Het humanitair oorlogsrecht (HOR) mag zich tegenwoordig in een grote belangstelling verheugen in juridische publicaties. Sommige aspecten van dit rechtsgebied blijven echter enigszins onderbelicht: dit geldt onder andere voor medische aspecten van het HOR. De artikelen van Mehring en Zwanenburg gaan vanuit verschillende invalshoeken beide in op deze aspecten. Mehring beschrijft de belangrijkste bepalingen in de verdragen van Geneve en de Aanvullende Protocollen betreffende de zorg voor zieken en gewonden, en de rechten en plichten van artsen die die zorg geven. Zij concludeert dat de medische ethiek kan helpen duidelijkere grenzen te stellen waar de bepalingen van de verdragen ruimte laten. Zwanenburg gaat in op enkele recente casus uit de praktijk betreffende de bescherming van gewonden, medisch personeel en medische inrichtingen. Hieruit blijkt dat de medische aspecten van het HOR in de praktijk een belangrijke rol spelen.

The Rights and Duties of Physicians in Armed Conflict

door Mr. Sigrid Mehring[1]

Physicians are not only essential, generally protected actors in armed conflict with a very specific set of rights, they also have certain duties. Recently, questions resurfaced concerning the duties of physicians in armed conflicts: namely the role of physicians in reporting violations of international humanitarian law, especially torture, and their own involvement in such practices. Through scrutinizing the protection of the wounded and sick, both combatant and civilian, on the one hand, and the protection of medical personnel on the other, this article sheds light on the parameters of medical treatment in armed conflict. The conclusion must be that although international humanitarian law provides a workable, intricate, and detailed basis for the work of physicians in armed conflict, the ethical boundaries of medical care and the associated possibility of 'medical' grave breaches deserve further study and attention.

I. Introduction

Physicians, among the medical personnel in charge of the medical treatment of the wounded and sick in armed conflict, present such an important, essential category of persons in armed conflicts that their rights and duties under international humanitarian law deserve an in depth analysis.[1] They are the first to treat wounded and sick combatants as well as civilians. In this

[1] Maurice Torrelli, 'La Protection du Médecin dans les Conflits Armés' In: C. Swinarski, *Studies and Essays on International Humanitarian Law and Red Cross Principles in honour of Jean Pictet*, Martinus Nijhoff Publishers, Geneva, 1984, p. 582.

position physicians can fulfill a further role by reporting on human rights abuses or violations of international humanitarian law. A recent example highlights this important role: with their insider-report of the 2008/2009 Gaza conflict, the Norwegian physicians Mads Gilbert and Erik Fosse were among the first eye-witnesses to provide an account of the events.[2] They found violations of the neutral status of the Red Cross by the conflict parties and reported on wounds from white phosphorus and DIME-bombs.[3] Physicians are in a privileged position to watch over the rights of the victims of armed conflicts.

However, their position is also susceptible for abuse. This was shown by a Report by the International Committee of the Red Cross (ICRC) of February 2007. The Report addresses the medical treatment of 14 high-value detainees in Guantanamo Bay and calls for more transparency and improvement of the conditions in the detention unit by the United States.[4] One Chapter of the Report is wholly dedicated to the discussion concerning medical ethics of the physicians treating the detainees and the ICRC establishes:

> 'The alleged participation of health personnel in the interrogation process and, either directly or indirectly, the infliction of ill-treatment constituted a gross breach of medical ethics and, in some cases, amounted in participation in torture and/or cruel, inhuman or degrading treatment.'5

Even though the Report does not explicitly state whether the ICRC is of the opinion that physicians have committed violations of international humanitarian law and it is doubtful whether and to what extent international humanitarian law is applicable in the so called "war on terror",[6] it nevertheless demonstrates that questions of medical ethics in armed conflicts are still at the heart of international humanitarian law.

This Article will examine the legal framework in international humanitarian law relevant to understanding the rights and duties of physicians as part of medical personnel in armed conflicts. The focus will be on the protection of the medical personnel which is inextricably linked to the protection of its performance of medical duties essential for the treatment of those in need of medical care.

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[2] Mads Gilbert and Erik Fosse, Inside Gaza's Al-Shifa Hospital, *The Lancet* (373) 2009.

[3] Although so-called 'focused lethal munition' is not prohibited under international disarmament agreements, experts have voiced concerns about their effects. UN Report of the Secretary-General on the Protection of Civilians in Armed Conflict of 29 May 2009, UN Doc S/2009/277, para. 36; see also UN Report of the United Nations Fact-Finding Mission on the Gaza Conflict (*Goldstein Report*) of 25 September 2009, UN Doc. A/HRC/12/48, para. 907 – 908.

[4] International Committee of the Red Cross, *ICRC Report on the Treatment of Fourteen 'High-Value Detainees' in CIA Custody,* WAS 07/76, 14 February 2007.

[5] ICRC Report, p. 26 – 27.

[6] Certain aspects of the 'War on Terror' are to be classified as an armed conflict: Silja Vöneky, The Fight against Terrorism and the Rules of the Law of Warfare, In: C. Walter et al. (Eds.), *Terrorism as a Challenge for National and International Law*, 2004, p. 944; Hans-Peter Gasser, International Humanitarian Law, the Prohibition of Terrorist Acts and the Fight against Terrorism, *YIHL* (4) 2001, p. 345; Catherine Moore, The United States, International Humanitarian Law and the Prisoners at Guantanamo Bay, *Journal of International Human Rights* (7) 2003, p. 3. Conversely: Christopher Greenwood, International Law and the 'War against Terrorism', *International Affairs* (78) 2002, p. 305 who rejects the classification as an armed conflict; J.B. Bellinger, Legal Issues in the War on Terrorism – A Reply to S. Vöneky, *German Law Review* (8) 2007, p. 872 who agrees with the classification as an armed conflict yet denies treating prisoners as prisoners of war.

II. The Rights and Duties of Physicians in Armed Conflict under the Geneva Conventions of 1949 and the Additional Protocols of 1977

The protection of medical personnel in armed conflicts is the logical corollary to the protection of the wounded and sick. Physicians, as medical personnel, minimize the number of victims of war. The Conventions and Additional Protocols establish a tight framework of physicians' rights and duties, yet also their protection. To understand the overall role of physicians as medical personnel in armed conflict, the relevant provisions will be outlined below.

On 12 August 1949 the four renewed Geneva Conventions were adopted.[7] Next to retaining the basic principles of the initial Conventions, the Geneva Conventions of 1949 also launched some new concepts that revolutionized the laws of armed conflict: the victims of war are addressed as 'protected persons' and medical personnel was finally included. With their universal ratification,[8] the Conventions are widely accepted as customary international law.

On 8 June 1977 the ICRC adopted the set of Protocols Additional to the Geneva Conventions of 12 August 1949. Unlike the Conventions, the Additional Protocols are both a convergence of Geneva and The Hague Law: they address both the protection of the victims of war, as well as the means and methods of warfare. The first Additional Protocol (AP I)[9] supplements the provisions dealing with international armed conflicts, whereas the second Additional Protocol (AP II)[10] addresses non-international armed conflicts.

