AMA has long endorsed the World Medical Association [Declaration of Tokyo](#).

An individual who has decision-making capacity and has made a voluntary decision to refuse food to achieve a political end meets none of the conditions under which it would be appropriate to provide medical care without consent. Someone who is able to object so vigorously to an unwanted intervention that it can only be administered under restraint cannot be said to be in a situation in which harm from failure to treat is imminent.

In 2012, then-AMA President Jeremy Lazarus wrote to Secretary of Defense Chuck Hagel expressing concern about the treatment of hunger strikers at Guantánamo; specifically, that force-feeding detainees violates core ethical values of the medical profession, and that every competent person has the right to refuse medical intervention, including life-sustaining interventions. The AMA also wrote to President Obama in 2009 and to the White House in 2005 to reaffirm its position on hunger strikes. In 2006, the AMA wrote to the UN high Commissioner for Human Rights outlining its position on the health care rights of Guantánamo detainees, which is as follows:

- Every patient is entitled to the same standard of care whether the patient is a civilian, U.S. soldier, or detainee while under U.S. custody (that position is consistent with a recommendation by a U.S. Army functional assessment team on detainee medical operations that the standard of care in any location should be the same for all).
- Patients must have access to care.
- The facility must have the capacity to deliver care.

A question was raised whether the AMA had plans to update its policy to address the distinction between involuntary feeding (where a detainee would accept nasogastric feeding without the use of physical force) and force-feeding (e.g., as it is practiced at Guantánamo).

The U.K.'s long experience with hunger strikes and force-feeding was also discussed. In particular, doctors refused to force-feed hunger strikers in the Maze prison during the 1970s. Several died as a result. Much was learned from that tragedy about the medical consequences of hunger striking that informed future hunger strike management in the UK.

It is most important to remember that hunger strikers do not wish to die. They are striking as a political protest. There are four major areas of ethical issues associated with hunger strikes:

1) Consent to treatment / patient autonomy

- Autonomy is the principal and most observed ethical concept.
- Autonomy requires that the decision-maker have capacity; be informed; be acting voluntarily; and be able to refuse treatment (which requires accepting that patients might make bad choices).

2) Confidentiality

- Doctors must be able to interview patients in private, to develop trust that they will not pass information on to interrogators or others, so they can better assess the extent to which a

Post-Conference Summary

hunger striker is acting voluntarily (versus subject to pressure) and effectively provide information about the medical consequences of hunger striking.

- 3) Dual loyalties (possible conflicts between physicians responsibilities to patients and other responsibilities they may be assigned in military or correctional settings)
- 4) Is refusing to force-feed a hunger striker assisting a suicide?
 - No – again, hunger strikers do not wish to die. Typically, they want the situation in which they find themselves to end. They are making a political protest in the only way they can.

The role of doctors is clear: The Declaration of Malta, the Declaration of Tokyo, and standard ethical rules everywhere all make clear that force-feeding is absolutely unacceptable in law and ethics and doctors should not be involved.

Finally, one panelist presented a recent case of hunger striking, and resistance to force-feeding, in Switzerland. In 2010, a 57 year old prisoner in Switzerland went on hunger strike for several intermittent periods. He petitioned the courts for release from prison based on his weakened physical state. In August of 2010, the courts rejected his petition, and in doing so indicated that an order to force-feed him could be forthcoming. The Division of Penitentiary Medicine in Geneva hospital responded to that indication, just a month later, by launching a coordinated national action to resist such an order. All important medical stakeholders agreed that force-feeding was torture and that no doctor should or would participate in it. Their position was based in large part on the following [standards for health care services in prisons](#) developed by the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment: equivalence of care; patient's consent and confidentiality; preventive health care; humanitarian assistance; professional independence; and professional competence. On the basis of that consensus, stakeholders made their case publicly (in particular through publications in Swiss medical journals).

In October of 2010 the prisoner arrived at Geneva hospital. Two weeks later the order to force-feed was issued. Dr. Wolff refused. He argued, among other things, that force-feeding was illegal, unethical, contrary to the patient's advanced directives, and posed a significant risk to the patient's health. To further support him, Dr. Wolff's bosses ordered him *not* to force-feed the prisoner.

The issue resolved on December 24, 2010 when the prisoner ended his hunger strike – before the courts further weighed in. The episode led to positive change: the Canton of Valais, which issued the order to force-feed, subsequently changed its law and guidelines on hunger strike management to respect detainee autonomy / decisions to hunger strike even in the face of risk to death.

Additional information on hunger strikes at Guantánamo and in other settings is available [here](#), [here](#), [here](#) and [here](#).

