BRILL
NIJHOFF

JOURNAL OF INTERNATIONAL HUMANITARIAN LEGAL
STUDIES 4 (2013) 197-219

INTERNATIONAL
HUMANITARIAN
LEGAL STUDIES

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Healthcare on the Battlefield

In Search of a Legal and Ethical Framework

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Abstract

During armed conflicts healthcare workers or medical personnel often work under extremely difficult and dangerous circumstances. In such situations doctors and nurses, hospitals and medical units are at a serious risk of being attacked. Medical personnel also face complex ethical dilemmas when it comes to the treatment of patients from all sides of a conflict. This concerns military medical personnel in particular: as members of the armed forces, they face dilemmas of 'dual loyalty' where they may have to choose between the interests of their employer (the military) and the interests of their patients. This contribution looks at these issues from the perspectives of medical ethics, international humanitarian law (IHL), and human rights law (HRL). The article argues that the standards of medical ethics continue to apply during armed conflicts, and that during such situations medical ethics, IHL and HRL are mutually reinforcing. The principle of 'medical neutrality' and the human 'right to health' are positioned as key norms in this field. The article presents a normative framework for the delivery of health care on the battlefield in the form of a set of commitments for actors involved in the conflict, including the belligerent parties and (military) medical personnel.

Keywords

Medical ethics – medical neutrality – international humanitarian law – right to health – AAAQ – minimum core obligations – access to healthcare – medical personnel – military medical personnel – protected persons

* This contribution builds on the following book chapter: B. Toebes, 'Doctors in Arms: Exploring the Legal and Ethical Position of Military Medical Personnel in Armed Conflicts', in

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Introduction

This contribution focuses on the difficulties surrounding the delivery of healthcare services during armed conflicts.[1] As will be illustrated more elaborately below, the delivery of healthcare services on the battlefield raises a number of problematic issues, varying from attacks on healthcare personnel and their units, to the difficult ethical dilemmas faced by, in particular, healthcare workers that are embedded in the military. The aim of this contribution is to underline that during armed conflicts, healthcare workers (or medical personnel) do not operate in a moral and legal vacuum. The paper attempts to demonstrate that the intertwined fields of medical ethics, international humanitarian law (IHL), and human rights law (HRL) provide a compelling framework stipulating legal and moral obligations for all sides of the conflict to respect, protect and to guarantee the safety, impartiality and neutrality of medical personnel during armed conflicts.

A core notion around which this analysis will revolve is the so-called principle of 'medical neutrality'. As will be clarified below, while this principle is a key concept of medical ethics, it also finds explicit recognition in IHL and HRL standards. The British Medical Association (BMA) explains that 'medical neutrality' embraces two dimensions: firstly, healthcare providers delivering care impartially must not be attacked or persecuted for doing so; and secondly, healthcare providers should practice medicine impartially without regard to factors such as the nationality, class, sex, religion or political beliefs of the patient.[2]

As such, the first dimension of medical neutrality pertains to the notion that all healthcare workers should be able to carry out their duties and to use their hospitals and medical equipment in an undisturbed fashion. According to the ICRC study 'Healthcare in Danger', around the world, people who risk their lives to provide health care in conflict areas are under a serious threat:

> Hospitals in Somalia and Sri Lanka are shelled; ambulances in Libya and Lebanon are shot at; medical personnel in Bahrain face trial for treating protestors; and health staff in Afghanistan receive threats from both sides to stop working with or treating 'the enemy'. From Colombia to Gaza, the

M. Matthee, B. Toebes and M. Brus (eds.), *Armed Conflict and International Law: In Search of the Human Face* (2013), at 169–194.

1 While the focus in this paper is on armed conflicts, the framework defined in this paper is also applicable to emergency situations that do not reach the threshold of an 'armed conflict'.

2 British Medical Association, *The Medical Profession and Human Rights: Handbook for a Changing Agenda* (2001), at 241.

> Democratic Republic of the Congo to Nepal, there is a lack of respect for the neutral status of health-care personnel, facilities and transport, by both those attacking them and those who misuse them for military gain.[3]

The second dimension of medical neutrality concerns the position of *military* medical personnel in particular. Given that military personnel are members of the armed forces, they may be confronted with difficult ethical dilemmas where there may be a need to choose between the concerns of the employer (the military), and the patient. Such dilemmas, often addressed as conflicts of 'dual loyalty' or 'mixed agency' arise where their professional duty to preserve life is not in conformity with their professional duty towards their employer, or their personal wish to serve the military. While on many occasions there will be no conflict between these duties, situations could arise where military personnel may be pressured to compromise their professional duty to care for the sick and wounded for the sake of military objectives.[4] A study by Physicians for Human Rights provides a number of illustrative examples of situations where the medical doctors' professional duty is compromised. To mention a few:

- They may be asked to attend first to soldiers with less severe wounds as a means to return them to battle;
- They may be asked to declare an entire troop fit for engagement when they are not;
- They may be compelled to prepare a sick soldier as quickly as possible for a new battle situation;
- They may be called to participate in interrogation of suspects of terrorism, which may culminate in torture or cruel and inhuman and degrading treatment;
- They may be asked to prepare and be present at executions;
- They may be asked to administer pharmaceutical substances or vaccines to (own or enemy) soldiers without medical justification;

3 ICRC, *Health Care in Danger*, http://www.redcross.int/EN/mag/magazine2011_2/4-9.html (last accessed 16 January 2014).

4 See, *inter alia*, International Dual-Loyalty Working group, 'Dual-Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms', in F. Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge, International Library of Ethics, Law, and the New Medicine*, Volume 41 (2008), at 15–38. Also available at Physician for Human Rights, http://physiciansforhumanrights.org/library/reports/dual-loyalty-and-human-rights-2003.html (last accessed May 2014).

