

Geneva: an 'illusion of knowledge' for ADF medical officers?

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'The greatest obstacle to discovery is not ignorance-it is the illusion of knowledge'.

Daniel J Boorstin. 1914-2004. American historian and attorney, Librarian of the United States Congress 1975-1987.

Abstract

Generally medical students have little exposure to international humanitarian (IHL) and human rights law (IHRL). As medical officers in the Australian Defence Force (ADF) there are opportunities for selected officers to undergo such training however it is by no means universal and Reservists are probably least likely to receive such training. This paper argues that a baseline study of the current knowledge of Permanent and Reserve medical officers about IHL & IHRL is necessary. Those results will be helpful in determining if existing levels of understanding are adequate. New ways of delivering such education will be described.

Introduction

The Geneva Conventions¹ had their origins in the horrific suffering of wounded and dying combatants on the battlefield at Solferino in Italy². Exactly one hundred and fifty years ago, Henri Dunant, a Swiss businessman, resolved to find a humane means of caring for these soldiers and his efforts finally led to the Geneva Conventions (GC's). These four Conventions are international agreements on the humane treatment of wounded soldiers, ship wrecked sailors, prisoners of war and civilians caught up in armed conflict. All 191 States Members of the United Nations are Parties to the Geneva Conventions of 1949³. There are two Additional Protocols (AP) which cover aspects of international armed conflict⁴ (AP1) and non-international armed conflicts⁵ (AP2). These two AP's enjoy less than universal acceptance⁶: several major States such as the United States of America, for example, continue to hold reservations about the limited protection afforded to 'illegal combatants' by these AP's. However Common Article 3 which is 'common' to all 4 Conventions already establishes a bare minimum of humane treatment for any combatant. In the first decade of the twenty first century non-international armed conflicts are the most prolific.

Most military health personnel are aware that the GC's provide protection from attack for them, their patients and their facilities. This includes a right to use small arms for self defence. Even when captured by enemy forces, health personnel are also entitled to special treatment in order to care for prisoners of war. The use of the Red Cross (or Red Crescent) symbol of protection on uniforms, health facilities and ambulances is subject to strict regulation and is limited to non warlike humanitarian activities^{7,8}. The International Committee of the Red Cross was mandated by the international community to promote IHL and work for a better understanding of the law⁹.

The treatment of some enemy combatants in the 'Global War on Terror' has raised valid questions about the interpretation and application of the Law of Armed Conflict (LOAC) – a preferred term for IHL. These questions continue to be the subject of appeals to the US Supreme Court. In *Hamdan v Rumsfeld*¹⁰ the US Supreme Court held that even non-State illegal combatants such as al-Qaeda, who were not signatories to the Geneva Conventions, were nevertheless entitled to a basic minimum of humane treatment under Common Article 3 of the Geneva Conventions. That included protection from torture.

Some aspects of International Human Rights Law (IHRL) are also relevant to the knowledge of military physicians, particularly those which prevent torture and cruel inhumane or degrading treatment of prisoners. The relevant conventions and declarations in IHRL include the Convention Against Torture¹¹ (CAT) and the International Covenant on Civil and Political Rights¹² (ICCPR). Both prohibit torture. The 146 States that are Parties to the United Nations Convention on Torture¹³ affirmed that torture should be, without exception, a criminal offence with appropriate penalties. In part it states that:

No exceptional circumstances whatsoever, whether a state of war, or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture¹⁴.

To what extent (if at all) those Parties actually make it a prosecutable offence under domestic law is another matter.

Common Article 3 of the Geneva Conventions¹⁵ and the International Covenant on Civil and Political Rights¹⁶ also prohibit the practice of torture. This ban on torture is absolute, even in times of war and it is non-derogable.