1. Persons entitled to Treatment and Manner of Treatment

a. Respect for the Wounded and Sick

The identical article 12 GC I and II stating that 'members of armed forces and other persons mentioned […] who are wounded or sick, shall be respected and protected in all circumstances' contains the basis for the Geneva Conventions.[11] Those who are *hors de combat* due to being wounded, sick or shipwrecked and who refrain from acts of hostility should be protected in all circumstances. This is an absolute obligation that cannot be breached by invoking military necessity.[12] The severity of wounds or sickness needed for the protection is not detailed in the provision because any limitation would undesirably narrow the scope of protection.[13] The protection is

[7] Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in the Armed Forces in the Field (GC I); Geneva Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea (GC II); Geneva Convention relative to the Treatment of Prisoners of War (GC III); and Geneva Convention relative to the Protection of Civilian Persons in Times of War (GC IV), of 12 August 1949, 75 *U.N.T.S.* 31 – 417 (1950).

[8] See http://www.cicr.org/ihl.nsf/WebSign?ReadForm&id=375&ps=P. In comparison: the United Nations has 192 member states, see http://www.un.org/en/members/index.shtml.

[9] Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Additional Protocol I), of 8 June 1977, 1125 *U.N.T.S.* (1979) 3 – 608.

[10] Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Additional Protocol II), of 8 June 1977, 1125 *U.N.T.S.* (1979) 609 – 699.

[11] The provisions are applicable to those persons listed in article 13 GC I and II (article 12 GC II makes it equally applicable to the shipwrecked); a requirement for protection is the entitlement to the prisoner of war status of article 4 (A) of GC III.

[12] Hilaire McCoubrey, 'The Nature of the Modern Doctrine of Military Necessity' In: *Revue de Droit Militaire et de Droit de la Guerre*, (30) 1991, 215-252, p. 220 – 221 and 239.

[13] Jean Pictet, *La Convention de Genève pour l'Amélioration du sort des Blessés et des Malades dans les Forces Armées en Campagne*, Comité Internationale de la Croix-Rouge, Genève, 1952, p. 150.

twofold: they shall be 'protected,' which entails a positive obligation for adversary states, but also physicians and medical personnel,[14] to give them the necessary care; and 'respected' which entails a negative obligation meaning that no individual or State is to harm them in any way.[15]

Article 10 AP I extended this principle, namely that the wounded, sick and shipwrecked of all parties to the conflict, both military and civilian,[16] are to be protected and respected at all times. They shall furthermore be treated humanely. Article 10 (2) AP I moreover reiterates the principle that the wounded and sick should 'to the fullest extent practicable and with the least delay, receive the medical care and attention required by their condition'. 'No one is expected to do the impossible'[17] but an attempt should be made to provide the care and attention as required.

Whereas common article 3 to the Conventions simply required the wounded and sick to be 'collected and cared for', article 7 AP II ameliorated their protection by providing similar protection and respect to that of article 10 AP I. It is the 'keystone' of the regime concerning non-international conflicts. The protection is extended to 'all persons who do not take a direct part or who have ceased to take part in hostilities'.[18]

b. Medical Treatment

Article 11 AP I is aimed at protecting persons against certain medical procedures, and at the same time details the obligations of medical personnel when providing medical care.[19] Noteworthy is that it is not confined to the wounded and sick but rather *all* detained persons.[20] Article 5 (2)(e) AP II contains a comparable provision yet is limited to persons detained or interned 'for reasons related to the armed conflict' and only concerns prohibition of unwarranted medical procedures, equal to article 11 (1) AP I.[21]

Persons, both military and civilian, in the power of an adverse party, or those who are interned, detained or otherwise deprived of liberty *as a result of* a situation referred to in article 1 AP I, namely armed conflicts and occupation as determined in common article 2 Conventions of 1949 fall under the protection of article 11 AP I. The protected persons 'shall not be endange-

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[14] Alma Baccino-Astrada, *Manuel des Droits et Devoirs du Personnel Sanitaire lors des Conflits Armés*, La Croix-Rouge, Genève, 1982, p. 39.

[15] Pursuant article 14 GC II the wounded, sick and shipwrecked on hospital ships can be requested to be surrendered to an adversary warship if they are fit enough to be transferred and the ship requesting their surrender is able to afford them with adequate medical care. Hilaire McCoubrey, *International Humanitarian Law - Modern Developments in the Limitation of Warfare*, 2nd Ed., Ashgate Dartmouth, Aldershot, 1998, p. 123.

[16] Yves Sandoz et al., *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, Martinus Nijhoff Publishers, Geneva, 1987, para. 444; Maurice Torrelli, *Le Droit International Humanitaire*, Presses Universitaires de France, Paris, 1985, p. 46.

[17] Sandoz et al., *Commentary to the Additional Protocols*, para. 451.

[18] Ibid. para. 4634 and 4642. The principle of non-discrimination and the duty to treat wounded and sick on the basis of medical priority will be examined in subparagraph c), see below.

[19] Ibid. para. 460.

[20] Frits Kalshoven and Liesbeth Zegveld, *Constraints on the waging of War - an Introduction to International Humanitarian Law*, 3rd Ed., International Committee of the Red Cross, Geneva, 2001, p. 118.

[21] The ICRC Commentary states that: '[article 5 paragraph] 2 may be considered as a sort of guideline which may be developed, depending on the circumstances and the goodwill of those responsible; the few rules that are given serve as illustrations and should not be interpreted restrictively or rigidly'. Sandoz et al., *Commentary to the Additional Protocols*, para. 4581. See also Jann Kleffner, 'Protection of the Wounded, Sick and Shipwrecked' In: D. Fleck, *The Handbook of International Humanitarian Law*, Oxford University Press, New York, 2008, para. 606.

red by any unjustified act or omission' that voluntarily or by negligence affects a person's health and integrity.[22] Addressees of article 11 AP I are parties to the conflict and those under their responsibility. Private persons violating this article on their own behalf and not on behalf of the authority of one of the parties to the conflict, such as private doctors, are thus not affected.[23]

Moreover 'any medical procedure which is not indicated by the state of health of a person concerned *and* which is not consistent with generally accepted medical standards' (emphasis added) is prohibited. The first cumulative criterion was necessary to prohibit procedures detrimental to the health of a patient or not required by his health; medical procedures should be therapeutic or prophylactic.[24] Secondly, to offer sufficient protection, a medical procedure also needs to be compatible with generally accepted medical standards. The person conducting such a procedure, most probably a doctor or trained paramedic, should apply the standards he would apply 'under similar medical circumstances to persons who are nationals of the Party conducting the procedure and who are in no way deprived of their liberty'. The ICRC Commentary suggests that this criterion could be interpreted by the use of documents of the World Medical Association (WMA) but concedes that a 'universally adopted international instrument' is lacking.[25] A dynamic reference to the WMA documents could offer certainty which the provision is currently lacking. It could also guide medical personnel working in armed conflicts. Nonetheless, it is not clear whether this is exactly what the drafters intended and whether a reference to the WMA can suffice, especially if violations of such standards could be prosecuted as grave breaches of the Protocol.[26]

Article 11 (4) AP I gives teeth to the protection:[27] (1) any *wilful* act that (2) *seriously* endangers the health and integrity of a person (3) in the power of the adverse party and not its own national, *and* (4) does not meet the requirements of the previous three paragraphs or violates them 'shall be a grave breach of this Protocol'. The effect of the medical procedure must affect the person treated in a long-lasting or crucial manner. The provision only applies to acts committed against a person 'who is in the power of a party other than the one on which he

[22] The ICRC Commentary to the Additional Protocols specifies that the justification must be based on medical as well as ethical grounds. Sandoz et al., *Commentary to the Additional Protocols*, para. 467.

