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DOCTORS, TORTURE, AND THE CANADIAN ARMED FORCES

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INTRODUCTION

Throughout history, torture has been present. Prior to 9/11, for many in the Western world, the word *torture* would conjure up images of the past such as the medieval device infamously known as the rack. But this has all changed. Even in modern Western democracies torture is far from a memory. The world was shocked by the images of torture that came out of the American-run military prison in Abu Ghraib, Iraq: hooded Iraqis attached to electrodes, forced positions that simulated homosexual felacio, naked prisoners piled upon each other, and men cowering in fear from vicious guard dogs. Photos depicting smiling American tormentors fuelled anti-American sentiment and radical Islamist recruitment. Of course, court marshals occurred and some perpetrators were punished. Had Abu Ghraib been seen as the isolated actions of a few rogue soldiers, perhaps the Americans would have suffered fewer consequences. But this was not an isolated incident, nor was it a strictly American issue. Guantanamo Bay would forever associate America with the practice of water boarding and force-feeding. The United Kingdom was not immune – *enhanced interrogation techniques*[1], a pseudonym for torture that had previously been banned in the 1970's by British Parliament were dusted off and re-applied with vigour in Iraq. The U.K. subsequently underwent formal internal military reviews as well as a full-blown public inquiry pertaining to the torture-induced death of Baha Mousa who was killed while in British Army custody.[2] The Canadian Armed Forces, though not directly implicated in the torturing of Afghan detainees, came

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[1] George W. Bush, *Speech on Torture*, 2006). - in this speech, President Bush referred to the CIA's use of an alternative set of procedures that were used on a prisoner because he resisted interrogation. The term *enhanced interrogation techniques* became a common public term sometime after this speech.

[2] "Baha Mousa Public Inquiry Report." https://www.gov.uk/government/publications/the-baha-mousa-public-inquiry-report (accessed April 15, 2015).

under considerable scrutiny when it became apparent that the military was complicit in the transfer of Afghan detainees to Afghan authorities who practiced torture. Indeed, torture is no longer viewed as something practiced historically. What is perhaps more surprising is the new ways in which medical professionals, and more specifically doctors, are commonly being drawn into the world of torture because of the legitimacy that the profession can confer on the practice of torture. This paper will argue that the medical professionals within the Canadian Armed Forces are not immune to the possibility that they could be drawn in as facilitators and legitimizers of torture. It will demonstrate that, given the long history of medical complicity in torture, the Royal Canadian Medical Services (RCMS) has gaps in the training that it provides military health care providers that could result in clinicians not being fully aware of their professional obligations pertaining to torture and the appropriate treatment of prisoners or detainees. In no way is this paper suggesting that the RMCS is intentionally under-educating its people when it comes to torture – it aims only to demonstrate that a gap exists and that this gap in training could result in dire consequences should certain circumstances arise.

The first section of this paper will examine the history of torture. This will include the motivations behind the practice and how these have changed over time. It will also examine the effectiveness of torture in terms of extracting *truthful and actionable intelligence*. This will be followed by a section examining some legal aspects and definitions of torture and how these compare to the medical community's point of view including those of select major medical governing bodies such as the World Medical Association and its national level counterparts. The third section will focus on the ways in which modern-day medical professionals can, knowingly or unknowingly, become

complicit in torture including some modern day examples. The final section will focus on the Canadian Armed Forces and RCMS. It will discuss the concept of dual loyalty as well as examine the specifics of what junior clinical personnel are being taught about torture at the RCMS school in Borden. Any gaps identified will be examined with an aim to rectifying training deficiencies.