Contemporary problems with the respect for IHL & IHRL

The abuse of prisoners in Abu Ghraib prison in Iraq by 372nd Military Police Company (US Army) appears to have involved the complicity of health personnel¹⁷. A description of torture in Abu Ghraib prison was published in the *Lancet* in 2004¹⁸. This included failure by doctors to report physical evidence of torture, provision of confidential medical information to assist in interrogation techniques, reviving prisoners to enable continued torture and failing to maintain medical records of tortured inmates. The International Committee of the Red Cross '[f]ound that the medical system failed to maintain internment cards with medical information necessary to protect the detainees' health as required by the Geneva Convention¹⁹.

Similar abuses have occurred in Bagram prison in Afghanistan²⁰ where a US military medical officer confirmed the testimony of a tortured Iraqi detainee in October 2004. In 2004 the *New England Journal of Medicine* summarised the complicity of medical staff in torture in Iraq, Afghanistan and Guantanamo Bay²¹. The involvement of military physicians at Guantanamo Bay has further been documented by Jane Mayer²² and more recently by Philippe Sands²³ who detailed the involvement by doctors in the continuous interrogation of Detainee 063 (Mohammed al-Qahtani) over a period of 54 days. Throughout that interrogation medical members of the Behavioral Consultation Teams provided intravenous hydration, enemas and biochemical monitoring.

In September 2006 the ICRC visited Guantanamo Bay and interviewed 14 'high value detainees' about the treatment by their captors. The Report²⁴ indicated that twelve of the 14 detainees alleged that they had been subjected to 'systematic physical and/or psychological ill-treatment'. The third part of this Report concerns the roles of health professionals who participated in the torture of these detainees. They monitored the oxygenation of a detainee (Kaled Sheik Mohammed, the

architect of 9/11) who was being subjected to 'waterboarding' and halted the torture when oxygen levels dropped to life-threatening levels. Other health professionals measured the degree of lower limb oedema during the torture of detainees who were subjected to prolonged stress positions. One detainee alleged that a health professional had threatened that his medical care was dependent on the subject's cooperation with the interrogators. The ICRC reported instances of medical support for harsh interrogation techniques which caused bodily injury.

What do we know about IHL teaching?

Few studies have been made on the knowledge and attitudes of doctors about human rights and international humanitarian law. However a large study conducted by the Indian Medical Association of 4,000 members chosen at random showed that of the 743 respondents 49% believed force feeding was justified, 37% believed solitary confinement was not torture and 58% believed coercive techniques might be justified to elicit information from uncooperative suspects. Interestingly, 16% admitted to being witnesses to the infliction of torture and 18% confirmed that Indian doctors had knowingly participated in torture²⁵. A second study in India 10 years later assessed the attitudes towards torture of 98 fourth year medical students²⁶. When asked whether they approved of police beating suspects to obtain a confession or information, 48 (46%) were undecided and 28 (28%) agreed with such torture.

In the United States of America 94% of medical students have less than one hour of teaching about military medical ethics or the Geneva Conventions²⁷. In a survey of 8 US medical schools²⁸ only 37.4% of undergraduate students correctly answered a question about the applicability of the Geneva Conventions in the absence of a declaration of war. More than a quarter of students (26.5%) incorrectly believed that wounded enemy soldiers should be triaged as a lower priority than wounded friendly forces instead of determining that priority by the severity of injuries. More than one third (37%) were ignorant of the prohibitions under the GC's against depriving prisoners of food or water, exposure to thermal stresses, uncomfortable positions or threats of physical violence. In a scenario where a doctor was asked to inject a prisoner with a lethal or psychoactive or placebo (sham execution), 27% believed that they should comply with all but injecting a lethal drug and only 66% answered correctly that all 3 cases should be disobeyed. Those students with prior or current military service attained correct scores which were not significantly different from those medical students with no such exposure. Once graduated, military physicians are often ill equipped by unit preparation to deal with human rights issues. A 2005 Report from the US Army Medical Department²⁹ revealed that 31% of 988 medical personnel believed they were inadequately prepared to 'address human rights of detainees' in Iraq, Afghanistan and Guantanamo Bay³⁰.

Pagaduan-Lopez et al contend that often doctors do not know about the standard minimum rules for the treatment of prisoners and assume that abuse is the norm in all jurisdictions⁽³¹⁾.

