EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MOHAMMED ABDULLAH MOHAMMED BA ODAH, *et al.*,

Petitioners,

v.

BARACK H. OBAMA, *et al.*,

Respondents.

Civil Action No. 06-1668 (TFH)

SUPPLEMENTAL DECLARATION OF DR. JESS GHANNAM IN FURTHER SUPPORT OF PETITIONER TARIQ BA ODAH'S MOTION FOR HABEAS RELIEF

I, DR. JESS GHANNAM, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I incorporate by reference my initial declaration signed on June 21, 2015.

2. I have reviewed the declaration submitted in this case by the Senior Medical Officer (SMO) at Guantanamo Bay that describes Mr. Ba Odah's physical and mental condition and the care he is presently receiving.

3. My clinical experience, training and basic standard-of-care principles leads me to the conclusion that the SMO's declaration regarding Mr. Ba Odah is flawed and reflects a strikingly inadequate response to Mr. Ba Odah's reported condition. The SMO's course of treatment, as reported in his declaration, departs from basic tenants of diagnostic, preventative and remedial care, particularly for a patient who is so abnormally malnourished and underweight

as Mr. Ba Odah. It is difficult, if not impossible, to have confidence in the conclusions it draws about his physical and mental state.

Clinical Stability Can Only Be Established Through Appropriate Diagnostic Testing and Treatment

4. As a threshold matter, it is alarming to me that the SMO would admit that Mr. Ba Odah's health is poor, SMO Decl. ¶ 14, that he is dangerously underweight, SMO Decl. ¶ 22, that he has an active concern for Mr. Ba Odah's health, SMO Decl. ¶ 27, and that in the event of Mr. Ba Odah's continued deterioration, he will be admitted to an acute care facility for continual feeding and weighing, SMO Decl. ¶ 26, but then also conclude that Mr. Ba Odah is "clinically stable," SMO Decl. ¶ 22 – particularly when the SMO has been unable to perform even the most elemental medical diagnostic tests, such as an endocrine system assessment and metabolic panels, MRI, CBC or other routine examinations. These medical assessments are foundational and without the benefit of their results, I am forced to question the SMO's clinical conclusions.[1]

5. To overcome the SMO's stated concern for Mr. Ba Odah's wellbeing – a concern surely resulting, first and foremost, from Mr. Ba Odah's mere 74 pound body weight – a cautious and thoughtful doctor would either insist on performing the routine tests I have outlined above and in my initial declaration, or would decline to offer a clinical assessment. But under no

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[1] The SMO reports that he took Mr. Ba Odah's vitals most recently on April 2, 2015. He does not, however, appear to base his conclusion that Mr. Ba Odah is stable on those results, instead relying on Mr. Ba Odah's consistent weight and reported observations of Mr. Ba Odah "functioning normally." I address the inadequacy of that approach below, but note that even measuring Mr. Ba Odah's vital signs, while useful, is nonetheless an insufficient basis to determine whether he is stable. Vital signs offer insight into a narrow slice of a patient's functioning – blood pressure, temperature, and heart-rate – but only at fixed moment. They are a snapshot. What this means in Mr. Ba Odah's case is that his vitals could change dramatically depending on whether he was sitting or standing or when the measurements were taken. His results would also be sharply affected by whether he was evaluated immediately during or following a force feeding session when nutrients would be rapidly introduced into his system. His vitals would also be affected by whether he was experiencing a period of "waning" or declining health – a medical phenomenon I describe below that is common in patients with progressively serious chronic conditions. This contextual information is not provided by the SMO, thereby rendering the meaning of Mr. Odah's vital signs inconclusive.

reasonable circumstance would a doctor assert that a patient manifesting Mr. Ba Odah's obvious symptoms of extreme malnourishment is stable on the basis of any less.

6. The manifest gravity of Mr. Ba Odah's condition, in addition to the SMO's admission that he is at a dangerously low weight, compels a much higher and urgent level of care than is otherwise required to discharge a doctor's ethical responsibilities. Perceived immediate medical danger to a patient is a threshold that, once crossed, triggers a sober obligation on the part of an attending physician to perform diagnostic examinations to exclude the presence of conditions that could be debilitating or even fatal. Only then does a doctor have a sound and reasonable basis for declaring a patient stable. Failing to undertake basic diagnostic testing for a patient in Mr. Ba Odah's obvious state of ill health and electing to declare him clinically stable all the same, invites an intolerable level of risk of his decline and, in the worst case, his death.