History of Torture

For thousands of years torture has been used to achieve various ends. The ancient Greek practiced torture to extract truth from slaves for use in judicial proceedings – such methods were felt to enhance the truthfulness of evidence.[3] The Romans expanded its legal use to free persons for both determining proof and exacting punishment.[4] With the rise of Christianity, new outlooks related to principles of universal human equality eventually provided the catalyst for Pope Gregory the Great (6th century AD) to implement a ruling that discrediting any testimony obtained by torture.[5] Expanding this ruling beyond judicial proceedings, Pope Nicholas I banned the un-Christian practice of torture all together in 866 AD.[6] It remained banned in Europe until the 13th century when Pope Innocent IV re-emphasized the importance of torture within the Roman-canonical judicial system thereby ushering in its return for both confession extraction and punishment.[7] Europe essentially stepped backward in time, resurrecting the ancient thinking that viewed the use of torture as the only means of obtaining a reliable

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[3] Giovanni Maio, "History of Medical Involvement in Torture--then and Now," *The Lancet* 357, no. 9268 (May 19, 2001, 2001), 1609-11. p. 1609.
[4] Alfred W. McCoy, *A Question of Torture: CIA Interrogation from the Cold War to the War on Terror* (New York: Metropolitan Books, 2006). p. 16.
[5] Maio, *History of Medical Involvement in Torture--then and Now*, 1609-11 p. 1609
[6] McCoy, *A Question of Torture: CIA Interrogation from the Cold War to the War on Terror* p. 16.
[7] *Ibid*. p. 16.

confession.[8] Torture remained prominently embedded in Europe's legal systems before slowly beginning to fade away as individual states abolished the practice in the 18th and 19th centuries. These changes lead Victor Hugo to proclaim, in 1874, that "…torture had ceased to exist."[9] Unfortunately, Victor Hugo was wrong. Today's modern and advanced societies have routinely employed torture up to and including today. The Nazi's, the Soviet NKVD and KGB, the French in Algeria, and the American CIA in the War on Terror are just a few well-known examples of the continued use of torture.

Effectiveness of Torture

In the immediate aftermath of 9/11, many high ranking Americans justified the use of torture based upon the logic that harming one individual (through torture) could yield actionable intelligence that might result in the prevention of harm to many other people. This utilitarian "for the greater good" argument is often cited by those in favour of torture. The most cited counter argument pertaining to modern-day torture is that, in reality, torture is not effective at yielding useful or actionable intelligence because most people would say anything to stop being tortured. So who is right? The evidence accumulated over the course of history strongly suggests that, despite a small number of successes, torture not only fails at gathering actionable intelligence, it actually overwhelms intelligence officers with uncertain information leading to inefficiency and wild goose chases. Darius Rejali studied the alleged torture *successes* of the Gestapo and found them to be few in number and yielding of pathetic results, especially when

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[8] Maio, *History of Medical Involvement in Torture--then and Now*, 1609-11 p. 1609.
[9] McCoy, *A Question of Torture: CIA Interrogation from the Cold War to the War on Terror* p. 17.

"…compared with the devastating effects of public cooperation and informers."[10] Similarly, a Japanese field manual discovered in Burma in during WWII "…described torture as the clumsiest possible method of gathering intelligence."[11] Rejali noted that in addition to the potential lies from the person who actually *has* useful information, the more significant problem (from an intelligence gathering perspective) lies in "…the torture of the ignorant and innocent [that] overwhelms investigators with misleading information."[12]

The most recent official examination into state sanctioned torture is the US Senate Select Committee on Intelligence's 2014 report that studied the CIA's Detention and Interrogation Program.[13] The report, which is contested by some within the CIA, essentially concluded that the Agency misrepresented the effectiveness of *enhanced interrogation techniques* (a term viewed by many as a pseudonym for torture-assisted interrogation) and ultimately casts doubt upon CIA claims that they were able to extract *actionable intelligence* that lead to the thwarting of any meaningful threat to the United States or its allies.[14] In short, the CIA not only failed to provide evidence that torture works but also even went so far as to lie about its effectiveness to government officials.[15] Despite the program's apparent failure, many continue to defend the use of torture to gather intelligence.

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[10] Darius Rejali, "5 Myths about Torture and Truth," *The Washington Post*16 Dec, 2007.
[11] *Ibid*.
[12] *Ibid*.
[13] Senate Select Committee on Intelligence, *Committee Study of the CIA's Detention and Interrogation Program (Declassifed Revisions)*,[3 Dec 2014]).
[14] Jeremy Ashkenas et al., "7 Key Points from the C.I.A. Torture Report," *NY Times*9 Dec, 2014.
[15] Senate Select Committee on Intelligence, *Committee Study of the CIA's Detention and Interrogation Program (Declassifed Revisions)* p. 172.