Maxwell and Pounder have attempted to address medical undergraduate ignorance of human rights using a self directed module³². Their two week optional module on Medicine and

Human Rights was introduced at Dundee medical school in 1995. The module included knowledge of IHRL including compliance mechanisms as well as means by which doctors can be unwittingly drawn into human rights abuses. Overall the module aimed to develop student attitudes which respected human rights as an integral part of medical practice³³.

In Australia, Leitch and O'Connor have recommended that training of military health professionals in international humanitarian law be enhanced³⁴.

The ADF does provide IHL training to selected health professionals –for example such courses have been organised by ADF Legal Services at the Army Logistic Training Centre (ALTC), Bandiana - and as part of direct officer entry courses in all 3 Services. However such training is by no means universal and many senior medical officers, particularly in the Reserve branches, including the author have had no exposure to such military training. Without such knowledge, military health professionals are at an immediate disadvantage when ordered to support interrogation of prisoners which they suspect may breach the laws of armed conflict or human rights law.

ADF Proposals for Strengthening Ethical and Humane Treatment

No official Defence Instructions-General [DI (G)]'s, guidelines specifically cover the education on LOAC or IHRL specifically for ADF military health professionals. Nor is there a DI (G) specifically on training ADF military health professionals generally. There is, however, a comprehensive system for training on LOAC within the ADF generally³⁵. For example ADF legal officers' competency in LOAC is achieved by their completion of:

- (a) Defence Legal task journals on Operations Law;
- (b) The ADF legal officer training programme (LTM1 – LTM3);
- (c) The accreditation requirements in DI(G) OPS 33-1 for legal advisers to military commanders

While training in LOAC does not of itself cover all the issues that arise under IHRL, there is some degree of overlap suggesting that additional content on IHRL could be added to existing LOAC training to provide the necessary education for military health professionals. For military health professionals there is arguably a case for them to receive legal training which is focussed specifically on their needs.

Within Joint Health Command the imminent baseline study of ADF doctor's knowledge of IHL & IHRL should provide a snapshot of current understanding. It could prompt improvements to the way such education is delivered to a wider audience.

The use of on line modules on IHL & IHRL is now possible. The ADF already has an on-line learning software package (CAMPUS) available on the DRN. An on line educational module would have the following advantages:

- a) The member's current state of knowledge could be initially tested and with instant feed-back of those results.
- b) Deficiencies in the student's understanding could then be addressed by access to a comprehensive referenced on-line

tutorial on all the key subjects.

- c) The module could be easily and regularly updated by legal experts.
- d) On line education has inherent time and cost savings by avoiding lengthy and expensive campus based courses.
- e) completion of this module could be made a regular (say every 5 years) requirement for all ADF health personnel.

Concluding Remarks

The 2009 Defence White Paper³⁶ notes that:

[I]nvestment in recruitment, training, education and the career development of the ADF's junior personnel and leaders will continue to display substantial dividends in terms of our ability to achieve campaign objectives and reduced casualties, while maintaining the high ethical standards of ADF personnel, and the proud record of the ADF on operations³⁷.

The Centre for Military Leadership and Ethics at Joint Education, Training and Warfare Command now provides an opportunity for human rights to be debated more widely in Defence and in particular in the Australian Command and Staff College and Centre for Defence and Strategic Studies environments. This dialogue should include military health personnel who offer unique perspectives on the humane and impartial care of military personnel.