- They may be called to participate in research into or experimentation with biological, chemical or pharmaceutical substances on humans while foregoing medical ethical principles.[5]

These dilemmas raise intricate questions under medical ethics, IHL, and HRL, including the right to life, the prohibition of torture, the right to privacy, and the right to health. This paper focuses on the provision of healthcare on and around the battlefield, specifically, on issues surrounding 'triage', i.e. the process of determining the order of treatment of patients or casualties. As will be shown below, medical ethics (e.g. the principles of neutrality, confidentiality and informed consent), IHL, and HRL (in particular, the right to health), provide a legal-ethical framework upon which military medical personnel need to act and operate.

The paper will introduce HRL and medical ethics as two fields that need to be taken into account when it comes to armed conflicts, in addition to the rules of IHL. To do so, it will first discuss a few preliminary legal questions that arise when applying these intertwined fields of ethics and law during armed conflicts. Subsequently, it will present the legal framework applicable to belligerent forces (as those that have to respect, protect and guarantee the safety of military medical personnel and their medical units) and to military medical personnel (as those who have to respect, protect and fulfill the rights of the wounded and sick).

1 Healthcare on the Battlefield: The Intersection Between the Standards and Their Applicability

It was suggested above that the intertwined areas of medical ethics, IHL, and HRL provide a normative framework for healthcare provision on and around the battlefield and other emergency situations. This raises the question of how these different fields relate to one another, and whether priority should be given to one area over another. Firstly, it is worth observing that both IHL and HRL give clear cognizance of the principles of medical ethics. In terms of IHL, we see that Additional Protocol II to the Geneva Conventions explicitly refers to medical ethics, stating that "[u]nder no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom".[6]As such, the body of IHL

5 *Ibid.*, at 32.

6 Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (1977), 1125 UNTS 609 (entered into force 7 December 1978) (AP II), art. 10(1).

affirms that medical ethics are an important discipline during armed conflicts and closely entwined with IHL.

When it comes to HRL and the right to health in particular, we see that General Comment 14 on the Right to Health, which will be discussed further below, contains a similar reference:

> All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.[7]

Similarly therefore, medical ethics are recognized as important interconnected principles under HRL.

Thirdly, the question arises how IHL and HRL relate to one another when it comes to their applicability during armed conflicts. While the starting point has previously been that during armed conflicts, IHL functions as the *lex specialis* (more specific law) in relation to the more general human rights norms,[8] the International Court of Justice (ICJ) has recently argued in favor of a more fluid approach in its Advisory Opinion concerning the construction of a Wall in Palestine (Wall Opinion), stating that "[…] some rights may be exclusively matters of international humanitarian law; others may be exclusively matters of human rights law; yet others may be matters of both these branches of international law".[9] This could give room for the approach that where HRL is more detailed in regulating a certain matter, it would be the primary source of law.[10] Below it will be argued that the right to health, in connection with other health-related rights, contains more detailed provisions in relation to certain matters, in particular when it comes to the allocation of medical services and the regulation of the patient-doctor relationship. In such situations, therefore,

7 CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, 11 August 2000, UN Doc. E/C.12/2000/4, para. 12(c), www.un.org/Docs/journal/asp/ws.asp?m=E/C.12/2000/4 (last accessed 29 April 2014). Hereinafter referred to as 'General Comment 14'.

8 See, for example, Advisory Opinion, Legality of the Threat or Use of Nuclear Weapons 226 (1996), ICJ, 8 July 1996, para. 25.

9 Advisory Opinion, Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory 136 (2004), ICJ, 9 July 2004, para. 106. Hereinafter referred to as 'Wall Opinion'.

10 See also, N. Lubell, 'Challenges to applying human rights law to armed conflict', 87(860) *IRRC* 737 (2005), at 752.

these health-related human rights may function as the *lex specialis*, i.e. the more specific norms that should apply when it comes to providing care on the battlefield.

For the purposes of this article, we need to address this question in particular with regard to economic, social and cultural rights, as the analysis is primarily concerned with the right to health, which is generally considered to form part of this category of rights.[11] Unlike the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic Social and Cultural Rights (ICESCR) does not single out a set of non-derogable rights, i.e. rights which cannot be deviated from during armed conflicts and other situations of emergency.[12] However, it is increasingly argued that there is a minimum level of protection inherent in economic, social and cultural rights that should remain intact under all circumstances, including armed conflicts (see further below).[13] Below, in the analysis of the right to health, an overview of the relevant minimum obligations will be presented (see Box 4).

Another complexity that arises during international armed conflicts (IACs) concerns the extraterritorial applicability of HRL, for during IACs belligerent states may violate rights outside their territory. Article 2(1) of the ICCPR affirms that the rights set forth in that treaty apply on the State's territory. However, this position is eroding to a certain extent. Case law supporting the extraterritorial applicability of civil and political human rights now requires that a State exercise 'effective control' over a territory or a certain public power in the territory concerned.[14] The question arises whether the same approach can be upheld with respect to ICESCR, which does not contain a provision on its scope of application.[15] In its Wall Opinion, the ICJ explains that this is because, "[…] this Covenant contains rights which are essentially territorial. However, it is not to be excluded that it applies both to territories over which a State party

11 For a recent and more elaborate study on this matter see also A. Müller, *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law: An Analysis of Health Related Issues in Non-international Armed Conflicts* (2013).

12 The ICCPR and ICESCR were both adopted within the framework of the UN on 16 December 1966 (entry into force 1976). The ICCPR contains a derogation clause in art. 4(2).

