sician should ever be required to violate medical ethics. We further believe that military physicians should refuse to participate in any act that unambiguously violates medical ethics.

Military physicians who refuse to follow orders that violate medical ethics should be actively and strongly supported. Professional organizations and medical licensing boards should make it clear that the military should not take disciplinary action against physicians for refusing to perform acts that violate medical ethics. If the military nonetheless disciplines physicians who refuse to violate ethical norms when ordered to do so, civilian physician organizations, future employers, and licensing boards should make it clear that military discipline action in this context will in no way prejudice the civilian standing of the affected physician.

Guantanamo has been described as a “legal black hole.” As it increasingly also becomes a medical ethics–free zone, we believe it’s time for the medical profession to take constructive political action to try to heal the damage and ensure that civilian and military physicians follow the same medical ethics principles.

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Force-feeding, Autonomy, and the Public Interest

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Hunger striking is a nonviolent act of political protest. It is not the expression of a wish to die, nor is it akin to the decision of a terminally ill patient to discontinue food and fluid intake. Rather, it is brinkmanship. Faced with hunger-striking detainees, prison authorities have three choices: force-feed the hunger strikers, let them die, or accede to their demands.

As the World Medical Association (WMA) suggests, most bioethicists unequivocally oppose force-feeding. Enteral feeding through a nasogastric tube while a detainee is strapped to a chair violates a mentally competent patient’s right to refuse treatment and is physically violent. The WMA is less categorical about artificially feeding unconscious or delirious hunger strikers through their abdominal wall. Under these circumstances, physicians may permissibly weigh their patient’s best interests and prior expressions of intent before deciding about continued treatment.

Physicians who care for hunger-striking detainees weigh autonomy and best interests; rarely must they consider security interests. Local authorities, however, do not have this prerogative. Whereas bioethicists are keen to uphold autonomy and avoid force-feeding, public officials are bound to maintain public order and prevent the deaths of detainees. Those responsibilities leave officials only two choices: forced or artificial feeding, or accommodation. Accommodation deserves first consideration because it may be a reasonable choice. Faced with hunger-striking Palestinian detainees in 2012–2013, for example, Israeli officials satisfied some prisoners by improving prison conditions or modifying their prison terms. Similarly, the Turkish government met some hunger strikers’ demands last year. In each case, the hunger strike ended. Strikers played their hands deftly, carefully choosing realistic aims and employing nonviolent protests to gain symbolic but important concessions. Local medical organizations also played a role: the Israeli Medical Association instructed its members to comply with WMA guidelines, thereby pushing public officials to earnestly explore accommodation.

The situation at Guantanamo deserves similar creativity. The detainees’ demands are not monolithic. Prisoners who are cleared for release require expedited repatriation, whereas others may be satisfied with customary legal proceedings, better prison con-
dions, or both. Accommodating
the protesters on some counts may
not be impossible. But whereas
the freed Palestinian hunger strik-
ers were previously paroled pris-
oners, not public enemies, some
Guantanamo detainees may be
militants representing genuine
security threats, and authorities
may not be able to meet all their
demands. Nor is it sensible to let
prisoners die; widespread rioting,
civil unrest, and attacks on mili-
tary and civilian personnel often
follow the deaths of hunger strik-
ers. And if one cannot allow hun-
ger strikers to die or accede to
their demands, then force-feeding
must be back on the table.

There is no doubt that when
mentally competent people refuse
to eat or be fed, force-feeding or
artificially feeding them violates
the principle of autonomy. But
autonomy is not sacrosanct. Per-
suasive moral arguments appeal
to the sanctity of life to permit
caregivers to override respect for
autonomy when necessary to avert
an easily preventable death from
starvation. Respect for auton-
omy, moreover, conflicts with oth-
er important, nonmedical prin-
ciples. Among military personnel,
for example, autonomy, privacy,
and the right to refuse certain
treatments are limited and sub-
ordinate to security interests and
the conditions necessary to main-
tain a fighting force. Similarly,
the imperative to respect a detain-
ee’s right of informed consent is
not obviously superior to the in-
terests of public security. There
are usually good reasons for keep-
ing captured enemy combatants
locked up and alive. In fact, that
is the norm of military detention.
A prisoner’s desire to go free or
die trying cannot override this
basic interest of the state. A dem-
ocratic government cannot be so
hamstrung that the possibility of
viable incarceration evaporates.

Of course, this argument
should not be construed as per-
mission to violate a fundamental
human right in the name of mil-
tary necessity. But the right of
informed consent is not such a
fundamental right — it is subor-
dinate to human rights that pro-
tect people from murder, servi-
tude, torture, and cruelty. One
might argue, then, that force-feed-
ing assaults a person’s dignity,
and surely that is true when the
feeding is accompanied by phys-
ical violence. But that argument
does not repudiate force-feeding;
it only mandates a search for non-
vio1ent and humane methods.