Endnotes

1. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949, opened for signature 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) ('Geneva Convention I'); Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea of August 12, 1949, opened for signature 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950) ('Geneva Convention II'); Geneva Convention relative to the Treatment of Prisoners of War of August 12, 1949, opened for signature 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950) ('Geneva Convention III'); Geneva Convention relative to the Protection of Civilian Persons in Time of War of August 12, 1949, opened for signature 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) ('Geneva Convention IV') (collectively, 'Geneva Conventions').
2. International Committee of the Red Cross. 'Henri Dunant (1828-1910)', June 4 1998. <http://www.icrc.org/Web/eng/siteeng0.nsf/htmlall/57JNVQ> accessed 30 August 2009
3. International Committee of the Red Cross. States party to the Geneva Conventions and their Additional Protocols Geneva Conventions of 12 August 1949 and their Additional Protocols of 8 June 1977. <http://www.aiipowmia.com/legis/protocoles.pdf> accessed 30 August 2009
4. Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts. Opened for signature 12 December 1977, 1125 UNTS 3, art 75 (entered into force 7 December 1978) ('Additional Protocol I').
5. Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflict. Opened for signature 12 December 1977, 1125 UNTS 609, art 4 (entered into force 7 December 1978) ('Additional Protocol II').
6. There are 161 Parties to AP1 and 156 Parties to AP2. <http://www.aiipowmia.com/legis/protocoles.pdf> accessed 30 August 2009.
7. François Bugnion. 'The red cross and red crescent emblems' International Committee of the Red Cross. (31 October 1989) <http://www.icrc.org/Web/Eng/siteeng0.nsf/html/57JMB8> accessed 30 August 2009.
8. Section 15(1) of the Geneva Conventions Act 1957 (Cth) provides that it is an offence to use any of the recognised emblems of the Red Cross movement, including the emblem of the Red Cross and Red Crescent. Katharine Philp. 'Unauthorised use of the Red Cross emblem' *Tress*

