Chapter 7
Doctors in Arms: Exploring the Legal and Ethical Position of Military Medical Personnel in Armed Conflicts

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Abstract This contribution discusses the legal and ethical position of military medical personnel during armed conflicts. In such situations two difficult issues arise. Firstly, military health workers frequently become the object of an attack, which is a violation of their neutrality as medical personnel. Secondly, they themselves face difficult issues of 'dual loyalty': they need to navigate between the interests of the patient, on the one hand, and that of their employer, the military, on the other. This contribution attempts to clarify and strengthen the legal position of military medical personnel, in particular when it comes to providing medical services around the battlefield. To do so, a basis is sought in the intertwined areas of international humanitarian law (IHL), human rights law (HRL), and medical ethics. It is argued that insufficient attention has been paid to bringing these three discourses together conceptually. It will be shown that these three disciplines provide a somewhat incoherent yet compelling framework for medical personnel during armed conflicts. In a nutshell, this framework guarantees the inviolability and neutrality of medical personnel and it stipulates that medical considerations should prevail over military ones when it comes to priority setting between patients.

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7.1 Introduction

Avril was a great scholar who inspired many others in the field of international humanitarian law and beyond. Unfortunately, the person who was least aware of her greatness was herself. Had she known that a whole book would be dedicated to her, she would have beamed her humorous and selfless smile. If only we could see that smile on her face today… and if only we could hear her views on the interesting topics that are addressed in this volume. Indeed, several times during the process of writing this Chapter I had an urgent wish to speak to Avril and to hear her views on the matter. An issue that we discussed on several occasions concerns the applicability of human rights law during armed conflicts. For example, for our book on depleted uranium weapons, we discussed whether economic, social, and cultural rights continue to apply during armed conflicts.[1] While this matter has now to some extent been addressed in the literature,[2] a next step would be to see how the legal framework so defined applies to the various parties involved in an armed conflict.

Given my background in health and human rights, in this contribution I focus on the position of medical personnel in armed conflicts, as a group that are in a vulnerable position when it comes to carrying out their professional duties. While it is a generally accepted principle of law and ethics that medical professionals should not be obstructed in the exercise of their duties, they frequently become the object of an attack. According to the International Committee of the Red Cross (ICRC), violence against healthcare workers is one of the most serious humanitarian challenges in the world today. The ICRC, in its study 'healthcare under attack', gives the following examples:

[1] McDonald et al. 2008, in particular Chapter 9, Toebes 2008.

[2] *Inter alia,* Mottershaw 2008; Lubell 2005 and also Toebes 2008.

> (…) urban fighting may prevent health-care personnel from reaching their places of work, first-aiders may be unnecessarily delayed at checkpoints, soldiers may forcibly enter a hospital to look for enemies or shield themselves from attack, and ambulances may be targeted or illegally used to carry out attacks. Whatever the context, poor security conditions in many parts of the world mean that the wounded and sick do not get the medical attention to which they are entitled.[3]

The specific focus in this contribution is on the position of *military* medical personnel. More than civilian medical personnel (and medical personnel working for aid organisations), military medical personnel faces dilemmas of 'dual loyalty', meaning that they may have to balance between the orders of their employer (the military) and their patients. As such, they often face tremendous moral dilemmas while carrying out their tasks in extremely complex and dangerous situations.[4] For example, as will be discussed more elaborately below, their employer may ask them to prioritize between patients on considerations that are not purely medical in nature, or they may be asked to declare military personnel 'fit to fight'. In such situations, the following question arises: how should the military health worker balance such interests, and based on which rules or principles?

Analyzing the position of military medical personnel challenges us to look into the interfaces between IHL and HRL, which was mentioned above as an important issue of scholarly debate. This can help us obtain a better understanding of how these different fields can be applied in an interrelated fashion, at a more practical level. A third interrelated discipline concerns medical ethics, the body of principles adopted by the medical profession regulating the ethical aspects of their profession. This body of principles includes, for example, the duty not to take considerations like age, ethnic origin, or gender to intervene between the professional's duty and the patient.[5] Importantly, the World Medical Association (WMA) has issued two sets of guidelines in relation to the position of medical personnel during armed conflicts.[6] These guidelines focus on the medical neutrality and the so-called 'dual loyalty' of doctors during armed conflicts, two concepts that will be discussed more elaborately below. Within medical-ethical circles it has been suggested that such matters are also human rights issues, and that the normative standards for doctors are also grounded in human rights law[7]:

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[3] ICRC 2012b.

[4] For an insightful and compelling insight see the ICRC video, ICRC 2012c.

[5] International Code of Medical Ethics (Declaration of Geneva), Adopted by the 2nd General Assembly of the World Medical Association (WMA), Geneva, Switzerland, September 1948. http://www.wma.net/en/30publications/10policies/g1/index.html. Accessed May 2012; Bloche et al. 2005, pp. 3–6.