Meanwhile Alan Dershowitz has written that, despite the many arguments that point to the ineffectiveness of torture, the fact is that it *sometimes* does work.[16] In fact, most of the pro-torture argument hinges upon the following highly improbable sequence of events: intelligence officers capture someone who actually has useful information, they recognize that this is the case and, presuming this person speaks, they then accurately sift through the lies and truths spoken in order to compile and disseminate the actionable intelligence gained in a manner fast enough to allow a meaningful response to the threat. All of these must align to enable a response but, to be considered a successful response, the lives saved (if any were saved) must outnumber the lives put at risk from the negative consequences that stem from being a state known to participate in torture. These include enemy radicalization, terrorist recruitment, reprisal torturing, and damage to international reputation. The scope of this paper does not permit a deeper examination of this debate in terms of its history or specifics; it serves only to highlight some key elements of the issue.

The Law on Torture

It seems clear that states will amend or interpret domestic laws and executive directives pertaining to torture in ways that will suit their national interests. In other words, if condoning the use of torture facilitates results in the achievement of a particular national security priority, then it can be culturally institutionalized. On the other hand, if outlawing torture gains a particular advantage in the international arena then it will be outlawed. When domestic or international law causes complications, then torture can be

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[16] Alan M. Dershowitz, *Why Terrorism Works* (New Haven and London: Yale University and Press, 2002). p. 137.

covertly outsourced to a third party state or organization. The point is that most states, Canada included, will always have the potential to resort to "legal" torture in dire circumstances.

The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment defines torture as follows:

> For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[17]

The United States adopted the convention "…only to the extent that it is consistent with the Eighth Amendment… [which] may not prohibit the use of force to obtain information; so if the United States chose to employ nonlethal torture in such an extreme case it could arguably remain in technical compliance with its treaty obligation."[18] Dershowitz also describes a common U.S. tactic of outsourcing torture to states like Jordan and Egypt who have and use techniques considered illegal in the U.S.[19] Canada is often considered a state that would never torture and it signed and ratified the UN Convention without reservation. But it would be naïve to conclude that there are no circumstances under which Canada would seek to disregard its legal commitments or seek to outsource torture if it was deemed to be in its national interest. Take for example

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[17] *Convention Against Torture and Other Cruel, Inhuman Or Degrading Treatment Or Punishment,* (): .
[18] Dershowitz, *Why Terrorism Works* p. 136. – Dershowitz fails to mention that the *jus cogens* status of the UN Concention Against Torture would almost certainly quash any domestic or international efforts to defend torture under the auspices of the Eighth Amendment.
[19] *Ibid*. p. 138.

the Supreme Court of Canada's 2002 decision in the case of *Suresh v. Canada.* Mr. Suresh faced deportation to Sri Lanka because of his alleged ties to the Tamil Tigers, "…an organization alleged to be engaged in terrorist activity in Sri Lanka, and whose members are also subject to torture in Sri Lanka.[20]" Although he was not deported, in its decision the Court allowed for significant ministerial discretion for determining whether or not individuals should be deported to a state known to torture:

> Although it is unnecessary in this case to review the Minister's decisions on deportation, where such a review is necessary the reviewing court should generally adopt a deferential approach to the Minister's decision on whether a refugee's presence constitutes a danger to the security of Canada. This discretionary decision may only be set aside if it is patently unreasonable in the sense that it was made arbitrarily or in bad faith, cannot be supported on the evidence, or the Minister failed to consider the appropriate factors. Likewise, the Minister's decision on whether a refugee faces a substantial risk of torture upon deportation should be overturned only if it is not supported on the evidence or fails to consider the appropriate factors. The court should not reweigh the factors or interfere merely because it would have come to a different conclusion.[21]

Whether or not a minister would actually deport someone to face torture may be politically reckless but the point is that, in Canada, it is not only possible but entirely legal.