[23] Michael Bothe et al., *New rules for Victims of Armed Conflicts - Commentary on the two 1977 Protocols Additional to the Geneva Conventions of 1949*, Martinus Nijhoff Publishers, The Hague, 1982, p. 112; 116.

[24] ICRC, Conference of Government Experts on the Reaffirmation and Development of International Humanitarian Law applicable in Armed Conflicts, *Report on the Work of the Conference,* Vol. 1, CE 1972, July 1972, p. 33 – 34; also Waldemar Solf, 'Development of the Protection of the Wounded, Sick and Shipwrecked under the Protocols Additional to the 1949 Geneva Conventions' In: C. Swinarski, *Studies and Essays on International Humanitarian Law and Red Cross Principles in honour of Jean Pictet*, Martinus Nijhoff Publishers, Geneva, 1984, p. 241.

[25] Sandoz et al., *Commentary to the Additional Protocols*, para. 476. See also Bothe et al., *New rules for Victims of Armed Conflicts*, p. 113. With regard to Additional Protocol II, the ICRC Commentary specifies that 'generally accepted medical standards' are 'i.e. medical ethics'. Sandoz et al., *Commentary to the Additional Protocols*, para. 4593.

[26] Hervé Ascencio, 'Bioétique et Droit Humanitaire' In: S. Maljean-Dubois, *La Société Internationale et les Enjeux bioétiques - Treizième Rencontres Internationales d'Aix en Provence - Colloques de 3 et 4 décembre 2004*, Éditions A. Pédone, Paris, 2005, p. 106.

[27] Article 28 Geneva Convention 1929 already called upon the signatories to amend their military penal laws to accommodate '[repression], in time of war, [of] individual acts of robbery and ill treatment of the sick and wounded of the armies, as well as to punish, as usurpations of military insignia, the wrongful use of the flag and brassard of the Red Cross by military persons or private individuals not protected by the present convention'. Liselotte B. Watson, 'Status of Medical and Religious Personnel in International Law' In: *JAG Journal*, (1965) Vol. 20: 41 - 59, p. 44.

depends'. The paragraph expressly does not use the nationality category to avoid definitional problems. In general, Article 11 AP I is applicable to a party's own nationals but denial of the provisions cannot result in a grave breach.[28] Classifying an act as a grave breach is the utmost sanction within the system of international humanitarian law. This is a serious consequence that can be incurred by medical personnel in the provision of medical care to nationals of another party to the conflict.

Pursuant to article 11 (5) AP I, the wounded and sick have a right to refuse surgical procedures even if required by their state of health. The medical personnel should try to obtain the refusal in written form, 'signed or acknowledged by the patient'.[29] Because of practical realities, a voiced refusal by a patient should be sufficient but some proof of refusal should be provided to avert charges of seriously endangering a person's health.[30]

Article 11 (6) AP I determines categorically that every party to an armed conflict is to keep a record of all blood and skin donations under its responsibility, and less stringently, that all parties should *endeavor* to keep a record of all other medical procedures carried out on persons in their power or those deprived of their liberty. Whether in practice it is indeed feasible to keep a record of *all* medical procedures carried out on *all* persons within the power of a party to the conflict is questionable.

c. The Prinicple of Non-Discrimination

Article 12 GC I and II establishes the principle of non-discrimination, one of the fundamental norms of international humanitarian law:[31] 'sex, race, nationality, religion, political opinions, or any other similar criteria' shall not play a role in the treatment of the wounded and sick.[32] The list is non-exhaustive.[33] Article 10 (2) second sentence AP I concisely reiterates the principle yet leaves out an enumeration of possible grounds for discrimination. A differentiation between the wounded and sick is only acceptable if the severity of wounds or the overall medical condition justify a difference in treatment. The principle of non-discrimination except on medical grounds is also applicable in non-international armed conflicts pursuant articles 7 (2) and 9 (2) AP II. Naturally, during triage a physician will differentiate between those to be treated and determine the order and means of treatment; as long as the choice is based on medical reasons and not on other considerations, this is a legitimate and necessary procedure. It should be assumed that medical ethics govern all decisions by medical personnel.[34]

d. Prohibited Procedures

Biological experiments, willfully leaving the wounded and sick without medical assistance and care, and creating conditions exposing them to contagion or infection are all strictly prohibited

[28] Solf, 'Studies in honour of Jean Pictet', p. 242. This restriction was meant to ensure the sovereignty of parties to a conflict over their own nationals and was in line with article 85 (1) AP I concerning grave breaches. Sandoz et al., *Commentary to the Additional Protocols*, para. 493 (b); Bothe et al., *New rules for Victims of Armed Conflicts*, p. 118.
[29] In this paragraph, the term 'patient' is used for the first time in Additional Protocol I.
[30] Baccino-Astrada, *Manuel des Droits et Devoirs du Personnel Sanitaire lors des Conflits Armés*, p. 42.
[31] McCoubrey, *International Humanitarian Law*, p. 82 – 83.
[32] The principle of non-discrimination is reiterated in article 30 GC II concerning hospital ships: they are also to treat all wounded, sick and shipwrecked equally and not distinguish between nationalities.
[33] Pictet, *Commentary I*, p. 151 – 152.
[34] Bothe et al., *New rules for Victims of Armed Conflicts*, p. 108; Torrelli, *Le Droit International Humanitaire*, p. 47.

pursuant article 12 GC I and II. Article 11 (2) AP I specifies further procedures that are prohibited even when carried out with the consent of the treated person,[35] except if they are consistent with the test as described in article 11 (1) AP I. Prohibited are (a) physical mutilations, (b) medical or scientific experiments,[36] and (c) the removal of tissue or organs for transplantation.[37] The risk of abuse concerning these procedures was considered exceptionally great requiring them to be listed separately.[38] Geneva Law only allows therapeutic[39] and prohibits all non-therapeutic experiments[40] under the condition that they are justified by the health of persons *and* in their interests.[41] Though prohibited in the relationship between an occupying power and persons in its power, article 11 (2) AP I is not concerned with procedures by a person's own medical profession.[42]

Pursuant to article 11 (3) AP I, donations of blood and skin-grafts, even when they are not required by a person's own health but rather to benefit another, are justified exceptions to paragraph 2 (c). They were considered too essential in emergency situations in armed conflicts to be categorically prohibited.[43] However these procedures may only be carried out if the donation or graft is provided voluntarily, for therapeutic purposes, and again under conditions consistent with generally accepted medical standards.[44]

e. *Treatment of Prisoners of War*

Pursuant to article 12 GC III, the detaining power is responsible for the treatment given to all prisoners of war including those wounded and sick, and has under article 15 GC III the duty to provide 'free of charge for [the prisoners of war's] maintenance and for the medical attention required by their state of health'.[45]

Articles 13 and 14 GC III determine that prisoners of war are to be protected and respected at all times; wounded, sick and shipwrecked combatants who are in the hands of the enemy would simultaneously be protected under Geneva Convention I and II respectively. Additionally, prisoners of war *must* be treated humanely at all times (article 13 GC III). What is considered

[35] It is considered improbable that a person in the custody of an adversary party can voluntarily give his informed consent in such a situation. Baccino-Astrada, *Manuel des Droits et Devoirs du Personnel Sanitaire lors des Conflits Armés*, p. 41.