[6] Regulations in Time of Armed Conflict, adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, last amended by the World Medical Association General Assembly, Tokyo, 2004, available at http://www.wma.net/en/30publications/10policies/a20/, accessed February 2013.

[7] International Dual-Loyalty Working Group 2002, pp. 15–38.

> (…), a human rights analysis enables the health professional to resolve these conflicts by reference to an agreed upon, universally applicable set of moral principles. In health care settings, considerations of human rights concerns, as elaborated through the various instruments, conventions and treaties discussed above, should be a requisite for resolving dual-loyalties conflicts.[8]

It is therefore of interest to explore how medical ethics, HRL, and IHL are intertwined when it comes to the legal position of military medical personnel, so as to clarify and strengthen their complex position. While these three disciplines contain similar standards in relation to the position of military medical personnel, their overlap and congruity, as well as the applicability of each specific field is still subject to a great deal of confusion.

Looking into the position of military medical personnel means looking into the law that applies during armed conflicts. This raises several complicated preliminary questions. A first complication is that not all conflicts are the same, and that different sets of rules of IHL apply to international armed conflicts (IACs), non-international armed conflicts (NIACs), and conflicts that do not reach the threshold of a NIAC. While this will be discussed more elaborately below, it is important to note as a starting point that HRL has the potential to fill a regulatory lacuna in situations where IHL only applies to a limited extent (NIACs) or not at all (riots and internal disturbances).

Secondly, we need to take into account that armed conflicts involve different types of actors that may have different positions and responsibilities under international law. For the purposes of this contribution, we can roughly make a distinction between three actors: states and non-state actors involved in the conflict, as well as military health workers. This raises many intricate questions, including whether the mentioned standards apply extraterritorially and whether non-state actors and health workers themselves are bound by the international standards.

7.2 Identification and Definition of the Problem

With the synonymous terms ‘medical personnel’ and ‘health workers’ in this contribution I refer to both physicians and nurses. A commonly accepted definition of ‘medical personnel’ can be found in Protocol I to the Geneva Conventions: persons assigned exclusively to the search for, collection, transportation, diagnosis, or treatment, including first-aid treatment, of the wounded, sick, and shipwrecked, and the prevention of disease, to the administration of medical units, or to the operation or administration of medical transports.[9] The Protocol makes a distinction between medical personnel of a party to the conflict, which can be

[8] International Dual-Loyalty Working Group 2002, p. 21.

[9] Article 8(3) in conjunction with 8 (5), Protocol (I) Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of International Armed Conflicts, Geneva, 8 June 1977, United Nations Treaty Series, Volume Number 75; See also ICRC 2012a,

military or civilian, as well as medical personnel of national Red Cross Societies and other national voluntary aid societies.[10] The body of IHL and related principles of medical ethics provide for the protection of all these types of medical personnel during armed conflicts.[11]

As mentioned, the focus in this contribution is primarily on *military* medical personnel. Contrary to civilian medical personnel (and medical personnel working for aid organisations), military health workers are members of the armed forces.[12] In this position, they are not to participate in the armed conflict as a party of the fighting force but solely in their role of providing medical services.[13] If captured by the enemy in an international armed conflict, they do not receive the status of Prisoner of War (POW); however, they receive the same treatment.[14]

More than civilian medical personnel or medical personnel employed by aid societies, military medical personnel are likely to be confronted with so-called 'dual-loyalty' or 'mixed agency' conflicts: they need to navigate between their duty to preserve life and reduce suffering, on the one hand, and their professional duty toward their employer, the military, on the other.[15] While on many occasions

(Footnote 9 continued)
Customary International Law, Rule 25, available at http://www.icrc.org/customary-ihl/eng/docs/v1_cha_chapter7_rule25. According to the ICRC, this definition is widely used in State practice.

[10] Article 8(3) sub. (a) and (b) Additional Protocol I to the Geneva Conventions (applicable during IACs), Ibid.

[11] *Inter alia*, Articles 24–27 Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Geneva, 12 August 1949, United Nations Treaty Series, Volume Number 75; Articles 36, 37 Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, Geneva, 12 August 1949, United Nations Treaty Series, Volume Number 75; Article 33 Geneva Convention (III) relative to the Treatment of Prisoners of War, Geneva, 12 August 1949, United Nations Treaty Series, Volume Number 75; Articles 12–16 Protocol I, *supra* note 9, (civilian medical personnel); Articles 9–11 Protocol (II) Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, Geneva, 8 June 1977, United Nations Treaty Series, Volume Number 1125; See also ICRC 2012a, Rule 25 on Medical Personnel of the ICRC Rules on Customary IHL, available at http://www.icrc.org/customary-ihl/eng/docs/v1_cha_chapter7_rule25. Accessed May 2012.

