

Forcefeeding and restraint of Guantanamo Bay hunger strikers



We write regarding the forcefeeding and restraint of Guantanamo Bay detainees currently on hunger strike.^{1,2} The World Medical Association specifically prohibits forcefeeding in the Declarations of Tokyo and Malta, to which the American Medical Association is a signatory.

Fundamental to doctors' responsibilities in attending a hunger striker is the recognition that prisoners have a right to refuse treatment. The UK government has respected this right even under very difficult circumstances and allowed Irish hunger strikers to die. Physicians do not have to agree with the prisoner, but they must respect their informed decision. Those breaching such guidelines should be held to account by their professional bodies. John Edmondson (former commander of the hospital at Guantanamo) instigated this practice, and we have seen no evidence that procedures have changed under the current physician in charge, Ronald Sollock.³

Edmondson, in a signed affidavit, stated that "the involuntary feeding was authorized through a lawful order of a higher military authority."⁴ This defence, which has previously been described as the Nuremberg defence,⁵ is not defensible in law. In a reply to an earlier draft of this letter, Edmondson said that he was not forcefeeding but "providing nutritional supplementation on a voluntary basis to detainees who wish to protest their confinement by not taking oral nourishment".

Recently, it was confirmed that health-care staff are screened to ensure that they agree with the policy of forcefeeding before working in Guantanamo Bay.¹ On his departure, Edmondson was awarded a medal for

his "inspiring leadership and exemplary performance [which] significantly improved the quality of health care for residents of Guantanamo Bay" and "scored an unprecedented 100% on both the Hospital and the Home Health surveys."³ The New York Times, however, reports that hunger striking detainees are strapped into restraint chairs in uncomfortably cold isolation cells to force them off their hunger strike.²

We urge the US government to ensure that detainees are assessed by independent physicians and that techniques such as forcefeeding and restraint chairs are abandoned forthwith in accordance with internationally agreed standards.

We declare that we have no conflict of interest.

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- 1 Okie S. Glimpses of Guantanamo: medical ethics and the war on terror. *N Engl J Med* 2005; **353**: 2529–34.
- 2 Golden T. Tough US steps in hunger strike at Camp in Cuba. *New York Times* Feb 9, 2006. <http://select.nytimes.com/gst/abstract.html?res=F70714F63F5A0C7A8CDAB0894DE404482> (accessed Feb 22, 2006).
- 3 Byrington S. Sollock takes command of Naval Hospital. *Guantanamo Bay Gazette* 2006; **63**: 3. <http://www.nsgtmo.navy.mil/Gazette%20Online/archived%20editions/2006/060113all.pdf> (accessed Feb 22, 2006).
- 4 Al Joudi et al vs George Bush in the US District Court for the District of Columbia. Case1: 05-cv-00301-GK. Document 48, Exhibit A. Filed Oct 19, 2005.
- 5 Spitz V. Doctors from hell: the horrific account of Nazi experiments on humans. Boulder: First Sentinent, 2005.

Clopidogrel and metoprolol in myocardial infarction

In their randomised trial comparing metoprolol with placebo in patients with acute myocardial infarction (Nov 5, p 1622),¹ the COMMIT Collaborative Group specify that evidence of moderate heart failure (Killip class II or III) was not an exclusion criterion. However, stage III of the Killip classification² is defined as severe (not moderate) heart failure and comprises patients with frank pulmonary oedema with rales throughout the lung fields. Stage II of the Killip classification² also includes patients with pulmonary congestion. According to guidelines by the American College of Cardiology and American Heart Association on the management of patients with ST-elevation myocardial infarction,³ β blockers should not be given acutely to patients with heart failure evidenced by pulmonary congestion or signs of a low-output state.

It is true that the European guidelines on the diagnosis and treatment of acute heart failure⁴ mention that in patients with overt acute heart failure and more than basal pulmonary rales, β blockers should be used cautiously and that among patients in whom ischaemia and tachycardia are present, intravenous metoprolol can be considered. However, most patients included in the COMMIT study did not present with tachycardia, as can be seen from table 1 of the paper. Furthermore, because the aim of the study was not to assess the efficacy of metoprolol in patients with acute myocardial infarction complicated by acute heart failure but in a wide range of patients with acute myocardial infarction, the recommended caution could not have been considered for each patient individually.

In this sense, ethical concerns arise from the randomisation of 9105 patients in Killip II stage and, much more importantly, of 2144 patients in Killip III stage to a β blocker or placebo.



See Online for webappendix

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