13 General Comment 14, *supra* note 8, paras. 43–44.

14 See, *inter alia*, Judgment, *Loizidou v. Turkey* (*Preliminary Objections*), Application No. 15318/89, ECtHR, Grand Chamber, 23 March 1995; and more recently Judgment, *Al-Skeini and Others v. The United Kingdom*,Application No. 55721/07, ECtHR, Grand Chamber, 7 July 2011; and Decision, *Lopez Burgos v. Uruguay*, Communication No. 52/1979, UN Doc. CCPR/C/13/D/52/1979, HRC, 29 July 1981. See also, N. Lubell, *supra* note 11, at 739–741.

15 Art. 2(1) ICESCR does not mention territory or jurisdiction, as opposed to art. 2(1) ICCPR.

has sovereignty and to those over which that State exercises territorial jurisdiction".[16] The ICJ subsequently concludes that Israel is bound by the provisions of the ICESCR and that "it is under an obligation not to raise any obstacle to the exercise of such rights in those fields where competence has been transferred to Palestinian authorities".[17] The difficult question that arises is what the extent of such obligations is, and whether this would also amount to a 'positive' duty to provide minimum health services in occupied territories. Based on the notion of 'minimum core obligations' (see further below), there are strong reasons to assume that Occupying States not only have negative obligations to respect the rights, but that they also have positive duties to realize the core elements of economic, social and cultural rights. This implies that they have duties to provide minimum socio-economic services to residents in territories under their occupation. For the right to health in Article 12 of the ICESCR specifically, this means that occupying states do not only have obligations to respect the undisturbed delivery of healthcare services, but that they also have positive obligations to provide essential health services in the territories that fall under their occupation.

The last complicating factor concerns the question whether HRL can also bind non-state actors that – contrary to States – have not ratified the human rights treaties. This question arises in particular with regard to non-international armed conflicts (NIACs) and other situations of internal unrest. For the purposes of our analysis, we need to address this question in relation to two groups: firstly, armed opposition groups, as those who potentially violate the medical neutrality of health workers during armed conflicts; and secondly, military medical personnel, as key actors in the delivery of health services on the battlefield. Are these groups also bound by HRL? When it comes to armed opposition groups, of decisive importance will be if and to what extent the armed opposition group concerned is taking over state functions. For, as Zegveld points out, the primary purpose of human rights is to check abuse of State power; hence the justification for armed opposition groups being bound may lie in the circumstances under which these groups operate.[18] Along these lines, Bellal *et al.* argue that an important factor in determining whether these groups are bound by HRL, will be whether they exercise an element of

16 Wall Opinion, *supra* note 10, para. 112.

17 *Ibid.* The ICJ took this position with reference to a similar position taken by the Committee on Economic, Social and Cultural Rights (CESCR) within the framework of its state reporting procedure; see CESCR, Concluding Observations on the Second Periodic Report Submitted by Israel, 23 May 2003, UN Doc. E/C.12/1/Add.90, paras. 15 and 31.

18 L. Zegveld, *Accountability of Armed Opposition Groups in International Law* (2002), at 167.

governmental functions and whether they have *de facto* authority over a population.[19] Arguing that they can be bound by HRL is in line with the increasing call on non-state actors to adhere to the human rights standards.[20]

Furthermore, the question arises whether medical professionals may also have responsibilities in relation to human rights, as important non-state actors in this field. First and foremost, they may carry certain *indirect* responsibilities in relation to the direct obligations of belligerent forces. This is because they are often at the forefront of situations where human rights violations by the belligerent forces are committed. As such, they may acquire important information about potential human rights violations that may be essential to report. However, the additional question is whether they may also carry *direct* legal responsibilities under HRL, i.e. whether by fulfilling their professional duties they may become complicit in human rights violations. A specific case can be made here in relation to military medical personnel. As *military* personnel, they are directly employed by the armed forces, an organ of the State; and as such they are State agents.[21] It can be argued that in this position, they carry direct responsibilities under HRL.

A *Relevant Medical-ethical Standards*

This section looks at relevant medical-ethical standards as the key moral principles in the healthcare field. Medical-ethical standards can be described as moral principles that apply to the practice of medicine and that are concerned with the way in which medical professionals exercise their occupation.[22] Medical-ethical principles are not legally binding norms; therefore, from a legal perspective, they may carry less weight than IHL and HRL. They are nonetheless authoritative in the health field and are therefore taken as a starting point in this analysis.

An important point of departure for analyzing the ethical duties of medical personnel is the Declaration of Geneva (World Medical Association, WMA). Representing doctors' organizations from most countries in the world, the

19 A. Bellal, G. Giacca and S. Casey-Maslen, 'International law and armed non-state actors in Afghanistan', 93(881) *IRRC* 47 (2011), at 69.

20 See, *inter alia*, N. Jägers, *Corporate human rights obligations: in search of accountability* (2002) and J. Cernic Letnar, *Human Rights Law and Business* (2010). To support this claim, reference is often made to the Preamble to the Universal Declaration of Human Rights, which refers to the human rights responsibilities of 'all actors in society'.

21 See Draft Articles on Responsibility of States for Internationally Wrongful Acts (2001), GA Res. A/RES/56/83 (adopted 28 January 2002), Art. 4(2).

22 British Medical Association, *supra* note 3, at 15.

WMA is a source of authoritative normative guidance. This document, which can be seen as a modern equivalent of the Hippocratic Oath, asks physicians to pledge that the health of their patients will be their first consideration and that they will not permit "considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient".[23] This is the principle of medical neutrality, which was also mentioned at the outset of this paper.