[12] The term 'civilian medical personnel' refers to medical personnel who are not members of the armed forces but who have been assigned by a party to the conflict exclusively to medical tasks. See ICRC 2012a, ICRC Customary IHL, Rule 25. http://www.icrc.org/customary-ihl/eng/docs/v1_cha_chapter7_rule25. Accessed May 2012; See also Frisina 2008, p. 49.

[13] While medical personnel are not allowed to take up arms so as to participate in the armed conflict, they may arm themselves with light individual weapons, as long as the weapons are only used in self-defence or the defence of the wounded in their charge. Article 22-1 Geneva Convention I, *supra* note 11, Article 13(2)(a) Additional Protocol I, *supra* note 9.

[14] Article 28 Geneva Convention I, *supra* note 11; See also Solis 2010, p. 192. They are then so-called 'retainees', which include medical personnel (surgeons, dentists, and other medical doctors) and chaplains. It should be noted that this category does not embrace medical orderlies or chaplains' assistants, as they are not considered 'permanent staff' and as these persons are armed and may lawfully directly participate in hostilities; See also Solis 2010, pp. 191, 192.

[15] See *inter alia*, International Dual-Loyalty Working Group 2002, pp. 31, 32.

there will be no conflict between these two objectives, situations may arise where they may be pressured to compromise their professional duty to attend to the sick and wounded for the sake of military objectives. While in some situations this pressure will be external (from their employer, the military), they may also feel an internal or personal tension, for example when they are faced with a need to offer services to the sick and wounded of the enemy.

A study by Physicians for Human Rights gives a number of examples of situations where the medical doctors' professional duty is compromised: they may be asked to attend first to soldiers with less severe wounds as a means to return them to battle, or they me 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 also be called to participate in the interrogation of suspects of terrorism, which may culminate in torture or cruel and inhuman and degrading treatment. Furthermore, they may be asked to prepare and be present at executions, and to administer pharmaceutical substances or vaccines to (their own or enemy) soldiers without medical justification. And by way of a final example, they may be called upon to participate in research into or experimentation with biological, chemical, or pharmaceutical substances on humans while foregoing medical-ethical principles.[16]

While all these issues are important and require further study, the focus in this chapter will be mainly on the delivery of healthcare on and around the battlefield. This raises in particular issues relating to the allocation of health resources by the armed forces, and the position of the medical personnel in that respect. It also engages the issue of triage, i.e., the process of determining the priority of patients' treatments. In relation to these matters, I will focus on the responsibilities of states and other belligerent parties, on the one hand, and on the position of military medical personnel, on the other. As mentioned, we will look into how IHL, HRL, and medical ethics regulate these issues.

7.3 Three Intertwined Disciplines, and Their Applicability During Armed Conflicts

IHL, also known as the law of armed conflict, consists of a set of rules that seek, for humanitarian reasons, to limit the effects of an armed conflict. It protects persons who are no longer participating in the hostilities and restricts the means and methods of warfare. IHL contains many provisions on the position of medical staff and the delivery of medical services.[17] It regulates the inviolability of medical services in situations of armed conflict. It purports to ensure the undisturbed and safe delivery of medical care during armed conflicts and it prescribes that

[16] International Dual-Loyalty Working Group 2002, p. 32.

[17] ICRC 2004.

individuals who do not participate directly in hostilities and who are *hors de combat* should be cared for without discrimination. An important feature of this body of the law is that the vast majority of the norms only apply during international armed conflicts, meaning a conflict between two states, while a limited set of rules apply in situations that can be characterized as non-international armed conflicts.[18] The applicable norms during such conflicts are, mostly, common Article 3 to the Geneva Conventions, as well as Additional Protocol II to the Geneva Conventions (if the threshold for the application of this Protocol has been met).[19]

With medical ethics, reference is made to a system of moral principles that apply to the practice of medicine, and tends to be understood as being concerned with professional ethics.[20] A core principle underlying medical ethics concerns the principle of medical neutrality. According to the British Medical Association (BMA), medical neutrality embraces two issues: while healthcare providers themselves should practice medicine impartially without regard to factors such as the nationality, class, sex, religion, or political beliefs of the patient, healthcare providers providing care impartially must not be attacked or persecuted for doing so.[21] This shows that medical neutrality has two dimensions: on the one hand, the doctor's duty to perform his work impartially and, on the other, the State's duty to ensure that this impartiality is not being infringed upon. These two dimensions will be addressed more elaborately below, where a distinction is made between the responsibilities of states and other belligerents, on the one hand, and of military medical personnel on the other. Medical-ethical principles do not differentiate between different types of armed conflicts, and as such we may assume that they fully apply during all types of conflicts, as has also been set out in the *Regulations in Time of Armed Conflict*. However, it must be observed that these are not legally binding norms and that hence their status may be less authoritative from a legal perspective.