7. I comment more on the phenomenon below, but acknowledge here the SMO's complaint that Mr. Ba Odah has refused to accept some necessary testing and other care offered to him at Guantanamo. As a result, the SMO has relied on observations – occasionally direct, but far more often from others at the prison – to form his clinical assessment. Frankly, that approach is unacceptable. While observations of a patient's behavior are certainly relevant to a health-assessment, they can never replace "hands-on" clinical examination and diagnostic testing. Moreover, observations of Mr. Ba Odah by others, many of whom appear not to be health professionals, are inherently less reliable for clinical purposes and require contextualization and interpretation before being incorporated into a reliable medical assessment. Given the frequently antipathetic relationship between guards and their charges in any detention setting, the fact that the SMO relies on information and observations from Joint Detention Groups guards is suspect and generally unreliable, especially in such a grave situation.

8. The indirect observations from the Joint Medical Group and Joint Detention Group staff, as reported to the SMO, are of limited value for clinical purposes for yet other reasons. SMO Decl. ¶ 18. Often they omit dates, times, length of each observation period, and are thus an insufficient basis to form a reliable opinion of Mr. Ba Odah's condition. Moreover, the observations devote undo focus to superficial aspects of Mr. Ba Odah's behavior, rather than on related physiological and psychological markers that could help establish his relative health or illness. For example, as much as the SMO Declaration records that Mr. Ba Odah has been observed occasionally purging food in his cell, SMO Decl. ¶ 19, it fails to record how long after Mr. Ba Odah's prior feeding this occurred, whether Mr. Ba Odah appeared in pain during these episodes or the color of the discharge to note whether it reflected traces of blood – all of which would be highly relevant as a clinical matter.

9. Indeed there is a profound difference between vomiting (involuntary) and purging (voluntary) and the medical implications associated with each. Outside of obvious instances where a patient forcibly induces vomiting – say by inserting an object into the throat to trigger the gag-reflex, something the SMO's declaration does not describe or even suggest – the assessment of whether a patient has vomited or purged can only properly be made by a medical professional. What appears to be "purging in an effort to limit his caloric intake," see SMO Decl. ¶ 19, to an untrained attendant could just as easily be the result of an involuntary physiological process caused by pain, gastro-intestinal dysfunction, malnutrition and even conditions of confinement. Additionally, I must note that in a situation where a patient's calorie intake and absorption are of paramount importance, any description of reported purging should incorporate significantly more detail than what appears in the SMO's declaration to be reliable and of clinical value.

10. The SMO also reports that he placed Mr. Ba Odah in line-of-sight observation for a four day period. SMO Decl. ¶ 18. I question this protocol for observing Mr. Ba Odah or the suggestion that Mr. Ba Odah's observed behavior establishes his overall stable health. During the line-of-sight observation, JMG and JDG staff observed Mr. Ba Odah, among other things, walking in his cell, singing, and sleeping regularly. And on that basis, the SMO concluded that his energy level is normal. But as reported, the observations lack any specificity, context, or any input from Mr. Ba Odah himself that would make them useful from a clinical standpoint, especially for a patient possibly facing neurocognitive and physical deterioration due to malnourishment and prolonged solitary confinement. There is no documentation of dates, times, durations, or the qualifications of the observers. Doctors, however, are required to observe a patient's behavior in the context of an overall clinical and diagnostic evaluation in relation to many possible differential diagnoses. There is no such analysis in the SMO's declaration, which diminishes the reliability of his conclusions.

11. That aside, and taking the observations reported to the SMO at face value, none of the behaviors attributed to Mr. Ba Odah rule out the conclusion that he is gravely ill. In my experience, and as supported by clinical literature, patients in severely compromised states will periodically experience what are commonly termed "moments of clarity" marked by alertness, apparent good health, and during which they appear able to perform behaviors – particularly overlearned, reflexive behavior such as grooming, walking, or praying – before returning to relatively diminished psychological and physical states. This manner of "waxing and waning" is not only common, it is in itself a hallmark of patient's progressive deterioration and ill health. These periods of diminished functioning – the waning periods – are most revealing because they indicate the extent of a patient's deterioration.