When it comes to armed conflicts, the question arises whether this principle, and other medical-ethical standards apply unconditionally or whether they can be waived. The WMA has continuously argued in favor of the applicability of 'peacetime' medical ethics during armed conflicts. In 1956, it adopted the Regulations in Times of Armed Conflict.[24] Article 1 of this document states that:

> Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.[25]

In addition, these Regulations seek to ensure the undisturbed and safe delivery of healthcare services, and the security of healthcare personnel (Regulation 5). Furthermore, physicians must be granted access to patients, medical facilities, and equipment and the protection needed to carry out their professional activities freely (Regulation 12).

Notwithstanding the existence of these Regulations, in medical-ethical circles there remains much disagreement over whether medical-ethical standards

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23 World Medical Association (WMA), 'International Code of Medical Ethics (Declaration of Geneva)', Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948, http://www.wma.net/en/30publications/10policies/g1/index.html (last accessed 16 January 2014).

24 World Medical Association (WMA), 'Regulations in Times of Armed Conflict', adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, last amended by the WMA General Assembly, Tokyo, 2004, http://www.wma.net/en/30publications/10policies/a20/ (last accessed 16 January 2014).

25 *Ibid.*, Regulation 1. Likewise, Regulation 3 states that during armed conflict, standard ethical norms apply, not only in regard to treatment but also to all other interventions.

apply unconditionally during armed conflicts. Particularly in the US, a rather fierce debate ensued as to whether peacetimes medical ethics continue to apply during armed conflicts. This debate was provoked by the supposed involvement of US medical personnel in human rights abuses, including those perpetrated against detainees in Iraq, Afghanistan, and Guantanamo Bay.[26] In this context, some authors have pointed out that military medical practice is by its very nature unethical, and that it is unavoidable that military medical professionals subjugate their ethical concerns to military considerations.[27] An important opponent of the continued applicability of medical ethics during armed conflicts is Michael Gross, a scholar based in Israel, who asserts that:

> Strategic necessity – that is, the need to wage war in pursuit of legitimate national interests – firmly limits the medical rights that both combatants and noncombatant patients enjoy. Tactical necessity – the need to develop efficient means to wage war and achieve particular military objectives – will restrict access to medical care, will govern the distribution of scare resources, and may compel physicians to lend their expertise to the development of weapons systems.[28]

As a result, Gross has difficulty with the recognition of human rights on the battlefield:

> The right to medical care is an abiding problem for military medical ethics precisely because of the tendency to grant inordinate weight to

26 Physicians for Human Rights, 'Aiding Torture: Health Professionals' Ethics and Human Rights Violations Revealed in the May 2004 CIA Inspector General's Report', Physicians for Human Rights (August 2009), https://s3.amazonaws.com/PHR_Reports/aiding-torture-2009.pdf (last accessed 16 January 2014).

27 See, for example, E.G. Howe, 'Mixed Agency in Military Medicine: Ethical Roles in Conflict', in T.E. Beam and L.R. Sparacino (eds.), *Military Medical Ethics* (Volume I) (2003), pp. 331–65; and W. Madden and B.S. Carter, 'Physician-Soldier: A Moral Profession', in D.E. Lounsbury and R.F. Bellamy (as Editor in Chief and Director and Military Medical Editor respectively, with T.E. Beam and L.R. Sparacino as Speciality Editors) , *Military Medical Ethics* (Volume I) (2003), pp. 269–291. See also the reaction by D.R. Rascona to the views from Sidel land Levy, in V.W. Sidel and B.S. Levy, 'Physician-Soldier: A Moral Dilemma?' in T.E. Beam and L.R. Sparacino (eds.), *Military Medical Ethics* (Volume I) (2003), pp. 293–329. All chapters are available at https://ke.army.mil/bordeninstitute/published_volumes/ethicsVol1/Ethics-ch-11.pdf (last accessed 16 January 2014).

28 M.L. Gross, *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War* (2006), at 62.

> the welfare of all soldiers during war. The other patient rights that soldiers enjoy are similarly problematic, not because we grant them too much weight but because we run the risk of granting them too little.[29]

Undoubtedly, war raises tremendous moral dilemmas, but morally just decisions can also be taken in dire situations with limited resources. This author argues that even where resources are limited, there is no moral justification for giving priority to one's own soldiers, or for declaring soldiers fit to fight, when they are not. This is also the position taken in the above-mentioned WMA Regulations. A similar position was more recently taken by the so-called 'Dual-Loyalty Working Group', a joint initiative from Physicians for Human Rights and the University of Cape Town,[30] who argue in favor of the unconditional application of medical-ethical standards. Taking a rights-based approach, this group proposes a set of ten guidelines, seven of which are relevant for providing medical services on the battlefield:

> "1. The military health professional's first and overruling identity and priority is that of a health professional (...)
> 2. Civilian medical ethics apply to military health professionals as they do to civilian practitioners (...)
> 3. The military health professional should adhere to the principle of confidentiality in a manner consistent with practice in civil society (...)
> 4. The military health professional is a member of the national and international health professionals' community (...)
> 5. The military health professional should treat the sick and wounded according to the rules of medical needs and triage (...)
> [...]
> 9. Military health professionals should report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities and report human rights violations perpetrated by their own troops as well as by others (...)"[31]

29 *Ibid.*, at 100.

30 Allhoff, *supra* note 5, at 33–37. See also L. London *et al.*, 'Dual Loyalty among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict', 15(4) *Cambridge Quarterly of Healthcare Ethics*, 381 (2006), at 381–391.

31 Allhoff, *ibid.*, at 33–37. The other guidelines concern the issues of chemical weapons, torture, capital punishment, and human experimentation.