Torture, the Historic Role of Doctors, and Physician Complicity Today

If one accepts that states can theoretically adapt or circumvent their own laws in order to gain intelligence via torture, then it follows that citizens of a state can become complicit with this practice. Here lies the origin of how doctors became involved in torture. It was in 16th century Europe when the first instance of physician complicity in

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[20] *Suresh V. Canada (Minister of Citizenship and Immigration), [2002] 1 S.C.R. 3, 2002 SCC 1. Accessed 26 April 2015.*
[21] *Ibid.*

torture, which was legal at the time, is recorded. "The German *Constitutio Criminalis Carolina*, written in 1532, required physicians to certify that an accused being considered for torture did not fall into one of the following six categories: "…the blind, the mute, the handicapped, the insane, the ill, and the pregnant."[22] In addition, doctors were required to offer advice regarding whether or not an accused could survive a particular method or severity of torture, advise when to stop the torture to avoid killing the accused, determine whether unconsciousness was real or simulated, and treat the accused injuries in order to facilitate further torture.[23] The torture physicians of the 16th and 17th centuries were engaging in a legal and legitimate practice, they were not coerced into playing their part.[24] Though some doctors spoke out against torture, their motivations were not for the good of the patient nor under the pretenses of the Hippocratic Oath to *do no harm* but rather in support of the perception that the practice yielded unreliable testimony.[25] As noted above, the 18th and 19th centuries saw European states gradually ban torture but this movement was by no means led by physicians who, for the most part, had merely been enablers of a legal and well established practice. It was during this time, in 1789, that Dr. Joseph-Ignace Guillotin and Dr. Antoine Louis took steps that would foreshadow the future role that many "…medical professionals would assume in facilitating twentieth century torture."[26] In a famous speech advocating an anti-torture law, Guillotin proposed a universal method of execution to be used for all classes of convicts.[27] Louis

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[22] Maio, *History of Medical Involvement in Torture--then and Now*, 1609-11 p. 1610.
[23] *Ibid*. p. 1610.
[24] *Ibid*. p. 1610.
[25] *Ibid*. p. 1611.
[26] Stephen H. Miles, *Oath Betrayed* (New York: Random House Inc., 2006). p. 27.
[27] *Ibid*. p. 27.

subsequently invented the decapitating machine commonly known today as the guillotine.[28]

With torture largely outlawed in Europe, its practice was driven underground throughout the 19th century before "it exploded into sight as a global crime against humanity in the twentieth century."[29] Dr. Stephen H. Miles is a leading researcher and activist in the fight against medical complicity in torture. His recent research contests that physicians (and psychologists) throughout the world have been and remain complicit in torture via the following ways:

- Examining prisoners and certifying them capable of withstanding harsh interrogation.
- Monitoring and treating persons during interrogation so that health-endangering treatment may proceed.
- Concealing evidence of abuse, either by designing nonscarifying techniques or by ensuring that medical documents or death certificates do not record injuries.
- Conducting abusive research.
- Overseeing the systemic neglect of prisoners' needs for health care, sanitation, food, and shelter.
- Failing to report prisoner abuse.[30]

Miles' observations represent a marked deviation from the general historical function of doctors in torture which was typically quite passive; they were "experts, advisers, and healers, [who] never took part in torture and, [unlike today], did not invent new methods or improve old ones.[31] But if the torture doctors in question are acting under the protection of the laws of their state, much as was the case in Europe 400 years ago, are these doctors doing anything wrong? The next section will examine the answer to this question from a physician governance point of view.

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[28] *Ibid*. p. 27.
[29] *Ibid*. p.28.
[30] *Ibid*. p.31
[31] Maio, *History of Medical Involvement in Torture--then and Now*, 1609-11 p. 1610.