HRL, thirdly, refers to the body of international law designed to promote and protect the rights of individuals. States that ratify human rights treaties commit themselves to respecting those rights for everyone residing on their territory. Important human rights in the context of medical professionals are the rights to life, privacy, and the prohibition of torture and inhuman and degrading treatment, as

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[18] Common Article 3 of the Geneva Conventions, *supra* note 11.

[19] According to Additional Protocol II, *supra* note 11, Article 1, this Convention does not apply to situations of international disturbances and tensions, but rather to internal conflicts in which the organized armed groups exercise such control over a part of the territory that they are able to carry out sustained and concerted military operations—a requirement that is not mentioned for 'common Article 3 - conflicts'.

[20] British Medical Association 2001, p. 15; Bioethics, which is closely connected to medical ethics, is generally more concerned with ethical questions brought about by advances in biology and medicine. As such, bioethics can be broader than medical ethics, addressing the philosophy of science and issues of biotechnology. Given the substantive overlap between the two fields, the terms are used interchangeably in this chapter. For the purposes of our research topic, it is important to note that medical ethics and bioethics have increasingly incorporated rights-based approaches and have drawn closer to the international framework of human rights.

[21] British Medical Association 2001, p. 241.

well as the right to the highest attainable standard of health, the right to food, and the right to shelter.[22] Given that HRL and IHL are both aimed at protecting the well-being of human beings, from a normative perspective they are closely intertwined. For example, as will be clarified below, both bodies of law embrace norms guaranteeing access to health services. However, there are also several distinctions. Roughly speaking, while IHL has a narrow scope containing a detailed set of provisions that primarily apply during armed conflicts, HRL has a broad scope, embracing a broad set of norms that apply primarily during peacetime, on a state's territory. Furthermore, while IHL regulates the actions of a belligerent state and of those parties it comes into contact with, both hostile and neutral, HRL is understood to primarily regulate the relationship between states and individuals.

A fourth (sub-)category consists of so-called 'patients' rights', which are often seen as an elaboration of human rights in the field of healthcare.[23] Human rights and patients' rights are increasingly overlapping, and there is an increasing congruence between the two fields. Patients' rights and human rights have a common and overlapping core, which is the state's duty to provide healthcare services. Beyond that, patients' rights are primarily focused on realizing a set of rights in the patient-doctor relationship, while human rights are more focused on the state's duty to respect and to guarantee a wide range of health-related rights. As in this contribution we will focus on the patient-doctor relationship on the battlefield, patients' rights have a potential role to play. While their role will not be discussed at length, some references will be made and it will be suggested that this area of the law has the potential to play a more substantial role when healthcare services are provided during armed conflicts.

7.4 Some Further Issues of Applicability

Above, three disciplines were identified in connection with the position of military medical personnel during armed conflicts. Before we can turn to the application of these norms in practice, we need to address a few preliminary questions that arise in particular in connection with the applicability of human rights norms during armed conflicts and to all the parties to the conflicts. For, as was mentioned above, human rights *primarily* bind states and they *primarily* apply during peacetime, on a state's territory.

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[22] Toebes 2012.

[23] Important instruments in this field are the UNESCO Universal Declaration on Bioethics and Human Rights, and the Council of Europe's Convention on Human Rights and Biomedicine. The UNESCO Universal Declaration on Bioethics and Human Rights, 19 October 2005. http://www.unesco.org/new/en/social-and-human-sciences/themes/bioethics/bioethics-and-human-rights/. Accessed 27 January 2013. The Council of Europe's Convention on Human Rights and Biomedicine, Oviedo, 4 April 1997 and Additional Protocols, Strasburg. http://conventions.coe.int/Treaty/en/Treaties/Html/164.htm and http://www.coe.int/t/dg3/healthbioethic/. Accessed 27 January 2013; For an account of the meaning and implications of patients' rights see Hartlev 2012.

7.4.1 IHL and HRL: lex specialis

The question arises how IHL and HRL relate to one another when it comes to their applicability during armed conflicts. Traditionally, the starting point has been that during armed conflicts, IHL functions as the *lex specialis* (more specific law) in relation to the more general human rights norms. In its Advisory Opinion concerning the Legality of the Threat or Use of Nuclear Weapons, the ICJ stated in relation to the interpretation of the right to life:

> The test of what is an arbitrary deprivation of life, however, then falls to be determined by the applicable *lex specialis*, namely, the law applicable in armed conflict which is designed to regulate the conduct of hostilities.[24]

However, eight years later the ICJ argued in favor of a more fluid approach in the Wall case:

> (…) 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.[25]

As stated by Lubell, this latter approach implies that where human rights law is more detailed in regulating a certain matter, it would be the primary source of law.[26] As will be more elaborately discussed below, HRL and patients' rights contain more detailed provisions in relation to certain matters, for example when it comes to the allocation of health resources and the regulation of the patient-doctor relationship. I therefore argue that in such situations these rights may function as the *lex specialis*, or as the norms that give more substance to the IHL norms.