This group brings together medical ethics and human rights. By doing so, it reinforces the unconditional applicability of medical-ethical standards during armed conflicts, as the applicable human rights standards contain notions similar to the medical-ethical standards. It explains the importance of human rights law in this field as follows:

> For health professionals, a human rights framework provides a steady moral compass, a blueprint of a just and humane social order that at its core articulates the principles of the dignity and equality of every human being. [...] a human rights analysis enables the health professional to resolve these conflicts by reference to an agreed-upon, universally applicable set of moral principles.[32]

Given this close connection between medical ethics, IHL, and HRL, and the importance of their intertwined applicability during armed conflicts, we will now turn to an analysis of the applicable norms of IHL and HRL.

B *IHL and the Provision of Healthcare During Armed Conflicts*

IHL contains many norms regulating and protecting the position of medical staff and the safe and undisturbed delivery of medical services during armed conflicts. IHL is therefore mainly focused on the first dimension addressed in this paper, i.e. the protection from attack of medical personnel and units. According to the ICRC, it is a rule of customary international law that "[m]edical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. [...]"[33]

This rule, which dates back to the 1864 Geneva Convention, applies both during IACs and NIACs. Looking at IACs more specifically, Geneva Conventions I, II, and IV, and Additional Protocol I contain similar rules.[34]

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32 *Ibid.*, at 21.

33 Rule 25 of Customary International Humanitarian Law. J-M. Henckaerts and L. Doswald-Beck, *Customary International Humanitarian Law* (Volume I) (2005), at 78–86 . Hereinafter referred to as ICRC Customary Law Study. See also Rules 28 and 29 on the protection of medical units and transports respectively.

34 Geneva Convention for the Amelioration of the Condition if the Wounded and Sick in Armed Forces in the Field (1949), 75 UNTS 31 (entered into force 21 October 1950) (GC I), Arts. 24–26; Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea (1949), 75 UNTS 85 (entered into force 21 October 1950) (GC II), Art. 36; Geneva Convention Relative to the Protection of Civilian Persons in Time of War (1949), 75 UNTS 287 (entered into force 21 October 1950) (GC IV), Art. 20; Protocol Additional to the Geneva Conventions of 12 August 1949, and

These instruments also contain additional rules stipulating that medical personnel falling into the hands of the enemy should receive the same treatment of prisoners of war; that transports of the wounded and sick have to be respected and protected; and that medical aircraft shall not be attacked.[35]

During NIACs, the main rule that applies is 'common Article 3' of the Geneva Conventions, which contains a set of minimum standards for the protection of those who do not take active part in the hostilities, including the wounded and sick.[36] This standard does not provide explicit protection of medical personnel. According to the ICRC, however, we may assume that this provision embraces the protection of medical personnel, as it can be seen as a subsidiary form of protection granted to ensure that the wounded and sick receive medical care.[37] Furthermore, Additional Protocol II,[38] contains an explicit rule that medical personnel must be respected and protected.[39] And, as mentioned above, Rule 25 of Customary International Humanitarian Law applies.

In this context, it is also worth pointing out that many domestic military manuals contain rules regulating the inviolability of medical personnel.[40] The protection of medical personnel during armed conflicts is also enshrined in many domestic legal systems. Furthermore, the Statute of the International Criminal Court considers "[…] intentionally directing attacks against buildings, material, medical units and transport, and personnel using the distinctive emblems of the Geneva Conventions in conformity with international law" to be a war crime.[41]

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relating to the Protection of Victims of International Armed Conflict (1977), 1125 UNTS 3 (entered into force 7 December 1978) (AP I), Art. 15.

35 See, *inter alia*, Arts. 14–23 GC I; Arts. 7 and 12–40 GC II; Arts. 13–26 GC IV; Arts. 8–30 AP I; and Geneva Convention Relative to the Treatment of Prisoners of War (1949), 75 UNTS 135 (entered into force 21 October 1950) (GC III), Art. 33.

36 Common Article 3 to GCS I, II, III and IV.

37 ICRC Customary Law Study, *supra* note 34, at 80–81 (Rule 25).

38 According to Art. 1 AP II, this protocol applies to all armed conflicts which are not covered by Additional Protocol I and which take place in the territory of a Member State between its armed forces and dissident armed forces or other organized armed groups which, under 'responsible command', exercise such control over a part of its territory as to enable them to carry out 'sustained and concerted military operations' and to implement this Protocol.

39 Arts. 9–11 AP II.

40 See also, ICRC Customary Law Study, *supra* note 34.

41 Rome Statute of the International Criminal Court (1998), UN Doc. A/CONF.183/9 of 17 July 1998 (entered into force 1 July 2002), Art. 8(2)(b)(xxiv).

C The Human Rights Framework and the Provision of Healthcare During Armed Conflicts

In this section the meaning and implications of the internationally guaranteed human right to health will be dissected. The term 'right to health' is shorthand for the 'right to the highest attainable standard of health' as provided in Article 12 of the ICESCR. As pointed out by the former Special Rapporteur on the Right to Health, Paul Hunt, the right to health is a firmly established feature of binding international law.[42] In addition to Article 12, further provisions in a number of other international human rights instruments also recognize the right to health.[43] Furthermore, a study by Backman *et al.* has analysed the domestic implementation of the right to health. The study reveals that 63 national constitutional provisions, bills of rights, or other statutes include a right to health.[44] Finally, an increasing amount of case law on the right to health generated by national and international judicial bodies points to the increasing enforceability or 'justiciability' of the right to health.[45]

A detailed explanation of the right to health is provided by UN General Comment 14 on the Right to the Highest Attainable Standard of Health, which is an explanatory document on Article 12 ICESCR adopted by the Committee on Economic, Social and Cultural Rights, the Treaty-Monitoring body to the ICESCR (CESCR 2000). Although strictly speaking not legally binding, this document is the most authoritative document on the right to health. Therefore, this paper closely follows the approach taken in the General Comment.