Overarching Guidelines (Declaration of Tokyo and National Guidelines)

In 1975, the World Medical Association developed the *Declaration of Tokyo: Guidelines for Physicians concerning torture and other Cruel and Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* which has since been revised in 2006. Its key provisions stipulate that doctors shall:

- not countenance, condone or participate in the practice of torture
- not provide any premises, instruments, substances or knowledge to facilitate the practice of torture
- ensure patient confidentiality of personal medical information and report Geneva Convention breaches
- not be present during any procedure during which torture
- not force feed mentally competent prisoners[32]

Many National Medical Associations endorse the Declaration of Tokyo thereby making it a standard of practice for the medical community in that country. The Canadian Medical Association endorses it and adds the following additional statement regarding torture: "That the Canadian Medical Association believes that all physicians and medical associations should refuse to allow their professional or research skills to be used in any way for the purpose of torture or punishment of prisoners."[33] The Canadian Nurses Association's Code of Ethics makes the following comment: "Nurses do not engage in any form of lying, punishment or torture or any form of unusual treatment or action that is inhumane or degrading. They refuse to be complicit in such behaviours. They intervene, and they report such behaviours."[34]

The American Medical Association (AMA) has a more elaborate statement pertaining to torture that quite similar to that of the WMA:

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[32] World Medical Association, *The Declaration of Tokyo*, 1975 (revision 2006)).
[33] Canadian Medical Association, *Policy Resolution BD80-03-99 -Treatment of Prisoners*.
[34] Canadian Nurses Association, *Code of Ethics*, 2008). p. 17.

> Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment.
> Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened.
> Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue. Physicians who treat torture victims should not be persecuted. Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great.[35]

The British Medical Association (BMA) has issued similar statements condemning medical complicity in torture.[36]

Whereas states and lawyers can argue the merits of torture based upon concepts of jurisdiction, legality, geography, and national security, the medical profession harbors no such nuance – in fact, it is quite black and white. The Declaration of Tokyo instructs physicians in unambiguous terms: thou shalt not perform torture, witness torture, or do anything to assist, legitimize, or optimize the practice of torture. If a country's national medical association endorses the Declaration of Tokyo (or has its own similar resolution) then adhering to it becomes the standard of care. More importantly, veering from this norm could and should result in professional disciplinary action up to and including the revocation of one's license to practice medicine. The next section will examine some recent cases of medical complicity in and opposition against torture.

Contemporary Examples of Medical Complicity in Torture

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[35] American Medical Association, *Opinion 2.067 - Torture*, 1999).
[36] British Medical Association, "BMA Condemns Medical Involvement in Torture," (16 January, 2014).

Unfortunately, medical complicity in torture is not as rare as one would hope. Take Dr. Derek Keilloh, a British Army doctor who served in Iraq. In 2003, members of his unit tortured Mr. Baha Mousa, a detainee in British custody, so severely over the course approximately 36 hours that, ultimately, it killed him.[37] The case garnered international attention and prompted a public inquiry. On the positive side, the inquiry revealed that Keilloh, who was not present during the torture, lead an unsuccessful but medically competent attempt to resuscitate Mousa.[38] But his professional conduct was called into question because he failed to document 93 injuries that were found on a subsequent post-mortem examination – injuries that expert witnesses at the inquiry testified would have been "impossible" not to notice.[39] The self-regulated British Medical Practitioner Tribunal Service (MPTS) decided to have Keilloh struck off the register of physicians as a result of his repeated dishonesty pertaining to the case. Using Miles' framework of medical complicity in torture, Keilloh would be guilty of facilitating the practice of torture by falsifying a death certificate and by failing to report what he saw to a higher authority. In this case, a physician, who despite not charged with any criminal offense, was stripped of his license to practice medicine because of his failure to live up to the standards expected of the profession.