[36] Article 11 (2)(b) AP I thus broadens the prohibition of biological experiments to include medical and scientific experiments.

[37] The prohibition of experimentation is grounded in the experiences with experiments in World War II, whereas the prohibition of transplantation is grounded in the developments in transplantation medicine in the years after World War II. Solf, 'Studies in honour of Jean Pictet', p. 240.

[38] Sandoz et al., *Commentary to the Additional Protocols*, para. 478.

[39] Therapeutic: 'of or pertaining to the healing of disease'. *The Oxford English Dictionary*, 2nd Ed., Oxford University Press, Oxford, 2006.

[40] The terminology was developed after 1949. McCoubrey, *International Humanitarian Law*, p. 88.

[41] For prisoners of war who are also protected pursuant article 11 AP I, this is explicitly established in article 13 GC III. Article 32 GC IV forbids experiments on civilians that are not 'necessitated by the medical treatment of a protected person'.

[42] Solf, 'Studies in honour of Jean Pictet', p. 241.

[43] Ibid. p. 242; Baccino-Astrada, *Manuel des Droits et Devoirs du Personnel Sanitaire lors des Conflits Armés*, p. 41.

[44] This paragraph generated much discussion in the drafting sessions and country meetings. See O.R. XI, CDDH/II/SR.23, p. 223 – 224; CDDH/II/SR.29, p. 295 – 302.

[45] From the moment 'they fall into the power of the enemy', Geneva Convention III applies to all persons who fall under article 4 GC III, including the wounded and sick as defined in article 5 GC III. This can also be found in articles 14 GC I and 16 GC II. Furthermore, if in doubt, prisoner of war status is assumed (article 5 (2) GC III).

'humane' often depends on the circumstances of the situation at hand.[46] Article 13 of GC III stipulates that physical mutilation and 'medical and scientific experiments of any kind' are never humane and thus prohibited. The prohibition addresses all those in contact with prisoners of war, yet is aimed at the treating doctors to refrain from subjecting prisoners to experiments.

The exception provided to this prohibition in article 13 GC III is that such acts are allowed if 'justified by the medical, dental or hospital treatment of the prisoner concerned *and* carried out in his interest' (emphasis added).[47] The consent of the prisoner of war is not explicitly required. Though the exigencies of war surely require some concessions, the lack of the requirement of consent is not only baffling, but could also not have been within the aim of the drafters. Some argue that the provisions leave physicians with 'enough latitude to use all possible treatments for prisoners of war without the risk of being found guilty of a war crime'.[48] While it surely facilitates the work of a physician if he can take decisions on the manner of treatment, it clearly overemphasizes the physician's right to take decisions for his patients. Nonetheless, this is one of the only references to the actual substance of medical treatment,[49] a topic that is otherwise disregarded in the Geneva Conventions.

To guarantee the well being of the prisoners of war in prisoner of war camps, article 30 GC III determines that every such camp shall have an 'adequate infirmary' where a prisoner of war can receive the medical attention his condition or wounds require.[50] Prisoners of war should preferably be given attention by medical personnel 'of the power on which they depend and, if possible, of their nationality'. This requirement aims at medical care being provided 'within' the same nationality or party, to increase the comfort of the wounded and sick. It is certainly not a mandatory requirement as it depends on the circumstances and the availability of medical personnel from the relevant nationalities or parties because medical personnel of the detained power is only retained in prisoner of war camps if treating its 'own' prisoners of war.[51] In contrast, medical personnel is still to treat all wounded and sick equally, whether or not prisoners of war, without distinction by nationality or affiliation.[52]

f. Treatment of Civilians

The civilian wounded and sick, the infirm and expecting mothers are protected under article 16 GC IV.[53] Should civilians in besieged or encircled areas be unable to leave these areas and

[46] Kleffner, 'Protection of the Wounded, Sick and Shipwrecked', para. 603.2. Pictet carefully proclaims that a minimum of humanity requires a person to be able to live acceptably and as normal as possible. Jean Pictet, *Les principes fondamentaux de la Croix-Rouge proclamés par la XXe conférence internationale de la Croix-Rouge*, Institut Henry-Dunant, Genève, 1979, p. 23 – 24.

[47] De Preux has in mind all procedures not curative in nature. Concerning the grave breaches in article 130 GC III he states that 'It must be possible to use new medicaments offered by science, provided that they are administered only for therapeutic purposes'. Jean de Preux, *La Convention de Genève relative au Traitement des Prisonniers de Guerre*, Comité Internationale de la Croix-Rouge, Genève, 1958, p. 662.

[48] Horst Fischer, 'Protection of Prisoners of War' In: D. Fleck, *The Handbook of International Humanitarian Law*, Oxford University Press, New York, 2008, para. 719 (3).

[49] Another reference can be found in article 32 GC IV which prohibits medical experiments not 'necessitated by the state of health of a protected person'.

[50] Fischer, 'Protection of Prisoners of War', para. 719 (3).

[51] Medical personnel cannot be captured, only retained, articles 28 GC I and 37 GC II.

[52] Article 12 GC I and II.

[53] This is also the position taken in Oscar M. Uhler and Henri Coursier, *Commentary to the Geneva Convention Relative to the Protection of Civilian Persons in Time of War*, International Committee of the Red Cross, Geneva, 1958, p. 134. Moreover, article 4 (4) GC IV denies protection to those persons already protected under the other Conventions.

seek medical treatment, pursuant to article 17 of GC IV medical personnel should, if feasible, be allowed passage into such areas in order to supply medical treatment. It can be inferred that medical personnel upon its passage is protected, possibly under the other conventions, depending on the location and situation. The parties to the conflict should however take safety measures to ensure safe passage, such as notification of the adversary party.[54]

Civilian hospitals should be protected and respected at all times (article 18 GC IV). Wounded and sick combatants in civilian hospitals are equally protected, pursuant to article 19 GC IV. The treatment of wounded and sick combatants in civilian hospitals is not considered an act harmful to the enemy. However, if a hospital or civilian medical unit commits an act harmful to the enemy, it may lose its protection yet only after a warning has been given.[55]

Article 27 GC IV is central to the protection of civilians in occupied territory, and provides for the protection of the civilians in all circumstances and requires that they shall always be treated humanely. It also stipulates the treatment of women and furthermore reiterates the principle of non-discrimination. Article 32 GC IV then determines that no measure 'of such a character as to cause […] physical suffering or extermination' may be taken. This is elaborated in detail in the second paragraph stipulating that all 'measures of brutality' are prohibited, including medical experiments which are not 'necessitated by the state of health of a protected person'. The aim of the article is to prevent that civilians are used as 'guinea-pigs' as occurred in some atrocious experiments in World War II.[56]

