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."[3] 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.[1] 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.[2]

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-

ditions, or both. Accommodating the protesters on some counts may not be impossible. But whereas the freed Palestinian hunger strikers were previously paroled prisoners, 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 military and civilian personnel often follow the deaths of hunger strikers. And if one cannot allow hunger 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. Persuasive 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.[3,4] Respect for autonomy, moreover, conflicts with other important, nonmedical principles. Among military personnel, for example, autonomy, privacy, and the right to refuse certain treatments are limited and subordinate to security interests and the conditions necessary to maintain a fighting force.[5] Similarly, the imperative to respect a detainee's right of informed consent is not obviously superior to the interests of public security. There are usually good reasons for keeping 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 democratic government cannot be so hamstrung that the possibility of viable incarceration evaporates.

Of course, this argument should not be construed as permission to violate a fundamental human right in the name of military necessity. But the right of informed consent is not such a fundamental right — it is subordinate to human rights that protect people from murder, servitude, torture, and cruelty. One might argue, then, that force-feeding assaults a person's dignity, and surely that is true when the feeding is accompanied by physical violence. But that argument does not repudiate force-feeding; it only mandates a search for nonviolent and humane methods.

Two practical difficulties also plague any directive to prioritize autonomy. First, respecting autonomy requires firm knowledge of a striker's intent, which caregivers and prison authorities are unlikely to have. Given the lack of continuity of care, along with cultural differences, language barriers, and instructions that detainees may have received from their leaders, it would be extraordinarily difficult for anyone to determine whether a detainee was acting autonomously or under duress. Under these circumstances, the case for autonomous decision making weakens sufficiently to allow physicians to weigh a patient's best interest over his or her decision to refuse food. Second, 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 maximizes a striker's political leverage, draws doctors into the fight, and leaves medical workers to stand by helplessly if public officials make suboptimal decisions on the basis of erroneous information.

The moral and practical difficulties of dogmatically upholding respect for autonomy suggest that the WMA would not allow physicians to stand by and watch hunger strikers die. It is unimaginable that any decent society 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 anguished deaths are harrowing, and no rights-respecting government 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 interests or public interests, it makes no difference whether the authorities turn to humane force-feeding or to artificial feeding. But artificial feeding is not ideal: though less aggressive than force-feeding, it is also less salubrious — 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 detainees pose an excruciating dilemma. Physicians who decry disrespect of autonomy are left to watch treatable patients die. Physicians who extol the sanctity of life are committed to feeding healthy inmates by force. Public officials can neither accede to inmates' demands nor allow them to die when negotiations stall but instead require humane methods to keep inmates alive. In this environment, the medical community faces two challenges. First,

health care professionals will be called on to develop and administer humane methods for feeding striking detainees while providing general medical care under trying prison conditions. Second, health care professionals must also continue to scrutinize the behavior of public officials, cognizant of the medical interests of their patients and the collective interests of their community. Force-feeding should be rare, the product of serious but ultimately unsuccessful negotiations with strikers.

These are not easy straits to navigate. Armed conflict and other public emergencies pit personal, professional, and public interests against one another. Medical professionals, like other citizens in a thriving democracy, must simultaneously sustain the efforts of war and contain them.

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Failure to Launch? The Independent Payment Advisory Board's Uncertain Prospects

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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 nonpartisan 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