Post-Conference Summary

III. Obstacles to delivery of quality ethical medical care at Guantánamo

Prevailing narratives around Guantánamo

- Detainees have been dehumanized and presented as terrorist supermen
- Perception that Guantánamo is a theatre of war, and the associated claim that detainees continue to engage in asymmetric warfare on behalf of al Qaeda, as a justification for deviations from proper standards of care and ethics

The extreme and abnormal environment that is Guantánamo

- Medical professionals at Guantánamo are competent and arrive with a notion of how to be patient advocates / provide proper care, but they operate in an environment that makes doing so very difficult
- Very difficult for professional identity (physician) to transcend group identity (U.S. military jailing the “enemy”)
- Exacerbates the phenomenon in correctional settings where doctors identify with the guard force and security mindset

Lack of transparency

- Secrecy around relevant governing Standard Operating Procedures (SOPs)
- Absence of information about decisions military physicians have made and why; outcomes they have advocated for or objected to; internal responses to any such efforts
- Lack of clarity about detainees reportedly on hunger strike – which detainees actually fit the ICRC’s definition of a hunger striker?

Lack of resources to adequately treat an aging population that increasingly presents complex medical problems (including availability of / access to facilities, specialists, reliable internet)

- In El Sawah’s case, what authority do doctors have to ensure he gets a medically indicated stress test, which currently is not available at Guantánamo?

Incompatibility of policies, regulations, and SOPs with medical ethics and medical practices and standards of care (e.g., military policies and procedures for hunger strikes)

Absence of informed and voluntary consent for medical care

Lack of professional autonomy / independence of military health professionals

- Chain of command structure and lines of reporting for all medical personnel – are the medical and base commands sufficiently firewalled?
- Medical decisions made by non-medical military personnel can result in physicians being used as tools for maintaining prison order

Absence of support structures to encourage autonomy / independence of military health professionals

Rapid rotation of clinical staff impedes continuity of care, diagnosis, and treatment

Post-Conference Summary

Lack of thorough and systematic review of detainee deaths at Guantánamo

Lack of sufficient education, training, and preparation for health professionals deployed to Guantánamo, particularly around provision of medical ethics in correction-type environments

Failure of individual physicians to do no harm by unwillingness to object, speak out (from what we know)

- In El Sawah's case, how could doctors have intervened early on to stop his weight gain? What was their responsibility to do so? Did they have authority to do so? (See obstacles to physician autonomy / independence noted above)

Detainees' history of being subjected to torture and abuse at the hands of interrogators

- Lack of documentation of prior trauma (particularly psychiatric) in detainee records; exacerbated by rapid rotation of physicians in and out of Guantánamo

The impact of health professionals' involvement in interrogations on detainees' trust in military physicians

IV. Proposed solutions, corrective actions, and next steps

Identify pressure points in military command where advocacy for change would be most effective

- Re force-feeding, one participant cautioned that while many consider force-feeding unethical and there are many reasons for that view, it is not shared universally. It is important to listen and not to dismiss the opposing view out of hand.

Enhance education and training

- Bring human rights into the mainstream of medical ethics (IOM has a new project working on this that needs support)
- Ensure that issues of ethics and professionalism are incorporated into evaluation and accreditation systems
- BMA toolkit for ethical decision-making as a possible model for practical materials
- Seek to empower military physicians to object / speak out when appropriate
- Exposure to correctional medicine for health professionals before being deployed to Guantánamo
- Training specific to Guantánamo; its visibility and uniqueness
- Educate on the international right to health
- Re consent to treatment, reinforce that patient autonomy is not a freedom to choose *to agree with one's doctor*, it is simply a freedom to choose

Advocate for the ability to transfer detainees to the U.S. if adequate resources cannot reasonably be provided at Guantánamo

- Press for having Mr. El Sawah transferred out of Guantánamo to a place where he can get adequate care (specifically, appropriate cardiac stress testing)

Post-Conference Summary

- Advocate the same for any other detainee for whom adequate care cannot reasonably be provided on base
- Note: recently enacted legislation continues a ban on transferring any Guantánamo detainee to the U.S. for any purpose. It is an annual ban that will likely be revisited again next year. Efforts could be made to ensure that the ban does not get renewed.

Press for the release of Mr. Latif's autopsy report

Support military health professionals' independence / autonomy

- Major medical organizations need to stand by health professionals who want to resist involvement in force-feeding / actions that break trust with their patients
- Explicit expressions of support from major medical associations would make a significant difference; see as examples 1) the efforts of the BMA in defending physicians who conscientiously object; and 2) the Swiss (Geneva) hunger strike case discussed during the conference (Dr. Wolff's decision not to force-feed despite a court order to do so)
 - Resistance in the Swiss (Geneva) case worked because:
 - All relevant medical stakeholders stood as one behind Dr. Wolff's decision
 - Dr. Wolff works in an environment where a trusting doctor / patient relationship is possible (the correctional and prison health systems are separate)
 - The Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment visits each of the 48 member countries each 3-4 years to help ensure that fundamental human rights are respected in all member countries
 - Ultimately, the law was on his side (precedent from the European Court of Human Rights – which has the power to overrule Swiss federal court decisions – that found force-feeding to be torture)
 - Dr. Wolff works for the largest (and, so, powerful) hospital in Switzerland
- Strengthen the firewall between military and medical commands at Guantánamo; the base commander should no more be able to tell a doctor how to practice medicine than he can tell a JAG officer what the law is and how to practice law, or even tell a Chaplain how to interpret his religion
- Establish a committee or body of civilian physicians, experts in medical ethics, that military doctors could call on for support
- At societal level reassert civilian control over military and affirm it through a licensure process. State office of professional medical conduct / licensing board could serve as a resource for support for military physicians being asked to do things they do not want to do
- Appoint an Ombudsman or IG at Guantánamo, who would report to a senior official outside the JTF-Guantánamo chain of command
- Attempt to better understand sociology of apparent failure by military physicians; gather data on why Guantánamo physicians make certain choices so interventions can be tailored accordingly