2. The Physicians' Rights and Duties

As the wounded, sick and shipwrecked are, as established, to be protected and respected, it is only logical that those who take care of them should be protected as well if they are to provide adequate care. Articles 24 GC I and 36 GC II hence provide medical personnel with equal protection 'in all circumstances'. Article 9 AP II introduces a comparable protection in non-international armed conflicts. The protection ceases when medical personnel violates its neutrality and becomes in any way involved in the conflict.[57]

a. Definition and Tasks

Additional Protocol I defines medical personnel in article 8 (c) AP I.[58] It determines that medical personnel must be thus assigned and furthermore assigned *exclusively* to the 'search for, collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or for the prevention of disease'.[59] Only in carrying out these tasks will medical personnel specified in three categories enjoy protection: (i) civil and military medical personnel belonging to a party to the conflict which includes the medical personnel

[54] Article 15 AP I.
[55] Articles 19 GC IV and 13 AP I.
[56] Uhler and Coursier, *Commentary IV*, p. 224. Prominent testimonies of the atrocious experiments can be found in *United States of America v. Karl Brandt, et al. ['The Doctors' Trial']*, Trials of War Criminals Vol. I & II, Judgment (19 August 1947).
[57] Pictet, *Les principes fondamentaux de la Croix-Rouge*, p. 49 – 50.
[58] Surprisingly, the Geneva Conventions of 1949 never defined the term 'medical personnel'.
[59] The tasks are listed in article 8 (e) AP I.

as defined in articles 24[60] and 25 GC I[61] and article 36 GC II[62]; (ii) recognized and authorized medical personnel of national Red Cross and voluntary aid societies as defined in article 26 GC I[63] and article 24 GC II; and (iii) medical personnel as described in article 9 (2) AP I,[64] the latter being a reference to medical personnel of aid societies of neutral countries and international humanitarian organizations as will established in article 27 GC I.[65]

Pursuant article 8 (k) AP I medical personnel is considered permanent if it is exclusively assigned to medical purposes for an indeterminate period, and temporary when it is engaged in medical purposes only for limited periods.[66] The protection is absolute and complete for national medical personnel attached to the armed forces and exclusively engaged in medical care ('permanent medical personnel'), yet conditional for other medical personnel in armed conflicts. Nevertheless, following article 8 (k) AP I the term 'medical personnel' addresses both permanent and temporary medical personnel, unless otherwise specified in a provision.

b. Identification

To enjoy protection and respect, medical personnel should be recognizable as such.[67] All medical personnel is obliged to wear a white armlet, issued and stamped by its military authority, showing the Red Cross emblem.[68] It is furthermore required to carry at all times an identity disc, as mentioned in article 16 GC I and 19 GC II, and an identity card that fulfills the criteria of article 40 GC I and 42 GC II. Temporary medical personnel need only wear the armlet when carrying out medical duties and their identity documents need to indicate their special

[60] Article 24 GC I offers protection for medical personnel 'exclusively' engaged in the 'search for, collection, transport or treatment of the wounded and sick'.

[61] Article 25 GC I affords temporary medical personnel, engaged in medical activities only if the need arises, protection *only* when carrying out the in article 24 GC I specified duties. It only applies to temporary medical personnel that is trained for carrying out medical duties but has other tasks within the armed forces and can be identified following article 42 GC I, excluding regular combatants carrying out the described tasks out of necessity. Pictet, *Commentary I*, p. 247.

[62] Article 36 GC II offers protection for medical personnel on hospital ships.

[63] Pursuant article 26 GC I, such medical personnel only enjoys protection if they are subject to military laws and regulations of their country of origin and when carrying out the duties as mentioned in article 24 GC I. Additionally, their presence and assistance must be communicated to the other parties to the conflict.

[64] Article 9 AP I furthermore determines that the provisions aimed at the amelioration of the condition of the wounded and sick apply in situations as described in article 1 AP I, being situations referred to in article 2 of the Geneva Conventions of 1949, and without any discrimination.

[65] Article 27 GC I determines that medical personnel of recognized societies of neutral countries only enjoy the protection if the neutral country's government has consented to their involvement, the party to the conflict has authorized the contribution and also controls the relevant neutral society, and the adversary party was notified. Members of these societies have to be identifiable following article 40 (2) GC I.

[66] Sandoz et al., *Commentary to the Additional Protocols*, para. 395.

[67] Kalshoven and Zegveld, *Constraints on the waging of War - an Introduction to International Humanitarian Law*, p. 124.

[68] The emblem was first introduced in article 7 Geneva Convention 1864 and the mandatory armlet with the Red Cross emblem was introduced in article 20 Geneva Convention 1906. Article 38 (2) GC I and article 41 (2) GC II allow the use of two other symbols instead of the Red Cross, namely the Red Lion and Sun and the Red Crescent. A fourth, additional emblem was recognized by the Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem of 8 December 2005 (Additional Protocol III) which introduced the red frame in the shape of a square on edge on a white background, commonly known as the Red Crystal. See also J.R.G Jofriet, Het rode kristal: een nieuw onderscheidend symbool bij de vier Verdragen van Genève van 12 augustus 1949, *Militair-rechtelijk tijdschrift* (101:1) 2008, p. 1-4.

training.[69] Article 20 (2) GC IV establishes the same criteria for civilian medical personnel in occupied territory or zones of military operations; it is also to wear an armlet with the distinctive emblem and required to be issued an identity card, no identity disc.[70] Medical personnel may under no circumstances be deprived of its identification.[71] In addition, pursuant article 18 AP I each party to a conflict should endeavor to ensure the correct identification.

c. Rights of Physicians

Both civilian and military medical personnel is entitled to carry 'light individual weapons for their own defense or that of the wounded and sick in their charge'.[72] However, a distinction should be made between self-defense against an unlawful attack on protected persons and participation in hostilities. Only defense against violence as such is allowed.[73] For example if looters attacked a hospital or the adversary opened fire on the wounded and sick being treated, medical personnel could defend itself and the protected persons in its care.[74] This is not considered an 'act harmful to the enemy'. As soon as medical personnel uses weapons in harmful acts against the enemy, even by using force to resist the legal capture of a medical unit by the adversary party, it loses its protection.[75] The treatment of civilians by medical personnel in military medical units does not entail a loss of protection – pursuant article 22 (5) GC I civilians may thus be treated.[76]

d. Medical Units and Transport

Next to enumerating the protected tasks ('search for, collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or for the prevention of disease'), article 8 (e) establishes the protection under Additional Protocol I of medical units including all civilian and military medical establishments, whether mobile or fixed, temporary or permanent. Medical units and establishments, as defined in article 8 (e) AP I, shall be protected and respected at all times and should not be the object of attack.[77] Since the adoption of the first Additional Protocol, the protection includes civilian medical establishments. Medical establishments should be situated with a reasonable distance to military objects so that the safety of patients and staff is not imperiled. The protection ceases when establishments or units are used to carry out 'acts harmful to the enemy' (article 21 GC I). They furthermore lose their protection when they are used 'to shield military objectives from attack'.[78] Identification is essential for protection. The distinctive flag should be hoisted over such establishments, and 'any