7.4.2 Economic, Social, and Cultural Rights During Armed Conflicts

When it comes to providing medical services during armed conflicts, a key right is the human right to the 'highest attainable standard of health' (in short: the right to health).[27] It is important to point out that this right belongs to the category of economic, social, and cultural rights, which is usually distinguished from civil and political human rights. While the meaning and scope of the right to health will be more elaborately discussed below, a preliminary question that arises is whether

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[24] See for example ICJ, *Legality of the Threat or Use of Nuclear Weapons,* Advisory Opinion, General List No. 95, 8 July 1996, I.C.J. Reports 1996, p. 8, para 25.

[25] ICJ, *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory* (hereinafter *Wall Case*), Advisory Opinion, General List No. 131, 9 July 2004, I.C.J. Reports 2004, para 106.

[26] Lubell 2005, p. 752.

[27] For a recent analysis see Toebes 2012.

economic, social, and cultural rights, including the right to health, apply during armed conflicts. Answering this question enables us to assess if and to what extent there is a human right to medical services during armed conflicts, and a correlative duty on the part of the belligerent forces and military medical personnel to provide such services.

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 derogated from during armed conflicts and other situations of emergency.[28] Rather, the ICESCR contains two limitation clauses, neither of which specifically mentions war or any other type of emergency. While Article 2(1) ICESCR sets out a clause based on limitations of available resources, Article 4 ICESCR contains a general clause, which allows for limitations if 'determined by law, compatible with the nature of rights, and solely for the purpose of protecting the general welfare in a democratic society'. As mentioned, notions of emergency and armed conflict do not appear in these clauses, and as such it is unclear if and to what extent these limitation clauses apply during armed conflicts. However, 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.[29] The UN has consolidated this approach through the definition 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.[30] Along these lines, General Comment 14 on the right to health defines a set of core obligations, i.e., minimum entitlements flowing from the right to health that exist under all circumstances.[31] While all these obligations have potential relevance to situations of armed conflicts, the following obligations are of particular importance during such situations:

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[28] International Covenant on Civil and Political Rights (ICCPR), New York, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171 and vol. 1057, p. 407. http://www2.ohchr.org/english/law/ccpr.htm. Accessed 27 January 2013; International Covenant on Economic, Social and Cultural Rights (ICESCR), New York, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3. http://www2.ohchr.org/english/law/cescr.htm. Accessed 27 January 2013; ICCPR and ICESCR, both adopted within the framework of the UN on 16 December 1966 (entry into force 1976). Derogation clause in the ICCPR: Article 4-2 ICCPR.

[29] Committee on Economic, Social and Cultural Rights 1990, General Comments 3 and 14, paras 10 and 43, 44 respectively; The 'Limburg Principles' claim in para 4 that limitations on rights should not affect the 'subsistence or survival' of the individual or integrity of the person (para 47); Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, June 1986, Maastricht University, the Netherlands, E/C.12/2000/13, p. 3. http://www.unhchr.ch/tbs/doc.nsf/0/6b748989d76d2bb8c125699700500e17/$FILE/G0044704.pdf. Accessed May 2012; See also Toebes 2008, pp. 209–210.

[30] Committee on Economic, Social and Cultural Rights 2000, General Comment 14, paras 43 and 44 and more generally, Committee on Economic, Social and Cultural Rights 1990, General Comment 3, para 10.

[31] Committee on Economic, Social and Cultural Rights 2000, General Comment 14, paras 43–44.

- 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.[32]

This overview of core obligations also illustrates that a minimum right to health is not only about providing access to healthcare services, but also about securing a number of underlying determinants of health (e.g. access to clean water and shelter). Altogether, based on these notions, we may conclude that during all types of armed conflicts, States parties have a duty to secure access to, *inter alia*, minimum health services and basic healthy conditions, at the very least on a State's own territory and extending to where it exercises its jurisdiction. This leads to the conclusion that during armed conflicts of all natures combatants and civilians have a minimum right to a limited set of health-related services, based on the internationally guaranteed 'right to health', and supported by IHL.[33]

7.4.3 HRL's Extraterritorial Applicability

A further complication is that, in principle, human rights apply only territorially, that is to say within a State's national borders.[34] This implies that during IACs, States in principle do not have to realize the rights of individuals on the territory of the adversary. However, this narrow interpretation of HRL is eroding. Without discussing this in detail, there is by now a considerable amount of case law supporting the extraterritorial applicability of human rights law.[35] A decisive factor is whether the State exercises 'effective control' over a territory or a certain public power in the territory concerned.[36] This implies that in situations where the belligerent state is the occupying power, it has to respect the human rights of the individuals living in the occupied territory.