A second, less specific example, of medical complicity in torture is evident through a simple examination of the U.S. Senate Select Committee on Intelligence's review of the CIA's detention and interrogation program. A search of the document reveals a plethora of violations of the Declaration of Tokyo. It is clear that it was routine

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[37] "Baha Mousa Public Inquiry Report." Accessed 15 April 2015.
[38] *Ibid.*
[39] British Medical Association, "BMA Stresses Need for Ethical Awareness in Conflict," 21 Dec, 2012.

for medical personnel for medical personnel to be present during torture, in fact, it seems the CIA felt if necessary to have medical personnel observe.[40] One interrogation was paused so that CIA medical personnel to treat a detainee's "…swelling in order to allow for further use of standing sleep deprivation."[41] The report goes on to detail how "…at least five CIA detainees were subjected to "rectal rehydration" or rectal feeding without documented medical necessity."[42] Psychologists played a particularly vital role in that they developed many interrogation techniques and, ultimately formed a company in 2005 to facilitate their work for the CIA.[43] This company billed the U.S. government $81 million dollars between 2005 and 2009, not including a CIA-provided "… multi-year indemnification agreement to protect the company and its employees from legal liability arising out of the program.[44] Countless other examples of medical complicity in the program appear throughout the report including this medical officer's observations and comments about waterboarding:

> "The sessions accelerated rapidly progressing quickly to the water board after large box, walling, and small box periods. [Abu Zubaydah] seems very resistant to the water board. Longest time with the cloth over his face so far has been 17 seconds. This is sure to increase shortly. NO useful information so far. He did vomit a couple of times during the water board with some beans and rice. It's been 10 hours since he ate so this is surprising and disturbing. We plan to only feed Ensure for a while now. I'm head[ing] back for another water board session."[45]

What kind of doctor is this? The cavalier attitude apparent in this email demonstrates the extent to which torture had become normalized in Guantanamo Bay. This physician

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[40] Senate Select Committee on Intelligence, *Committee Study of the CIA's Detention and Interrogation Program (Declassifed Revisions)* p. 40.
[41] *Ibid*. p.3 of Executive Summary.
[42] *Ibid*. p. 4 of Executive Summary.
[43] *Ibid*. p. 11.
[44] *Ibid*. p. 11.
[45] *Ibid*. p. 41.

showed a complete disregard for the standards of practice required by both the American and World Medical Associations: s/he was present during torture, s/he modified a patient diet to facilitate torture, and although not mentioned in the report, it appears that s/he did not object to or report the torture to appropriate authorities. Unfortunately, this physician and the many other medical personnel who assisted in the facilitation of torture in Guantanamo Bay will likely never face any legal or professional consequences for their actions. Their state-defended anonymity makes them untouchable, a fact that is legally formalized by American state-secrets doctrine.[46]

Fortunately, not everyone who worked in Guantanamo Bay blindly followed orders and participated in these inhuman practices and torture. But standing up against torture can have severe personal consequences. In November 2014, the *NY Times* reported what is considered to be the "…first known defiance of Guantanamo's force-feeding procedure": an American Naval Nursing officer who refused to force-feed a Guantanamo Bay detainee on hunger strike.[47] The American Nurses Association (ANA), citing professional ethical guidelines, has launched a campaign in support of this officer who now faces potential disciplinary consequences from the Navy.[48] A board of inquiry would have the authority to dishonorably discharge him thereby eliminating his pension entitlements.[49] This represents a modern day case of dual loyalty that military medical professionals are at risk of encountering. When the military chain of command orders a medical professional to perform and act that runs afoul of his or her ethical or

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[46] American Civil Liberties Union, "Background on the State Secrets Privilege," https://www.aclu.org/background-state-secrets-privilege (accessed 4 May, 2015).
[47] Benedict Carey, "Nurses Urge Leniency Over Refusal to Force-Feed at Guantanamo Bay," *NY Times*19 November, 2014.
[48] *Ibid.*
[49] *Ibid.*

professional standards, what is he or she to do? This author believes that the nurse in this case chose correctly but it seems clear that his choice may have dire consequences for his career.