12. To take an example from the SMO's declaration, it is less relevant to me that on two occasions in recent months Mr. Ba Odah managed to take advantage of his recreation time. It is much more clinically relevant, that despite being committed to his cell for extended hours at time, he is unwilling or unable to leave his cell on the overwhelming majority of other occasions when he is allowed to do so. Similarly, it is less relevant to me that Mr. Ba Odah is reported to vigorously resist treatment – although there is ample clinical explanation for that too – as it is that, on at least one occasion documented by the SMO, he was overcome and collapsed to the floor. The times when Mr. Ba Odah is at his most compromised are critical clinical moments and are important in making a differential diagnosis. These moments reveal the depth of the medical crisis Mr. Ba Odah is facing.

13. Relatedly, that Mr. Mr. Ba Odah's weight has not recently declined further does not allay the concern that his condition is potentially grave. Mr. Ba Odah's weight appears to be holding at just 74 pounds. Stable weight, however, is not necessarily a reflection of stable medical condition. It bears little relationship to the potential presence of cardiac dysfunction, gastro-intestinal corrosion and failure, potential onset of respiratory failure; it says nothing about Mr. Ba Odah's blood pressure, or psychological or neurological deterioration. Consistent body-weight is merely one isolated piece of data - and in this case, a strikingly superficial piece of data – and is insufficient to assess the quality of health in a man otherwise so degraded. The paucity of information underlying the SMO's assessment is worrisome.

Mr. Ba Odah's Refusal to Accept Care

14. The SMO's declaration describes numerous instances of Mr. Ba Odah refusing the care offered to him at Guantanamo. First, a physician's ethical obligation to treat a potentially gravely ill person is not abrogated when a patient refuses care. And doctors do not discharge their medical, ethical duty simply by *attempting* to treat an uncooperative patient. This is particularly true when a patient appears to be as compromised as Mr. Ba Odah and treatment takes place in a custodial detention setting where patient-doctor relationship and trust are easily compromised. Indeed imprisoned patients who experience acute absence of agency and the psychological disorientation and trauma that usually accompanies that state, often reject medical attention and other forms of care because it is one of very few aspects of their daily routine over which they can exert a modicum of control. In that sense, refusal of care is often yet another sign of the psychological deterioration in a patient and – where other symptoms of ill-health are so pronounced – cause for additional concern.

15. It is important to note that, however implausible the scenario may be in the Guantanamo context, medical ethical guidelines are explicit that when a patient expresses mistrust in their caregivers – either directly or through their behavior – it becomes the doctor's professional (indeed moral) responsibility to transfer that patient to another competent, trusted doctor who can properly treat the patient. So, though the SMO's declaration builds a record of his efforts to provide care to Mr. Ba Odah, the ethical guidelines governing the practice of medicine actually require that the SMO facilitate Mr. Ba Odah's access to competent care from another physician.

16. Even well-meaning attempts to revisit a patient who consistently declines treatment, though appearing to evidence due diligence on the part of the attending physician, is the wrong course of conduct. Unwelcome offers of care are oppressive and traumatic to patients

who mistrust their doctors. Revisiting a patient day after day to renew the offer of treatment can re-traumatize and intimidate patients, often eliciting precisely the "vigorous" reactions the SMO declaration attributes to Mr. Ba Odah.

17. And in my opinion, it is also of little consequence that on occasion, Mr. Ba Odah accepts some treatment. It says nothing about his relative level of trust or mistrust for the doctors at Guantanamo. In my experience, patients often accept some care if they determine it is essential despite their overriding aversion to cooperating with their caregivers. It is noteworthy that, according to the SMO, Mr. Ba Odah has a record of refusing treatment that predates the assumption of his current role as Guantanamo. This suggests that Mr. Ba Odah learned to be mistrustful of doctors at Guantanamo long ago, but is attempting to negotiate that mistrust and his acute medical needs as he sees fit. This too is a common and clinically predictable phenomenon for patients in a detention setting.