Two practical difficulties also
plague any directive to prioritize
autonomy. First, respecting auton-
omy requires firm knowledge of
a striker’s intent, which caregiv-
ers and prison authorities are
unlikely to have. Given the lack of
continuity of care, along with cul-
tural differences, language bar-
riers, and instructions that de-
tainees may have received from
their leaders, it would be extraor-
dinarily difficult for anyone to
determine whether a detainee was
acting autonomously or under du-
ress. Under these circumstances,
the case for autonomous deci-
sion making weakens sufficient-
ly to allow physicians to weigh a
patient’s best interest over his or
her decision to refuse food. Sec-
ond, clinicians face a crisis of
confidentiality if hunger strikers
agree to accept food and fluids
once their condition deteriorates
but demand that caregivers keep
these instructions secret. In these
instances, confidentiality maxi-
mizes a striker’s political leverage,
draws doctors into the fight,
and leaves medical workers to
stand by helplessly if public of-

ficials make suboptimal decisions
on the basis of erroneous infor-
mation.

The moral and practical dif-
ficulties of dogmatically uphold-
ing respect for autonomy sug-
gest that the WMA would not
allow physicians to stand by and
watch hunger strikers die. It is
unimaginable that any decent so-
ciety today would leave 10 Irish
Republican Army hunger strikers
to die of starvation as the British
did in Northern Ireland in 1981.
Accounts of their slow and an-
guished deaths are harrowing,
and no rights-respecting govern-
ment or medical association
should ever permit a repetition
of that event. Instead, we should
think about how to feed hunger
strikers humanely. Once respect
for autonomy falls to best inter-
ests or public interests, it makes
no difference whether the au-
thorities turn to humane force-
feeding or to artificial feeding.
But artificial feeding is not ide-
al: though less aggressive than
force-feeding, it is also less salu-
brious — surely it is healthier to
prevent starvation than to treat it.
Politically, hunger strikes only
galvanize prisoners and enflame
their supporters. Letting strikes
drag out until detainees are at
death’s door is not a solution.

Hunger strikes by security de-
tainees pose an excruciating di-
llemma. Physicians who decry dis-
respect of autonomy are left to
watch treatable patients die. Phy-
sicians who extol the sanctity of
life are committed to feeding
healthy inmates by force. Public
officials can neither accede to in-
mates’ demands nor allow them
to die when negotiations stall but
instead require humane methods
to keep inmates alive. In this en-
vironment, the medical commu-
nity faces two challenges. First,
Failure to Launch? The Independent Payment Advisory Board’s Uncertain Prospects

Jonathan Oberlander, Ph.D., and Marisa Morrison, B.A.

Controversy has followed the Independent Payment Advisory Board (IPAB) since its inception. The Affordable Care Act (ACA) established the IPAB as a 15-member, nonelected board. Among other duties, the IPAB is empowered to recommend changes to Medicare if projected per-beneficiary spending growth exceeds specified targets. Congress must consider Medicare reforms proposed by the board under special legislative rules, including limits on debate, which are designed to ensure speedy action. If Congress does not enact legislation containing those proposals or alternative policies that achieve the same savings, the IPAB’s recommendations are to be implemented by the secretary of health and human services. Other rules make it difficult for Congress to override these procedures (supermajorities are required) or eliminate the board altogether (the ACA allows Congress to do so only in 2017 through a supermajority vote).1–3

In 2010, Obama administration officials hailed the IPAB as “the most important institutional change” in the ACA and a crucial component of health care cost containment.4 The IPAB enjoys strong support among many health policy analysts who are attracted to the vision of a non-partisan board insulated from political pressures that can formulate more rational and coherent Medicare policy.5 The IPAB’s supporters also praise it as a fail-safe ensuring that growth in Medicare spending is moderated, regardless of congressional inaction. President Obama has proposed strengthening the board’s role by lowering the Medicare spending targets that would trigger IPAB action.

The IPAB’s critics see it in a very different light. Because the board is prohibited by law from making recommendations that raise revenues, increase cost sharing of Medicare beneficiaries, or restrict benefits and eligibility, it is expected to focus on savings from medical providers. A broad coalition of health care industry groups, fearful that the board’s proposals will result in reduced Medicare payments, fiercely opposes the IPAB. In addition, Republicans view it as an instrument of rationing and bureaucratic intrusion into medicine. In the 2012 vice-presidential debate, Congressman Paul Ryan (R-WI) warned that the IPAB would be “in charge of cutting Medicare each and every year in ways that will lead to denied care for current seniors.” House Republicans have voted to repeal the IPAB and the entire ACA, though those measures have not cleared the Democratic-majority Senate. In January 2013, the GOP adopted a House