Canadians are by no means immune to such dilemmas. The recent Afghan detainee transfer scandal, although it did not seem to force such dilemmas on medical personnel, brought the issue of torture to the forefront of the minds of many Canadians. To find a specific Canadian example, one needs only to look back to the early 1990's. Major Barry Armstrong, once famously known as the whistleblower that sparked the Somalia Inquiry, faced such a dilemma. When Canadian soldiers tortured and murdered Shidane Arone (a Somali civilian) and then tried to cover it up, Armstrong, with the assistance of his wife, reported the scandal to the press.[50] Several years of inquiry followed leaving an embarrassing mark on Canada's international reputation and causing Canadians to question the professionalism of its armed forces and, more specifically, its leadership. At the crossroads of dual loyalty, Armstrong chose the path paved by professional ethics rather than a path of blind military loyalty. He retired six months after returning from Somalia and has largely faded from the national memory.[51] He is not celebrated as a great Canadian citizen nor do the Royal Canadian Medical Services hold him up as an example for other medical professionals to emulate. Perhaps it is time this changed.

Canadian Military Education – are professional guidelines pertaining to torture taught to military medical personnel?

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[50] *Somalia Affair: The Whistleblower*, Television, directed by CBC News 1993). Accessed 26 April 2015.
[51] *Ibid.*

If positive examples, such as that which was set by Armstrong, are not being discussed by Canadian Armed Forces medical personnel during their early training, it begs the question what *is* being taught regarding ethics and professional medical expectations. The Canadian Forces Health Services Training Centre (CFHSTC) located in Borden, Ontario is responsible for the vast majority of training for medical personnel in the Canadian Armed Forces. It conducts several courses including the Basic and Advanced Medical Officer Courses (BMOC and AMOC) for Physicians, the Basic Nursing Officer Course (BNOC) for nurses, courses for Pharmacists, Bioscience Officers, Health Care Administrators, and a series of courses offered over the career of our front line Medical Technicians up to the level of Physician Assistant. Given that every medically-oriented position in the Canadian Armed Forces is given training at this school, it is vital that they teach professional and ethical standards.

And they do. The current medical director at the CFHSTC in Borden, Major Richard Morin, confirmed that the school teaches military health care provider responsibilities to enemy combatants (and refugees, displaced persons, …) making reference to the Geneva Conventions only. The teaching is explicit that torture is viewed as a violation of the Laws of Armed Conflict. Unfortunately, the WMA Declaration of Tokyo and the UN Convention Against Torture are not taught or referenced in any course at the CFHSTC. Here lies the disconnect. It is important to note that this paper does not argue any conspiracy or incompetence behind this oversight. It seems logical that military medical professionals should be well-versed in the Geneva Conventions and Laws of Armed Conflict (and the varied interpretations thereof). But that is only half of the issue. In addition to being a medic or doctor during conflict, military medical personnel, where

applicable, are licensed by independent civilian governing bodies. These bodies expect doctors, nurses, and pharmacists to know what is expected of them in terms of ethics and professionalism. The fact that the CFHSTC does not spend any time covering the content of the WMA's Declaration of Tokyo is an oversight to say the least. If the CFHSTC does not teach this to medical personnel, no one else will and the knowledge gap created could set soldiers up for failure if and when they encounter a dual loyalty dilemma.

The Way Ahead for the Royal Canadian Medical Services

Correcting the gap in ethical training is relatively simple. The Royal Canadian Medical Services needs to ponder the message that it wants to send when it comes to addressing the dual loyalty dilemma. Black and white decisions are always simple. It is in the grey where military medical personnel will face the dual loyalty dilemma and they will be forced to decide if they are going to behave as an obedient officer or as a medical professional knowing that this choice could result in disciplinary consequences from the military or in professional consequences from their medical governing body. To begin, the RCMS must open up the topic for discussion.

Certainly, core courses for all medical personnel should review the WMA's Declaration of Tokyo and the CMA's policy resolution pertaining to torture. Nurses should be familiar with the CNA's ethical guidelines. Pharmacists, bioscience officers, health care administrators and medical technicians should all be exposed to this guidance as well as the UN Convention Against Torture. Each course should also conduct a case study of Dr. Barry Armstrong's actions in regards to the Somalia affair.