Emphasize patient-centered care

Increase the involvement of independent doctors

- More frequent visits to Guantánamo by civilian physicians, particularly to follow complex patients

Post-Conference Summary

- Establish a neutral medical corps for Guantánamo (with characteristics similar to ICRC and MSF)
- Have Public Health Service provide medical care practitioners for Guantánamo instead of the military
- Look to international models
 - There are 11 countries in the world where correctional doctors and prison command are completely separate

Physicians are necessary to the legitimacy of any correctional institution and that power should be leveraged to force improvements in conditions of confinement

Major medical associations in the U.S. should publicly acknowledge what is now known about physicians' role in post 9/11 abuses, and how those came about, as a step toward preventing their repetition. Such associations should speak out against or condemn the direction or coercion of, or willingness of physicians to, participate in these practices and should support physicians' capacity to practice ethical medicine in a challenging environment.

Look to constitutional law governing provision of medical care in correctional settings as a platform from which to urge reforms at Guantánamo:

- Duty to provide adequate medical care (cannot be deliberately indifferent to serious medical needs). Three components:
 - 1) right to care (access, professional opinion, care that has been ordered)
 - 2) medical necessity (determined by pain, outcome, and function)
 - 3) accommodation (prisoners and their health needs are not one size fits all – have to accommodate for disabilities, differences in function, etc.; cannot do everything in a correctional setting or at Guantánamo – transfer powers key)

Until the time comes that physicians are *not* put in situations where they are asked or ordered to violate medical ethics, physicians should look to ethical standards and their own conscience when treating those detained

Appendix: Post-conference developments related to medical care at Guantánamo

Legal development:

This year's National Defense Authorization Act at one point contained a package of reforms to current law designed to give the Obama administration additional flexibility to pare down the detainee population, and to ensure that detainees receive adequate care while the facility remains open. That package included a streamlined foreign transfer process – to replace the cumbersome and needlessly complex certification and waiver regime that has impeded many transfers to date – and exceptions to the categorical ban on transfers to the U.S.; one for detention and trial and the other for emergency medical care that cannot be provided on base.

A bipartisan majority of the Senate rejected an attempt by Senator Kelly Ayotte (R-NH) to strip out the improved Guantánamo transfer provisions and to impose an absolute ban on any transfer to Yemen (a result that would have made closure nearly impossible given that more than half of the remaining detainees are Yemeni). Unfortunately, the reform package did not survive the next step in the process fully intact. Leaders of the Senate and House Armed Services Committees negotiated a compromise bill, behind closed doors, that dropped both U.S. transfer provisions. President Obama has since signed the bill into law. As a result, at least for the next fiscal year, transferring detainees to the U.S. for medical care is prohibited by statute.

Policy developments:

In a November 21, 2013 letter to the United States Court of Appeals for the D.C. Circuit, the Department of Justice revealed that protocols for managing hunger strikes at Guantánamo have been revised, but the military has not disclosed the new policy and officials have refused to explain the changes. Several weeks later General John F. Kelly, USMC, Commander of U.S. Southern Command, reportedly ordered detention facility staff to stop providing the public with information on the number of detainees engaged in hunger strikes.

It has been reported that the Senate Intelligence Committee will vote on whether to declassify some portion of its 6,300 page report into the CIA's rendition, detention and interrogation program early in 2014. That report should shed important additional light on the role of health professionals in detainee treatment and interrogations.

Medical ethics development:

The Health Professions Council of South Africa's Professional Conduct Committee has ruled in the case of Dr. Wouter Basson (responsible for chemical and biological warfare for the apartheid government). Among other things, the Committee concluded that:

- “Medical ethics during war and peace are identical...”
- “[A] medical doctor is responsible as an individual for his or her actions.”
- “[I]f a doctor decided to use his medical knowledge and skills for actions contrary to medical ethics in the role of a soldier, then he should de-register from the council. He will then be relieved of the privileges and responsibilities of a doctor. ...respondent cannot rely on the contention that he acted as a soldier to the charge of breach of medical ethics.”