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[32] Ibid.

[33] See also Toebes 2008, pp. 209–214.

[34] See, *inter alia*, Article 2-1 ICCPR, *supra* note 28.

[35] *Inter alia*, ECtHR, *Loizidou v. Turkey (Preliminary Objections)*, No. 40/1993/435/514, 23 February 1995, and more recently *Al-Skeini and Others v. UK,* No. 55721/07, decision of 7 July 2002, available at http://hudoc.echr.coe.int. Accessed February 2013, and HRC, *Lopez Burgos*, UN Doc. A/36/40, Communication No. 52/1979, 29 July 1981, para 12.3, available at http://www2.ohchr.org/english/bodies/hrc/HRCommitteeCaseLaw.htm. Accessed February 2013; See also Lubell 2005, pp. 739–741.

[36] See the above-mentioned case law and *inter alia* Lubell 2005, pp. 739–741.

When it comes to economic, social, and cultural rights more specifically, the situation is less clear, as the ICESCR does not contain a provision on its scope of application.[37] In its Advisory Opinion concerning the Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory (the Wall case), 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 has sovereignty and to those over which that State exercises territorial jurisdiction.[38]

In the Wall case, the ICJ concluded 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.[39] 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.[40] In relation to Israel's position in the Occupied Palestinian Territories, this Committee stated that the State party's obligations under the Covenant apply to all territories and populations under its effective control.[41]

For the purposes of our analysis, this means that states exercising effective control over foreign territory have obligations under the ICESCR in that territory. The question arises how far such obligations should stretch, and whether this would also amount to a 'positive' duty to provide minimum health services in occupied territories. Coomans observes that an analysis by the Committee of the different types of obligations of occupying states is still lacking.[42] Based on the notion of 'minimum core obligations' (see above), I would argue that there are strong reasons to assume that also 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 socioeconomic services to residents in territories under their occupation. For the right to health in Article 12 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 (see further in Sect. 7.5.1).

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[37] Article 2-1 ICESCR, *supra* note 28, does not mention territory or jurisdiction, as opposed to Article 2-1 ICCPR, *supra* note 28.

[38] *Wall case*, *supra* note 25, para 112.

[39] *Wall case*, Ibid.

[40] For the state reporting procedure, see Articles 16–17 ICESCR, *supra* note 28.

[41] Committee on Economic, Social and Cultural Rights 2003, paras 15 and 31; See also Committee on Economic, Social and Cultural Rights 2001 and Coomans 2011, pp. 13–16.

[42] Coomans 2011, p. 15.

7.4.4 HRL and Non-State Actors

Furthermore, we need to address the question whether human rights norms can bind armed opposition groups (as participants in the armed conflict). It should be noted that this issue arises in particular in situations of NIACs, in which usually one or more non-state actors are involved.

Whether non-state actors are bound by HRL is a matter that has been the subject of intense debate. An important starting point is that HRL primarily binds States and that any form of third-party applicability should never undermine the primary responsibility of States as the entities that have ratified the human rights treaties. At the same time it cannot be ignored that human rights violations often take place in situations where blame cannot be directly placed on States only. Some actors, such as for example multinational corporations, have obtained such wealth, and such influence and power over the dignity, well-being, and health of individuals that there are strong reasons to argue in favor of some form of responsibility for human rights violations.[43] Along the same lines it could be argued that armed opposition groups are an important and powerful force during an armed conflict and that their activities can have a detrimental impact on the lives and health of persons engaged in and affected by the conflict. According to Bellal et al. an important factor for them to be bound by human rights law will be whether they exercise an element of governmental functions and whether they have *de facto* authority over a population.[44]

Secondly, the question arises whether military medical professionals may also have responsibilities in relation to human rights, as important non-state actors in this field. First and foremost, they may have certain indirect responsibilities in relation to the direct responsibilities of belligerent forces. This is because they are often at the forefront of situations where human rights violations by the belligerent forces are committed. This means that they may acquire important information about human rights violations that may be important to report. In addition, however, their responsibility may also be more direct, as in fulfilling their professional duties they may become complicit in human rights violations. As such the question arises whether they can also be bound directly by the human rights norms. As *military* medical personnel, they are directly employed by the armed forces, which is an organ of the state; and as such they are state agents.[45] It can be argued that in this position, they bear direct responsibilities under human rights law.

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[43] *Inter alia*, Jägers 2002 and Letnar Černič 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'.

[44] Bellal et al. 2001, p. 23.