By doing the above, the RCMS would gain greater institutional credibility. It would be getting ahead of an area that could cause future problems. More importantly, it

would better equip its people to deal with said problems when and if they should arise. The licenses of Canada's military doctors, nurses, pharmacists, and physician assistants are bestowed by civilian licensing bodies who expect the highest standards of ethics from their respective licensees. If the RCMS does not take a proactive approach with its ethical training pertaining to torture it could risk losing the faith of these licensing bodies. Military leadership sometimes speaks about the concept of "the *Globe and Mail* Test" referring to how particular military decisions or actions will be written about in the press thus informing the opinions of everyday Canadians. Let us examine two versions of one fictional scenario. A Canadian doctor is present during a harsh interrogation of an ISIS detainee by American military interrogators – this includes techniques similar to those used in Guantanamo Bay such as slapping, sleep deprivation, stress positions, and so on. The doctor is uncomfortable with the situation but is reassured by the Americans that he is only there to observe and treat any injuries that might be caused. So, the doctor despite his discomfort stays, observes, treats minor injuries, and perhaps at some point advises on how to insert a nasogastric tube needed to feed the detainee (against his will) because the detainee has started a hunger strike in protest. Two years later it makes national headlines that a Canadian doctor was present during the torture of an ISIS detainee. The doctor testifies that s/he thought s/he was doing everything right despite his/her discomfort. When asked about why s/he breached the professional standards set out by the WMA and CMA, all s/he can say is that s/he never heard of the Declaration of Tokyo or any other such guideline. S/he didn't think what was happening was torture.

In the alternate version of this scenario, the doctor, citing his professional obligations as per WMA and CMA policy, refuses not be involved in any way and walks out.

Which version reflects better on the doctor, the RCMS, and the Canadian Armed Forces? Though this specific scenario may not be likely, it is used to show an example in which ignorance and loyalty can combine to cause harm.[52]

Conclusion

Torture has been part of Western society for hundreds of years. Over that time, it gradually became outlawed through a series of national and international laws and conventions. Despite legal impediment and its proven ineffectiveness, states continue to find ways to justify and legitimize the use of torture when it suits their needs. Unfortunately, doctors and other medical personnel have long been associated with the practice of torture. Their role has shifted from that of a passive bureaucratic-like enabler of a well-established legal practice to an active participant in the development, use, and cover up of torture.[53] Today, Western doctors continue to be implicated in torture such as that occurring in Guantanamo Bay and in the case of Dr. Derek Keilloh from the U.K. Canadians are by no means immune to complicity in torture or the ethical, legal, and professional liability that flows therefrom. In fact, it is perfectly legal for the Canadian government to deport people to countries known to torture.[54] It was only twenty years

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[52] "Omar Khadr." http://en.wikipedia.org/wiki/Omar_Khadr (accessed May 4, 2015). In fact, the example used is not as unlikely as one would hope. The case of Omar Khadr is a well-known example of a Canadian citizen who, after being captured in combat in Afghanistan at the age of 15, was transferred to Guantanamo Bay where he faced interrogation and torture. Although no Canadian Doctor has been implicated, it is clear that he would have seen several doctors during his time in detention. Their role in his torture is not clear.
[53] Miles, *Oath Betrayed* p. 31.

ago that the Somalia Affair shook the very foundation of Canada's military. Somalia produced a shining example of a physician who stood up against torture (and murder) but today Dr. Barry Armstrong is rarely discussed or remembered in any meaningful way.

Armstrong has not only faded from the general Canadian memory, he does not even appear in any of the ethical training offered by the CFHSTC. Unfortunately, the CFHSTC is missing an important opportunity to imprint its ethical expectations pertaining to torture and other degrading treatment in the minds of its newest medical practitioners. The WMA declaration of Tokyo and the national medical/nursing association positions on torture (and similar organization for other professions) should be an integral part of the ethical training offered at CFTHSC. To do anything otherwise is inviting our people to fail when challenged with the dilemma of dual loyalty. For the majority of their careers, Canada's military medical personnel will have no trouble simultaneously living up to the standards of the military and the medical profession. But when satisfying the requirements of one means failing to meet the standards of the other, a difficult choice must be made. Not knowing what is expected further complicates that choice.

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[54] *Suresh V. Canada (Minister of Citizenship and Immigration), [2002] 1 S.C.R. 3, 2002 SCC 1. Accessed 26 April 2015.*

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