The right to health is an inclusive right which not only extends to timely and appropriate healthcare services, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to

42 P. Hunt, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. E/CN.4/2004/49/Add.1, 1 March 2004, para. 14.

43 Including Art. 25 of the Universal Declaration on Human Rights (UDHR); Art. 5(e) of the International Convention of All Forms of Racial Discrimination (CERD); Arts. 11(1) and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW); and Art. 24 of the Convention on the Rights of the child (CRC). At the regional level we come across the right to health in art. 11 of the (revised) European Social Charter (ESC); Art. 16 of the African Charter of Human and Peoples' Rights; and Art. 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.

44 Hunt, *ibid.*, para. 14.

45 G. Backman *et al.*, 'Health systems and the right to health: an assessment of 194 countries', 372(9655) *Lancet* 2047 (2008), at 2047-2085.

health-related education and information.[46] This is also reinforced by the notion that, as the General Comment explains, the right to health is closely related to and dependent upon the realisation of other human rights.[47] When it comes to securing health in armed conflicts, other important rights include the right to life, the prohibition of torture, the right to privacy and family life, and the rights to shelter, safe drinking water and sanitation. So for battlefield situations the right to health, in conjunction with other health-related rights, not only implies a right to medical services but also the realisation of a number of conditions to health.

The General Comment also identifies a set of principles that apply at all levels of the health sector that are also important in relation to the ensuring the safe delivery of healthcare services on the battlefield: availability, accessibility, acceptability and quality of health facilities (the so-called 'AAAQ').[48] As pointed out by the former Special Rapporteur on the Right to Health, this framework is especially relevant to *policy* analysis, while the identification of obligations further on in this paper (obligations to 'respect, protect and fulfill') may be more suited to *legal* analysis.[49] Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility.[50] The UN General Comments on the other substantive rights in the ICESCR contain similar principles, and also in a national health law context references are made to such principles.[51]

Furthermore, the General Comment distinguishes between so-called State obligations to 'respect', to 'protect', and to 'fulfill' the right to health. The obligation to respect the right to health is a negative obligation to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take legislative and other measures that prevent third parties including private insurers, private health care providers, and suppliers from interfering with the guarantees under the right to health. Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards the full realisation of the right to health.[52]

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46 General Comment 14, *supra* note 8, para. 11.

47 *Ibid.*, para. 3.

48 *Ibid.*, para. 12.

49 Hunt, *supra* note 43, para. 39.

50 General Comment 14, *supra* note 8, para. 12.

51 See in particular the UN General Comments on the rights to water, education, food and housing, CESCR (1997–2002), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11 (last accessed 22 May 2014).

52 General Comment 14, *supra* note 8, paras. 34–37.

Lastly, it has been argued on several occasions that there is a minimum level of protection inherent in economic, social and cultural rights that should remain intact under all circumstances, including armed conflicts.[53] The UN has consolidated this approach by means of the recognition of a 'minimum core' in economic, social and cultural rights: the idea that there is a minimum set of obligations inherent in these rights which should be guaranteed under all circumstances, including armed conflicts.[54] Along these lines, General Comment 14 defines a set of core obligations, i.e. minimum entitlements flowing from the right to health that exist under all circumstances.[55] It can be argued that such minimum obligations also apply during armed conflicts (see Box 4).

2 Towards a Legal and Moral Framework for the Provision of Healthcare on the Battlefield

In this section, an attempt is made to bring together all the norms and subsequent duties that flow from the norms presented above. To clarify the various undertakings, a number of Boxes are presented. Box 1 illustrates how safe and adequate healthcare delivery is protected through various norms under IHL, HRL, and medical ethics. While the context, applicability and enforceability of these norms differ, there is considerable normative overlap between the various standards so defined:

Box 1 illustrates that while IHL has a more limited applicability during NIACs, human rights law and medical ethics apply in the same fashion during

53 CESCR, General Comment 3: The Nature of States Parties' Obligations (Art. 2, para. 1 of the Covenant), 14 December 1990, UN Doc. E/1991/23, para. 10, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11 (last accessed 22 May 2014). Hereinafter referred to as 'General Comment 3'; and General Comment 14, *supra* note 8, paras. 43–44. See also, Along similar lines, the 'Limburg Principles' claim in para. 47 that limitations on rights should not affect the 'subsistence or survival' of the individual or integrity of the person. See, Maastricht University, Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, the Netherlands, June 1986, http://www.unhchr.ch/tbs/doc.nsf/0/6b748989d76d2bb8c125699700500e17/$FILE/G0044704.pdf (last accessed 16 January 2014). See also, B. Toebes, 'The Use of Depleted Uranium as a Potential Violation of Human Rights', in A. McDonald, J.K. Kleffner and B. Toebes, *Depleted Uranium Weapons and International Law* 187 (2008), at 209–210.

54 General Comment 14, *supra* note 8, paras. 43 and 44 and more generally; General Comment 3, *supra* note 54, para. 10.

55 General Comment 14, *supra* note 8, paras. 43–44.

BOX 1 *The Protection of Healthcare Settings During Armed Conflicts: Identification of Applicable International Norms*

	IHL / ICRC Customary Law/ Domestic law	**Human Rights**	**Medical Ethics**
IAC	Rule 25, ICRC Customary International Law Study; Arts. 24–25 GC I; Art. 26 GC II; Art. 20 GC IV; Art. 15 AP I; Art. 8 Rome Statute; Domestic military manuals: *respect for and protection of medical personnel and their equipment*	*Inter alia*, arts. 11–12 ICESCR:[56] *minimum right to essential medical services, minimum rights to shelter, sanitation and safe drinking water; respect for the rights of patients*	*Inter alia*, Declaration of Geneva (non-discrimination); Regulations in Time of Armed Conflict: *inter alia, medical neutrality, non-discrimination, confidentiality*
NIAC	Rule 25, ICRC Customary International Law Study; Art. 3 GC I-IV; Arts. 9–11 AP II: *respect for and protection of medical personnel and their equipment*	*Ibid.*	*Ibid.*

both NIACs and IACs. This underlines the importance of relying on human rights and ethical standards during NIACs.