[45] See Article 4(2) of the Draft Principles on State Responsibility: Responsibility of States for Internationally Wrongful Acts, United Nations, General Assembly, Resolution A/RES/56/83, adopted 28 January 2002. http://untreaty.un.org/ilc/texts/instruments/english/draft%20articles/9_6_2001.pdf. Accessed February 2013.

7.5 Military Medical Personnel Under International Law

7.5.1 Obligations of the Belligerent Parties

Having addressed a few preliminary questions, we can now look into the applicability of the available norms. We will first look at the obligations of belligerent forces in relation to military medical personnel. This will be analyzed against the backdrop of increasing reports about attacks on medical personnel by belligerent forces during armed conflicts. Rubenstein and Bittle have made a thorough analysis of such violations. In their analysis they make a distinction between four types of attacks: attacks on wounded and sick individuals; on medical personnel; on medical facilities and transports; and the improper use of facilities and emblems. Based on this analysis, they observe that (1) attacks on medical functions are part of a broad assault on civilians; (2) assaults on medical functions are used to achieve a military advantage, and (3) combatants do not respect the ethical duty of health professionals to provide care to patients irrespective of affiliation.[46] This leads to the conclusion that there is a compelling need to reinforce available standards that set out the responsibility of the belligerent forces in relation to (military) medical personnel.

As was mentioned above, for the applicability of IHL, we need to make a distinction between international and non-international armed conflicts (IACs and NIACs). But there are also several rules of customary international law that apply during both types of conflict. According to the ICRC, state practice establishes the following rule as a norm of customary international law:

> Medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. (…)[47]

This rule, which goes back to the 1864 Geneva Convention, is currently laid down in Geneva Conventions I, II, and IV, and Additional Protocol I, which apply during international armed conflicts (IACs).[48] These provisions also stipulate, *inter alia*, that if medical personnel fall into the hands of the enemy they shall receive the same treatment as prisoners of war, that transports of the wounded and sick shall be respected and protected, and that medical aircraft shall not be attacked.[49] The Statute of the International Criminal Court reinforces these rules by considering it a war crime to:

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[46] Rubenstein and Bittle 2010, pp. 329–340.

[47] ICRC 2012a, Rules of CIL, Rule 25.

[48] Geneva Convention I, *supra* note 11, Articles 24–26; Geneva Convention II, *supra* note 11, Article 36; Geneva Convention IV, *supra* note 11, Article 20; Additional Protocol I, *supra* note 9, Article 15.

[49] *Inter alia*. Articles 14–23 Geneva Convention I, *supra* note 11; Articles 7 and 12–40 Geneva Convention II, *supra* note 11; Article 33 Geneva Convention III, *supra* note 11; Articles 13–26 Geneva Convention IV, *supra* note 11; Articles 8–30 Additional Protocol I, *supra* note 9.

> (…) 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.[50]

As medical personnel are entitled to wear the distinctive emblems of the Geneva Convention, they fall under this protection. Furthermore, it is worth mentioning that another basis for the inviolability of medical personnel is provided by many domestic military manuals.[51]

During non-international armed conflicts (NIACs), the above-mentioned rule of customary international law also applies. Furthermore, the main rule that applies during NIACs is 'common Article 3' of the Geneva Conventions, which contains a set of minimum rules for the protection of those who do not take an active part in the hostilities, including the wounded and sick.[52] According to the ICRC, 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.[53] Furthermore, Additional Protocol II, which applies during NIACs of a certain intensity,[54] contains an explicit rule that medical personnel must be respected and protected.[55] In addition, the above-mentioned Stature of the ICC applies, as well as many domestic military manuals that equally apply during NIACs.

Similar standards can be found in the framework of medical ethics. The *Regulations in Times of Armed Conflict*, adopted by the World Medical Association (WMA) in 1956, make several references to the obligations of governments and armed forces in connection with the undisturbed delivery of healthcare.[56] With reference to the Geneva Conventions, Article 5 of these *Regulations* states that these parties to the conflict should ensure that physicians and other healthcare professionals are able to provide care to everyone in need in situations of armed conflict, including an obligation to 'protect health care personnel'. Physicians must be granted access to patients, medical facilities and equipment, and the protection needed to carry out their professional activities freely (Article 12).

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[50] International Criminal Court (ICC), Rome Statute of the International Criminal Court, Rome, 17 July 1998, UN Doc. A/CONF.183/9, Article 8(2) (b) (xxiv). http://untreaty.un.org/cod/icc/statute/romefra.htm. Accessed 27 January 2013.

[51] See also ICRC 2012a, ICRC Commentary in relation to Rule 25.

[52] Common Article 3 to Geneva Conventions I, II, III and IV, *supra* note 11.

[53] ICRC 2012a, ICRC Commentary to Rule 25.