[69] Article 41 GC I.
[70] See also article 18 (3) AP I. Temporary civilian medical personnel shall comply with these identification requirements when carrying out medical tasks. See Uhler and Coursier, *Commentary IV*, p. 164.
[71] Articles 40 (4) GC I and 42 (4) GC II.
[72] Articles 22 (1) GC I and 13 (2)(a) AP I.
[73] Sandoz et al., *Commentary to the Additional Protocols*, para. 561.
[74] Ibid, para. 560.
[75] Articles 21 GC I and 13 AP I. See also article 19 GC IV concerning the loss of protection of civilian hospitals.
[76] The same applies *vice versa*, see articles 19 GC IV and 13 (2)(d) AP I.
[77] Articles 19 GC I and 12 AP I.
[78] Article 21 GC I and article 12 (4) AP I. 'Acts harmful to the enemy' encompasses a wider category of acts than 'hostile acts' which cause the loss of protection of the wounded and sick. See Kleffner, 'Protection of the Wounded, Sick and Shipwrecked', para. 612.

necessary steps' should be taken to make the distinctive emblem clearly visible for land, navy, and air forces.[79] This is the responsibility of the party responsible for the establishment.[80]

Transports of the wounded and sick, as defined in article 8 (f – h) AP I, are equally respected and protected.[81] Upon capture, the care for the wounded and sick therein transported should be ensured. Both medical units as well as medical transportation should be 'marked by the distinctive emblem'.[82] There are no details as to how exactly this should be realized. As with medical establishments, medical transportation may never be used to carry out hostile acts against the adversary.[83]

Pursuant to article 22 GC II, medical personnel on hospital ships enjoy full and absolute protection essentially because 'military hospital ships […] may in no circumstances be attacked or captured'.[84] The same applies to hospital ships of national Red Cross societies or neutral countries if they fulfill certain additional requirements.[85]

e. *Civilian Medical Personnel*

Pursuant article 15 AP I, civilian medical personnel shall be respected and protected, and enjoy all benefits of the provisions of the Conventions and the Additional Protocol. The provisions in the Geneva Conventions and Additional Protocol I concerning identification apply equally to this category of medical personnel.[86] The article specifies that all parties to a conflict are to assist civilian medical personnel in continuing to carry out its medical tasks if necessary, especially an occupying power. Article 56 GC IV stipulates that during an occupation the occupying power is obliged to ensure that medical service and care 'of all categories'[87] can continuously be provided to wounded and sick civilians.[88] An occupying power should take into consideration 'the moral and ethical susceptibilities of the population'.[89] The provision adds onto article 27 GC IV which referred to the protection of the civilian population and respect for their 'religious

[79] Article 42 GC I. Art. 43 GC I concerns the identification of medical establishments of neutral countries.
[80] McCoubrey, *International Humanitarian Law*, p. 99.
[81] Article 35 GC I, article 38 GC II, article 21 GC IV and article 21 AP I. A discussion of the provisions detailing the protection of medical aircraft (articles 36 – 37 GC I, article 39 – 40 GC II, 24 – 31 AP I) and those concerning hospital ships (articles 22 – 35, 38 GC II, 22 – 23 AP I) is beyond the limits of this article.
[82] Article 18 (4) AP I. The medical units and transports can also use distinctive signals, as provided for in Chapter III of Annex I to AP I (article 18 (5) AP I).
[83] See *mutatis mutandi* art. 21 – 22 GC I.
[84] The San Remo Manual on International Law applicable to Armed Conflicts at Sea enumerates possible exceptions in para. 51. Louise Doswald-Beck (Ed.), *San Remo Manual on International Law applicable to Armed Conflicts at Sea*, Cambridge University Press, Cambridge, 1995.
[85] The notification requirements can be found in articles 24 (2) and 25 GC II.
[86] Herein also lies a danger that the greater the number of persons belonging to the broad category of medical personnel, the more difficult to guarantee the protection of every such person. Torrelli, 'La Protection du Médecin dans les Conflits Armés', p. 584.
[87] In encompassing both temporary and permanent medical personnel, this provision seems to differ from article 20 GC IV. Uhler and Coursier, *Commentary IV*, p. 314.
[88] This is only one of the obligations Torrelli lists in Torrelli 'La Protection du Médecin dans les Conflits Armés', p. 65.
[89] The Commentary claims that 'there does not seem to be any real distinction between "moral" susceptibilities and "ethical" susceptibilities'. It regards the two as synonyms. Uhler and Coursier, *Commentary IV*, p. 315. This could be contested but is beyond the limits of this article. For a discussion on the differentiation between ethics and morals, see Silja Vöneky, *Das Verhältnis von Recht, Moral und Ethik - Fragen demokratischer Legitimation am Beispiel von Ethikgremien in der Bundesrepublik Deutschland in rechtsvergleichender, europarechtlicher, völkerrechtlicher und interdisziplinärer Perspektive*, forthcoming.

convictions and practices, and their manners and customs'.

Article 15 AP I further determines that a party to the conflict may never oblige civilian medical personnel to give preferable treatment based on other than medical criteria. Furthermore, civilian medical personnel cannot be compelled to carry out tasks that are not compatible with its humanitarian mission.

Not all civilian medical personnel is automatically protected in armed conflict, but rather only when assigned as such by one of the high contracting parties.[90] The assignment, so says article 8 (c) AP I, may be permanent or temporary, however it appears that the sole purpose must be one of the purposes listed in sub-paragraph (e).

When working in civilian hospitals medical personnel enjoys additional protection because civilian hospitals cannot be objects of attack, unless used for military purposes,[91] and shall be protected and respected by the parties to the conflict pursuant article 18 of GC IV. The presence of wounded and sick combatants can never justify an attack on a civilian hospital.[92] Furthermore, article 57 GC IV provides that occupying powers may use civilian hospitals for the care of combatants if temporarily and 'only in cases of urgent necessity'. They will then have to provide an alternative for civilian wounded and sick.

f. Retained Medical Personnel

Medical personnel can never be captured by a belligerent party, it can only be retained.[93] The Conventions have created a two category-system: permanent military medical personnel and national aid societies can be retained; all other categories of medical personnel cannot even be retained.[94]

Article 28 GC I determines that permanent medical personnel, and that of national Red Cross or voluntary societies will not have prisoner of war status, but should still benefit from the provisions of Geneva Convention III if favorable to its wellbeing. In the power of the adverse party, medical personnel can be asked to carry out its medical duties to the benefit of prisoners of war of its party to the conflict, if necessary and as permitted by their state of health.[95] Medical activities should be carried out 'in accordance with their professional medical ethics'. The reference to 'professional ethics' as a framework within which medical personnel should operate when in camps of prisoners of war refers to the ethics of the medical personnel itself not of the detaining power.[96]

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[90] Sandoz et al., *Commentary to the Additional Protocols*, para. 354.

[91] Article 19 GC IV.

[92] Article 19 (2) GC IV. This implies that military wounded and sick may also be treated in civilian hospitals. This does not, as Kalshoven claims, follow from a mere analysis of article 18 GC IV. Frits Kalshoven, *Reflections on the Law of War - Collected Essays*, Martinus Nijhoff Publishers, Leiden, 2007, p. 1007.