Subsequently, we must specify the various obligations of belligerent forces and military medical personnel respectively. We will do so on the basis of the three frameworks from General Comment 14 that were identified above: the AAAQ; the triparte typology distinguishing between legal obligations to respect, protect and fulfill the right to health; and in relation to this, the identification of minimum core obligations. For this identification, a distinction is made between the belligerent forces (under A) and military medical personnel (under B).

56 For other relevant human rights treaty provisions on the right to health, see *supra* note 44.

A The Duties of the Belligerent Forces

When it comes to the belligerent forces, it is important to note that non-state armed groups are also heavily involved in attacks on medical personnel and their units. In July 2011, the ICRC published a study on violent incidents affecting healthcare based on an analysis of sixteen countries.[57] The report concludes that the danger to healthcare workers and facilities in armed conflict and other situations of violence is widespread and serious.[58] The study makes a distinction between violence affecting hospitals and other healthcare facilities, medical vehicles, and healthcare personnel.[59] While in 33% of the events the violence was committed by State armed forces, in 36.9% of the events it was committed by armed groups.[60] These findings underscore that State armed forces and armed groups are equally involved in such attacks and emphasize the need to also identify the obligations on the part of armed groups.

Based on the right to health framework and reinforced by medical ethics, the AAAQ provides a set of principles for the provision of basic medical services on the battlefield (see Box 2). It illustrates that the parties involved in an armed conflict should guarantee the availability, accessibility, acceptability and quality of medical services during armed conflicts. We may assume that these commitments apply to States as well as non-state actors exercising de facto authority over a population:

Furthermore, based on the identification of legal obligations to respect, protect and fulfill, we can identify a set of commitments for parties in the conflict exercising *de facto* authority over a population (see Box 3). This box illustrates that based on the right to health framework, as reinforced by medical ethics and IHL, belligerent parties have legal ('negative') legal duties to respect the right to health (e.g. refraining from attacks on medical units); and ('positive') legal duties to protect and fulfill the right to health (protect medical personnel), as well as ensure access to all health-related services.

Finally, a set of minimum obligations can be identified under human HRL, which apply under all circumstances, including armed conflicts. Box 4 denotes which minimum services should be provided during armed conflicts by those belligerent parties exercising '*de facto* authority' over a population.

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57 ICRC, Health Care in Danger, a sixteen-country study, July 2011, http://www.icrc.org/spa/assets/files/reports/report-hcid-16-country-study-2011-08-10.pdf (last visited 22 May 2014).

58 ICRC, *supra* note 58, at 11.

59 *Ibid.*

60 *Ibid.*, at 2. Other events were caused by the police (6.9 %), active fighting (6.7 %), and other people (16.5 %).

BOX 2 *The AAAQ and the obligations of the parties in an armed conflict*

Availability	Ensuring the availability of health resources necessary to treat the wounded and injured
Accessibility	
Non-discrimination	Equal treatment of all individuals involved in the armed conflict, e.g. not favoring one's own forces above the belligerent party
Economic accessibility	Affordability of necessary medical services for the treatment of the wounded and sick, if possible free of charge to all parties involved in the conflict
Geographic accessibility	Providing necessary medical services close to where the conflict takes place
Information accessibility	Providing adequate information about the necessary medical services
Acceptability	Respecting the different cultural backgrounds of patients, creating an environment where medical ethics can be respected
Quality	Ensuring the quality of necessary medical services, including adequate training of medical staff.[61]

BOX 3 *Belligerent Parties' Obligations to Respect, Protect and Fulfill Human Rights*

Respect	Respect the undisturbed and safe delivery of necessary medical services; Respect the medical neutrality of medical personnel; Refrain from limiting access to necessary medical services as a punitive measure.[62]
Protect	Protect medical personnel and patients from attacks by third parties
Fulfill	Provide essential medical services, including medical equipment and adequately trained medical personnel;Secure access to the underlying determinants of health, in particular safe drinking water, adequate sanitation and shelter.[63]

61 General Comment 14, *supra* note 8, para. 12.

62 This obligation to 'respect' is explicitly mentioned in General Comment 14. See, *supra* note 8, para. 34.

63 *Ibid.*, paras. 34–37.

BOX 4 *Minimum Services to be Provided by Belligerent Parties* (*Minimum Core Obligations*)

To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups
To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water
To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs
To ensure equitable distribution of all health facilities, goods and services
To provide appropriate training for health personnel, including education on health and human rights [64]

B *The Duties of Military Medical Personnel*

Next, the duties of military medical personnel should be identified. According to Michael Gross, "medical moral decision making changes substantially in wartime" and medical ethics must "compete with equally weighty and conflicting principles anchored in military necessity and national security".[65] Above an attempt has been made to refute this position by arguing that during armed conflicts medical-ethical principles continue to apply, reinforced by IHL and HRL.