- Cox.Newsletter 2009 March 2. <http://www.tresscox.com.au/resources/resource.asp?id=432> accessed 3 Sep 09.
9. International Committee of the Red Cross. 'Direct participation in hostilities: questions & answers' 2009 June 2. <http://www.icrc.org/web/eng/siteeng0.nsf/htmlall/direct-participation-ihl-faq-020609#a5> accessed 30 August 2009.
 10. *Hamdan v. Rumsfeld*, 548 U.S. 557 (2006)
 11. United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984. Entry into force 26 June 1987, in accordance with article 27 (1) U.N.T.S. 85 The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment State Parties were required to prosecute perpetrators of torture and their accomplices (Article 5) and inform and teach their citizens, including the medical profession, about torture (Article 10). It requires States to provide regular reports to the Committee Against Torture (*Committee*) on their implementation of the provisions contained in the Charter. The *Committee* is a 10 member statutory United Nations committee. There are two notable States namely the United Kingdom of Great Britain and Northern Ireland and the United States of America who refused to sign Article 22. Under article 22, a State party to the Convention may acknowledge the authority of the *Committee* to investigate complaint of torture made against a member State. The absolute prohibition on torture contained in Article 2 has since become accepted as part of customary international law. Since 2006 an Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, has been in force allowing "a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment,"¹¹ Australia, China, Iran, Iraq, Russia and the United States have failed to sign or ratify this Optional Protocol.
 12. United Nations General Assembly. International Covenant on Civil and Political Rights Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, in accordance with Article 49. U.N.T.S. 171
 13. United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984. Entry into force 26 June 1987, in accordance with article 27 (1) U.N.T.S. 85 < <http://www.hrweb.org/legal/cat.html> > accessed 27 August 2008
 14. Article 2(2) of the U.N. Convention against Torture <http://www.hrweb.org/legal/cat.html> accessed 10 September 2008
 15. Geneva Convention relative to the Treatment of Prisoners of War 12 August 1949 Geneva, Common Article³ 'In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each party to the conflict shall be bound to apply, as a minimum, the following provisions: I. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria. To this end the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons: (a) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; (b) Taking of hostages; (c) Outrages upon personal dignity, in particular, humiliating and degrading treatment; (d) The passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court affording all the judicial guarantees which are recognized as indispensable by civilized peoples.
 16. United Nations General Assembly. International Covenant on Civil and Political Rights Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, in accordance with Article 49. U.N.T.S. 171 Article 7: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation'
 17. 'Much of the evidence of abuse at the prison came from medical documents. Records and statements show doctors and medics reporting to the area of the prison where the abuse occurred several times to stitch wounds, tend to collapsed prisoners or see patients with bruised or reddened genitals. Kate Zernike, 'The Reach of the War: The Witnesses; Only a Few Spoke Up on Abuse as Many Soldiers Stayed Silent' New York Times. (22 May 2004). <<http://query.nytimes.com/gst/fullpage.html?res=9F00E6D91F3FF931A15756C0A9629C8B63&sec=&spoon=&pagewanted=2>> accessed 31 August 2008
 18. Miles SH. Abu Ghraib: its legacy for military medicine. *Lancet* 2004 364: 725-729.
 19. International Committee of the Red Cross. Report of the International Committee of the Red Cross on the Treatment by the Coalition Forces of Prisoners of War and Other Protected Persons by the Geneva Convention in Iraq during Arrest, Internment, and Interrogation. Feb 2004. <http://www.globalsecurity.org/military/library/report/2004/icrc_report_iraq_feb2004.htm> accessed 31 August 2008
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 21. Lifton RJ. Doctors and Torture. *NEJM* 2004;351:415-416. <<http://content.nejm.org/cgi/content/full/351/5/415>> accessed 31 August 2008
 22. Mayer J. The Experiment: The Military Trains People to Withstand Interrogation — Are Those Methods being Misused at Guantánamo? *The New Yorker* 2005 July 11. http://www.newyorker.com/archive/2005/07/11/050711fa_fact4 accessed 3 Sep 09.
 23. Sands P. *Torture Team*, London, Allen Lane, 2008 at 206.
 24. International Committee of the Red Cross, Report on the Treatment of Fourteen 'High Value' Detainees in CIA Custody 2007 February).
 25. Jagdish Sobti, Chaparwal B, Choudhary PK, Erik Holst, Bhatnagar NK. Knowledge, attitude and practice of physicians in India concerning medical aspects of torture. *New Delhi Indian Medical Association*; 1996.
 26. Verma SK, Biswas G. Knowledge and attitude on torture by medical students in Delhi. *Torture* 2005; 15: 46-50.
 27. O'Rielly KB. Future doctors flunk military medical ethics test. *American Medical News* 2007 Dec 17. <http://www.ama-assn.org/amednews/2007/12/17/prsb1217.htm> accessed 28 Feb 2009
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 29. Office of the Surgeon General, Assessment of detainee medical operations for OEF, GTMO and OIF (2005)
 30. Jesper Sonntag, 'Doctors' involvement in torture' (2008) 18 *Torture* 161-175.
 31. Pagaduan-Lopez J, Aguilar AS, Castro MCR, Eleazar JG, McDonald A, Schweickart AP. Crossing the line: a nationwide survey on the knowledge, attitudes and practices of physicians regarding torture. *Psychosocial Trauma Quarterly* 1997 (Jan-Mar): 21-2.
 32. Rachel Maxwell and Derek Pounder, 'The medicine and human rights special study module A Physicians for Human Rights (UK) initiative' *Medical Teacher* 1999; 21: 294-298.
 33. Id
 34. Leitch R, O'Connor MC. Appropriate Medical Monitoring? *ADF Health* 2005; 6: 15-18.
 35. See DI (G) OPS 33-1 and ADDP06.4 – Law of Armed Conflict. These deal with some, but not all, issues affecting military health professionals in issues related to LOAC and IHRL. Significantly, clause 8 of DI (G) OPS 33-1 provides that "ADF members are to be trained [in LOAC] to the level of understanding *appropriate for their duties and responsibilities*." [Insert added; emphasis added]. Clause 6 of DI (G) OPS 33-1 provides that the training adviser for LOAC training in the ADF is the Director-General of Defence Force Legal Services. The Service Chiefs are responsible for LOAC training and consequences of any breaches of LOAC, and the Directors of each Service's legal services are to provide their service's with legal support, including training (Clauses 11-15).
 36. Australian Defence Force. *Defending Australia in the Asia Pacific Century: Force 2030* at 8.70. http://www.defence.gov.au/whitepaper/docs/defence_white_paper_2009.pdf accessed 30 August 2009.
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