[93] In World War II, medical personnel was often unduly retained to treat the prisoners of war by adverse parties. Jean Pictet, *Development and Principles of International Humanitarian Law*, Martinus Nijhoff Publishers, Dordrecht, 1985, p. 32. Furthermore Torrelli, 'La Protection du Médecin dans les Conflits Armés', p. 596 – 597;. McCoubrey, *International Humanitarian Law*, p. 97.

[94] Medical personnel as well as the crew on hospital ships cannot be captured, pursuant article 36 GC II. Jean Pictet, *La Convention de Genève pour l'Amélioration du sort des Blessés, des Malades et des Naufragés des Forces Armées sur Mer*, Comité Internationale de la Croix-Rouge, Genève, 1959, p. 210.

[95] José Francisco Rezek, 'Protection of the Victims of Armed Conflicts - Wounded, Sick and Shipwrecked Persons' In: United Nations Educational Social and Cultural Organization and Henry Dunant Institute, *International Dimensions of Humanitarian Law*, Martinus Nijhoff, Paris, 1988, p. 157.

[96] De Preux uses the French wording. Preux, *Commentary III*, p. 233.

While article 28 GC I refers to 'professional ethics', the almost identical article 33 GC III speaks of 'professional etiquette'.[97] The French version of both articles uses the term 'conscience professionelle' which highlights the subjective character of this provision,[98] yet omits the ethical aspect. It is not clear why article 33 GC III deviates from the terminology of article 28 GC I. As it stands, it demonstrates that the rules governing the relationship between a physician and his patient in armed conflicts are not sufficiently clear. Moreover, these two references regrettably stand alone in the system of the Geneva Conventions. Although in sum, a doctor who is retained for medical services in a prisoner of war camp is to act in accordance with his own professional (or medical) ethics,[99] the vagueness of the terminology and the discrepancy between the different formulations demands further study.

The retained medical personnel is to carry out the provision of medical care 'within the scope of the military laws and regulations of the Detaining Power and under the control of its competent services'.[100] The Detaining Power should provide the medical personnel with the necessary means to carry out its profession, especially to the benefit of those prisoners of war of the party to the conflict on which the medical personnel itself also depends.[101] Nothing in these provisions relieves the detaining party of its duties towards the prisoners of war and their care and protection.[102] Retained medical personnel is to be returned to the party of the conflict it belongs to as soon as this is possible and practicable.[103]

g. The General Protection of Medical Duties

If medical personnel is to carry out its duties conscientiously, independently and responsibly in times of armed conflict, it will have to be protected from undue interference by any state, especially an occupying state. The broadest protection for medical personnel in armed conflicts is provided by article 16 AP I and 10 AP II. The articles build on the provision of article 18 (3) GC I whereby persons treating the wounded or sick are protected from molestation or conviction for these acts.[104] This protection was deemed necessary after World War II considering physicians continuing their work under an occupying power were often prosecuted as collaborators[105] and at times killed for treating the wounded and sick from an adverse party or for being part of the latter.[106]

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[97] The formulations in article 28 GC I and article 33 GC III differ in several places, e.g. subparagraph (a) refers to 'labour units' in Geneva Convention I and to 'working detachments' in Geneva Convention III.
[98] Pictet, *Commentary I*, p. 273.
[99] This would be in line with the provision of article 16 AP that will be examined below.
[100] Article 28 (2) GC I and 33 (2) GC III.
[101] This implies differentiated treatment, though de Preux states that as long as this recommendation does not lead to discrimination, it might be preferable in order to provide the best medical care for wounded and sick prisoners of war. Preux, *Commentary III*, p. 233.
[102] Article 28 (4) GC I and 33 (4) GC III.
[103] Article 30 GC I. Rezek, 'Protection of the Victims of Armed Conflicts', p. 158.
[104] Article 18 (3) GC I: 'No one may ever be molested or convicted for having nursed the wounded or sick'. Pictet, *Development and Principles of International Humanitarian Law*, p. 70.
[105] Georg Bock, 'Der Schutz sanitätsdienstlicher, ärztlicher und seelsorgerischer Aufgaben' In: H. Gasser, *Die Genfer Zusatzprotokolle*, Osang Verlag, Bonn, 1993, p. 190.
[106] Franz W. Seidler and Alfred M. De Zayas, *Kriegsverbrechen in Europa und im Nahen Osten im 20. Jahrhundert*, E. S. Mittler & Sohn GmbH Hamburg, 2002, p. 176 – 178.

The articles detail and specify the general protection for medical duties. This also benefits those treated. Both articles establish that nothing justifies punishing a person for carrying out medical activities on any person if these activities are compatible with medical ethics. 'Medical activities' is a broad term which includes the work of military and civilian medical personnel, and also all others such as nurses or midwives. It is thus formulated broadly to include different persons carrying out medical activities.[107] It also includes retained medical personnel carrying out its activities for a detaining power and so reinforces a physician's 'freedom of conscience' under articles 28 GCI and 33 GC III.[108] The provision protects all those performing medical activities in accordance with medical ethics from (penal and other) sanctions especially when treating enemy combatants.[109] Lacking a specific addressee, it can be inferred that the paragraph is addressed to all those in a position to punish. This includes for example a physician's own authorities but also a superior in the hierarchy of a hospital.[110]

Furthermore persons cannot be compelled to perform duties contrary to (1) 'the rules of medical ethics', (2) any other medical rules that are designed for the benefit of the wounded and sick,[111] or (3) to violate the Geneva Conventions or Additional Protocol I, respectively Additional Protocol II. Equally, they shall not be compelled to refrain from taking necessary medical actions. Overall, this implies that no person can be compelled to perform an act contrary to the interest of a patient.[112] Examples of prohibited acts would include the administration of mind-altering drugs for interrogations[113] or medical experiments.[114] Article 16 (2) AP I gives a person carrying out medical activities the right to refuse an illegal order.[115]

A legal compulsion to denounce the wounded and sick patients which was a common requirement for medical personnel in World War II is precluded in article 16 (3) AP I.[116] If a physician feels it is necessary to communicate information about a patient to the authorities, he is not prohibited from doing so. However, medical personnel cannot be compelled to disclose information about a patient if the information is considered to be detrimental to the patient or his family. The exceptions to this provision are twofold: first of all, a physician can be compelled to disclose by his own national law, or second of all if his patient has a communicable disease and disclosure is prescribed by law. Concerning the former, it can be seen that the protection is limited regarding the own authorities but complete regarding occupying or other adverse authorities. The paragraph was met with much criticism, as national law can override international humanitarian law, and the wounded and sick might be discou-