Firstly, when it comes to the above-mentioned AAAQ, the principle of 'non-discrimination' under 'accessibility' implies a duty on the part of medical personnel to treat everyone equally, and not to discriminate between patients on criteria other than medical ones. Also the principle of 'acceptability' is an important guidance during battlefield situations. 'Acceptability' means, *inter alia*, that healthcare services must be respectful of medical ethics and culturally appropriate. Being 'respectful of medical ethics' includes, according to General Comment 14, respecting the confidentiality of patients.[66] With this notion the General Comment implicitly refers to patients' rights as established under various instruments. Patients' rights involve the important notion of informed consent, i.e. the duty on the part of medical professionals to ask for the consent of patients and to inform them about their conditions.[67] Box 5

64 *Ibid.*, paras. 43–44.

65 Gross, *supra* note 29, at 325.

66 General Comment 14, *supra* note 8, para. 12.

67 See, *inter alia*, art. 6 Universal Declaration on Bioethics and Human Rights (adopted within the framework of UNESCO, 2005) and arts. 5–9 Convention on Human Rights and Biomedicine (Oviedo Convention, 1997; adopted within the framework of the Council of

BOX 5 *Duties under the AAAQ for Military Medical Personnel*

Availability	In collaboration with the military, maintain the availability of necessary medical facilities and services
Accessibility	
Non-discrimination	Equal treatment of all individuals involved in the armed conflict, e.g. not favoring one's own forces above the belligerent party
Economic accessibility	In collaboration with the military, maintain the affordability of necessary medical facilities and services
Geographic accessibility	In collaboration with the military, maintain an adequate geographic spread of necessary medical facilities and services
Information accessibility	Providing adequate information about medical services (informed consent);If the situation allows, establishing a good patient-doctor relationship
Acceptability	Respecting the varying cultural backgrounds of patients;Respecting medical ethics: *inter alia* designed to respect and protect confidentiality
Quality	Providing good quality medical services.[68]

BOX 6 *Duties to 'Respect, Protect and Fulfill' of Military Medical Personnel*

Respect	Respect for equal access to available medical services; Respect the confidentiality, privacy and self-determination of patients; Refrain from discriminating between patients; Refrain from prioritizing between patients on considerations other than medical ones.
Protect	Protect patients from attacks by third parties; Protect the confidentiality, privacy and self-determination of patients;
Fulfill	Provide medical services ('duty of care'); Report allegations and human rights abuses revealed during the clinical encounter; Maintain a dialogue with the employer and governments to ensure that they provide the necessary health infrastructure, also during the post-conflict period.

Europe). For a comprehensive study about patients' rights see M. Hartlev, 'Patients' rights', in B. Toebes *et al.*, *Health and Human Rights in Europe* (2012), at 111–144.

68 General Comment 14, *supra* note 8, para. 12.

gives an overview of how the AAAQ could apply to military medical personnel. While the emphasis is on military medical personnel, it could be argued that similar commitments can be defined for all medical personnel that is working in armed conflicts.

Furthermore, in relation to the belligerent forces, above a distinction was made between three types of human rights obligations: obligations to respect, to protect, and to fulfill human rights. Similar obligations can be defined in relation to military medical professionals, and potentially all medical personnel working in armed conflicts. Based on the above, military medical personnel have the following human rights obligations:

Concluding Remarks

At the outset of this paper it was illustrated that the delivery of medical services during armed conflicts is a huge challenge. Civil society organizations, including the ICRC, are stressing the increasing incidence of attacks on healthcare personnel and medical units during armed conflicts, thus calling on belligerent parties in the conflict to halt these attacks. A related problem is that during armed conflicts, medical personnel is confronted with very difficult ethical dilemmas in the exercise of their duties.

The aim of this contribution has been to bring together the health-related standards that apply during armed conflicts so as to demonstrate that during such situations, medical personnel or healthcare workers do not operate in a legal or moral vacuum. While it may be extremely difficult to enforce these rules, this should be no reason to ignore them altogether.

The notion of 'medical neutrality' has been positioned as the key norm in this debate around which the standards of IHL and HRL evolve. Medical neutrality as a medical-ethical standard is an important value that is firmly embedded in IHL and reinforced by HRL, in particular the right to health. Based on this norm, all parties involved in the conflict have legal and ethical duties to respect and protect healthcare workers in the exercise of their duties. Furthermore, healthcare workers themselves must respect the right of medical services of all individuals involved the conflict, as well as the patients' rights of those who are under their treatment and care.

While it is well-known that medical neutrality is guaranteed by IHL, it is less frequently brought in connection with HRL. This paper has made an attempt to underscore the importance of HRL, in particular the right to health, as an important additional framework for the protection of health and healthcare delivery during armed conflicts. While primarily a peacetime norm, there are

strong reasons to assume that it also applies to some extent during armed conflicts.

An attempt has been made to illustrate that the right to health framework provides a number of sophisticated tools for giving further substance to the notion of medical neutrality in battlefield situations. The AAAQ, as a framework suitable for health laws and policies, stipulates that healthcare services have to be made available, accessible, acceptable and of good quality during armed conflicts. *Inter alia,* this includes the principle not to hamper the accessibility of healthcare services through attacks on healthcare personnel; while healthcare workers themselves should respect the equal accessibility of available services. Along similar lines the identification of legal duties to respect, protect and fulfil provides a set of specific legal duties for all sides of the conflict. Lastly, the identification of minimum core obligations under the right to health emphasizes that belligerent parties have legal duties to respect and ensure equal access to health services, including safe drinking water and adequate sanitation.

The specific implications of this framework during armed conflicts may still require sophistication and adjustment. It may require experts from the fields of IHL, humanitarian assistance, HRL and medical ethics to sit together and to agree on the specific applicability of these standards during armed conflicts. In addition it will be important to explore how these norms can be enforced through existing human rights mechanisms. This requires a certain willingness on the part of human rights treaty-monitoring bodies to take on board the health-related human rights violations that occur during armed conflicts.