18. The SMO declaration also notes that Mr. Ba Odah has reported a myriad of symptoms to his counsel that he has never shared with medical staff at Guantanamo. In my experience, the SMO should be deeply concerned by the enormous discrepancy between the ostensibly mild complaints Mr. Ba Odah raises to prison staff and the potentially life threatening symptoms he reported to his counsel. I observe this dynamic in my practice regularly: patients communicate candidly and in detail to someone they know and trust and with whom they have a relationship – but not to their own doctor. Consequently, as a clinical matter, doctors place considerable weight on the symptomology reported by persons who are trusted by our patients and use those reported symptoms as the point of departure for further investigation. This is why comprehensive medical care often involves consultation with family members and loved-ones who know an ailing patient most intimately.

Other Severe Symptoms of Mr. Ba Odah's Ill Health as Reported by the SMO

19. The SMO's declaration describes other symptomology observed in Mr. Ba Odah that I find troubling and that calls for immediate intervention and care. The SMO recounts a recent episode during which Mr. Ba Odah made comments indicating that he has a sense of despair. SMO Decl. ¶ 16. Under the circumstances of Mr. Ba Odah's hunger strike and his dramatic weight loss, I would expect, without having interacted with Mr. Ba Odah, that the level of "despair" he is enduring is sufficiently acute to be of concern from a clinical psychological standpoint. This is particularly worrisome where Mr. Ba Odah is also likely coping with an array of severe physical ailments. Patients who are compromised psychologically typically experience worse physical health outcomes than patients who are psychological stable. And it is my assessment that sending a psychologist or an attendant from the Behavioral Health Unit to treat a patient likely experiencing considerable mental anguish is an inadequate response – especially when there are direct ameliorative steps available to the SMO that would immediately alleviate some of Mr. Ba Odah's suffering. Specifically, at a minimum, the SMO could recommend removing Mr. Ba Odah from his solitary living conditions in Camp V, if he has not already done so. Psychologists have the same ethical obligation to act if they determine that a patient is in imminent despair as physicians do for a patient who is acutely physically compromised – even if that patient refuses.

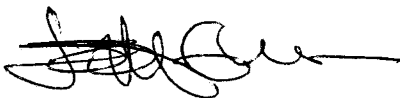
20. The SMO also concludes that Mr. Ba Odah is functioning normally in his daily life. SMO Decl. ¶ 26. Nonetheless, he reports that Mr. Ba Odah suffers from "pressure ulcers," the more common term for which are bed sores. Id. at ¶ 25. Reconciling those two assertions is impossible. Individuals functioning normally and healthily in their lives do not also suffer from bed sores, which is an indication that a patient's system is so degraded, and their level

incapacitation so severe, that they cannot move regularly enough to permit consistent blood flow to the areas of the body on which they rest their weight. Additionally, bed sores can arise in patients who are so frail that they have insufficient flesh or fat reserves to absorb the pressure caused by resting on a firm surface. From Mr. Ba Odah's reported symptoms, it appears he may suffer from both problems. In any event, he cannot be functioning normally and suffering with bed sores. I note that in a hospice setting, the onset of bed sores is typically viewed as a possible indication of below standard of care and triggers a specific protocol that medical facilities must follow to prevent their reoccurrence. That protocol is considerably more elaborate than providing extra cushions in the way the SMO has described; rather it involves moving patients at regular intervals and special wound care to avoid additional and potentially more severe, life-threatening infections.

21. But above all, in conclusion, it is simply a medical impossibility that an adult male at only 56% of his normal body weight is leading a normal life. And this is demonstrably obvious from the SMO's admission that Mr. Ba Odah is an "active concern" for JMG. As with "clinical stability," "active concern" is a medical term that suggests that a patient faces a potentially emergent situation – that he could decompensate at any moment – which requires highly sophisticated monitoring and time-sensitive intervention. In this limited sense alone, I agree with the SMO's medical conclusion.

I declare under penalty of perjury that the forgoing is true and correct.

Dated: September 9th, 2015
San Francisco, California



Dr. Jess Ghannam