[107] Bothe et al., *New rules for Victims of Armed Conflicts*, p. 127.
[108] Torrelli, 'La Protection du Médecin dans les Conflits Armés', p. 597.
[109] For an example of such punishments see McCoubrey, *International Humanitarian Law*, p. 95 – 96.
[110] Sandoz et al., *Commentary to the Additional Protocols*, para. 651.
[111] Bothe et al. state that the wording of 'other medical rules' in paragraph 2 would refer to such 'state of the art' rules that are 'of wider application' than medical ethics and can thus be interpreted internationally. Bothe et al., *New rules for Victims of Armed Conflicts*, p. 128 – 129.
[112] Sandoz et al., *Commentary to the Additional Protocols*, para. 696; Mr. Solf, Representative of the United States at the Diplomatic Conference concerning the limitations of medical ethics, O.R. XI, CDDH/II/SR.16, p. 150, para. 46.
[113] O.R. XI, CDDH/II/SR.27, Statement of the Belgian Representative, p. 269.
[114] Sandoz et al., *Commentary to the Additional Protocols*, para. 4695.
[115] Solf, 'Studies in honour of Jean Pictet', p. 244.
[116] The issue of a possible principle of non-denunciation was already discussed in the drafting process of Geneva Convention I in 1949 yet not included in the final version due to a lack of agreement. See Ibid. para. 670 – 676.

raged from seeking medical attention if being treated they risked denunciation.[117]

The last paragraphs of article 10 AP II correspond to the prohibition of article 16 (3) AP I. They establish that 'professional obligations […] be respected' – a negative obligation couched in weaker terms than the explicit prohibition of compulsion in article 16 AP I. Again, the duty to respect medical confidentiality has its limits in national law.[118] If national laws require denunciation, this provision does not prohibit such laws. Like article 16 (3) AP I, this provision was also a compromise, to the detriment of the wounded and sick.[119] The last paragraph of article 10 AP II determines that medical personnel may not be punished or sanctioned for refusing to divulge information about the persons treated.[120] Clearly, this provision is aimed at limiting a state's power to force physicians to denounce their patients. However the prohibition is again subject to national law which 'reduces the value of the principle' for the same reasons as laid out above.[121]

h. Medical Ethics

Articles 16 AP I and 10 AP II imply that acts contrary to medical ethics – in the French version 'la déontologie' – can be punished, yet does not specify who determines medical ethics, whose medical ethics, whether there are universal medical ethics, and when a punishment is in order.[122] In the drafting sessions,[123] the term 'medical ethics' was chosen over 'professional ethics' to indicate that the medical ethics were to benefit the wounded and sick, and not intended to benefit the medical profession itself.[124] As an explanation of this interpretation is lacking, the following inference can be made: the treatment of the wounded and sick is to be consistent with medical ethics; the relations between physicians, concerning their cooperation, education and sanctions is of less interest. In the French version this problem was avoided by the use of the word 'déontologie' which entails both the rules

[117] O.R. XI, CDDH/II/SR.16, p. 151 – 153; CDDH/II/SR.19, p. 180 – 182. See also Solf, 'Studies in honour of Jean Pictet', p. 245 – 246.

[118] Sandoz et al., *Commentary to the Additional Protocols*, para. 4696 – 4699. An amendment which limited national laws to those 'in force prior to the beginning of the conflict' was, after extensive discussions, rejected. O.R. XI, CDDH/II/SR.40, p. 429; CDDH/II/SR.41, p. 557; CDDH/II/SR.44, p. 485

[119] Solf, 'Studies in honour of Jean Pictet', p. 245.

[120] In article 16 AP I the two aspects were drawn together in a single provision.

[121] Sandoz et al., *Commentary to the Additional Protocols*, para. 4705.

[122] Sandoz in the ICRC Commentary assumes that medical ethics concern either the 'moral duties incumbent upon the medical profession' as decreed by the medical corps of a state, or international medical ethics. Regarding the latter, Sandoz refers to the rules and guidelines by the World Medical Association, most prominently its 'Regulations in time of Armed Conflict' (World Medical Association, *Regulations in times of armed conflict,* adopted by the 10th WMA Assembly, Havana, October 1956, and last revised in France, May 2006). The WMA is an organization for and by national medical associations who also draft and adopt its documents. Ibid. para. 653 – 659. Bothe interprets 'medical ethics' to mean national medical ethics based on the 'state of the art' in a country. He concedes that international rules of medical ethics might be developing but that these are not sufficiently developed to be referred to. In a footnote, he nonetheless also refers to the WMA documents that could provide a basis for international medical ethics. Bothe et al., *New rules for Victims of Armed Conflicts*, p. 128. For yet another interpretation, see Kleffner, 'Protection of the Wounded, Sick and Shipwrecked', para. 614.3.

[123] The original draft formulation was 'professional rules' which was changed to 'professional ethics' and later to 'medical ethics'. See *CE 1972,* p. 39 – 40.

[124] See Delegate W. Solf of the USA introducing the formulation at O.R. XI, CDDH/II/SR. 16, p. 150.

of the profession as well as the rules concerning the doctor-patient relationship.[125]

So far the reference to medical ethics, which surely provide a very important guide for physicians in their work, remains too unfounded and vague.[126] A relevant, practicable and agreeable interpretation would be desirable.[127]

III. Evaluation

Physicians play an integral role in armed conflicts. They ensure that those *hors de combat* due to wounds or sickness receive medical care and recuperate. Moreover, they also have a further role that was not foreseen by international humanitarian law as such: that of a 'watchdog' over the rights of the wounded and sick, both combatants as well as civilians. They are the first to see the tolls of armed conflict, as was demonstrated, amongst others, by the Norwegian physicians in the Gaza conflict. Conversely, attention should also be paid to violations of international humanitarian law *by* physicians. While the American Psychiatric Association refused to be involved in interrogations at Guantanamo Bay,[128] there are still physicians involved in practices that the ICRC classified as highly unethical.

Overall, international humanitarian law provides an intricate system regulating the rights and duties of physicians as medical personnel in armed conflicts. The protection of physicians only ceases when they commit acts harmful to an enemy. The Additional Protocols have added an ethical dimension to the medical care provided to the wounded and sick and to the protection of physicians: physicians are to adhere to the generally accepted medical standards and medical ethics. Yet the boundaries of medical care are still only vaguely defined and attention for violations of international humanitarian law by physicians is lacking. The broad margins of discretion awarded to medical personnel in the treatment of the wounded and sick during armed conflict should be limited by medical ethics. However if such a concept is to provide the boundaries for medical care, it needs to be interpreted in a reasonable way. The question where to find these universal rules of medical ethics applicable in armed conflict will need further examination.

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[125] Torrelli, 'La Protection du Médecin dans les Conflits Armés', p. 589. The French term 'étique' is used purely for the moral conundrum a physician must decide by his conscience. The definition of 'déontologie' in the Petit Robert reads: 'ensemble des devoirs qu'impose à des professionnels l'exercise de leur métier'. *Le nouveau Petit Robert*, 40ème édition, Dictionnaires Le Robert, Paris, 2007.

[126] Baccino-Astrada, *Manuel des Droits et Devoirs du Personnel Sanitaire lors des Conflits Armés*, p. 38.

[127] This will be conducted in Sigrid Mehring, *The Intersection of Medical Ethics and International Humanitarian Law*, in process.

[128] American Psychiatric Association, APA Statement on Psychiatric Practices at Guantanamo Bay, 27 June 2005, available online at http://www.psych.org/MainMenu/Newsroom/NewsReleases/2005NewsReleases/05-40psych-practiceguantanamo.aspx.