[54] According to Article 1 Additional Protocol II, *supra* note 11, 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.

[55] Articles 9–11 Additional Protocol II, *supra* note 11.

[56] World Medical Association (WMA) 1956. Available at http://www.wma.net/en/30publications/10policies/a20/. Accessed June 2012.

As mentioned, these medical-ethical rules and the body of international humanitarian law are very much intertwined. Additional Protocol II to the Geneva Conventions explicitly refers to medical ethics:

> Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.[57]

Thus affirming medical ethics as an important discipline during armed conflicts.

Altogether, both IHL and medical ethics clearly state the duty of belligerent parties to safeguard the undisturbed delivery of healthcare services as well as the duty to ensure that medical personnel can perform its duties in a neutral fashion. How is this regulated under HRL? While it was discussed above that the applicability of human rights law during armed conflicts is by no means straightforward, we will now look at the normative scope of protection that the human rights standards have to offer.

We should take as a starting point that *all* human rights can have relevance for the protection of individuals during armed conflicts. In other words, we should not focus too rigidly on a selection of rights. However, as was also mentioned above, some human rights are of particular importance when it comes to armed conflicts, including the right to life, the prohibition of torture, and inhuman and degrading treatment, as well as the rights to health, food, clothing, and shelter. The most appropriate standard to look at the context of providing healthcare, the allocation of health resources and triage is the 'right to the highest attainable standard of health' which is set out in, *inter alia*, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[58] In short, this norm grants a right to healthcare and to a set of underlying conditions for health to *vis-à-vis* their governments. The scope of this norm, commonly addressed as the 'right to health', has been clarified in General Comment 14, an explanatory document to Article 12 ICESCR, adopted by the Committee on Economic, Social and Cultural Rights

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[57] Article 10 para 1 Additional Protocol II (applicable during non-international armed conflicts), *supra* note 11.

[58] The first instrument to lay down a right to health was the Constitution of the World Health Organization (WHO, adopted 1946). Furthermore, the right to health can be found in Article 25 of the Universal Declaration of Human Rights (UDHR, 1948), as mentioned, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), *supra* note 28, Article 12 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW, 1979) and Article 24 of the Convention on the Rights of the Child (CRC, 1989), and 9, 25 and 26 of the Convention on the Rights of Persons with Disabilities (CRPD, 2006), as well as several other UN conventions. Furthermore, the right to health can be found in several regional human rights conventions. For example, Article 11 of the European Social Charter (ESC, 1965) stipulates a 'right to protection of health', and we find the right to health (care) in Article 35 of the European Charter on Fundamental Rights (EU). We also find the right to health in Article XI American Declaration of the Rights and Duties of Man (ADHR, 1948) and Article 10 of the 'Protocol of San Salvador' (Additional Protocol to the American Convention on Human Rights, 1988); Article 16 of the African Charter on Human and Peoples' Rights (1981); Article XVIII of the Universal Islamic Declaration of Human Rights (1981).

(CESCR) in 2000.[59] Although General Comments are in principle not legally binding, they provide an authoritative explanation of the human rights norms under the ICESCR.

Based on the right to health, States and potentially belligerent forces have duties in relation to patients and medical personnel. The right to health stipulates a duty on the part of states to grant healthcare services and to guarantee a range of underlying conditions for health to its residents.[60] In Sect. 7.4.2 it was argued that during armed conflicts, based on human rights, States and potentially other actors have at the very minimum a duty to ensure the safe delivery of medical services and other health-related services such as safe drinking water and adequate sanitation facilities.[61] Furthermore, based on the General Comment, these health-related services should be provided on the basis of the principles of 'availability, accessibility, acceptability and quality', generally addressed as the so-called 'AAAQ'.[62] Accessibility has four overlapping dimensions: non-discrimination, economic accessibility, geographic accessibility, and information accessibility.[63] Combining these two notions, here are some examples of what this may entail during armed conflicts:

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 those of 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 for medical staff.[64]

Furthermore, under human rights law, a distinction is often made between three types of obligations: (state) obligations to respect, to protect, and to fulfill human rights. This so-called 'tripartite typology of State obligations' was first introduced

[59] Committee on Economic, Social and Cultural Rights 2000.

[60] Committee on Economic, Social and Cultural Rights 2000, General Comment 14, para 4.

[61] Committee on Economic, Social and Cultural Rights 2000, General Comment 14, paras 44, 45 defines a set of minimum core obligations (see also above).

[62] Committee on Economic, Social and Cultural Rights 2000, General Comment 14, para 12.

[63] Ibid.

[64] Ibid.

in the early 1980s, and subsequently introduced into the UN human rights regime.[65] It is most frequently applied to economic, social, and cultural rights, and is intended to create clarity over the types of legal commitments that States and other actors are required to make in relation to the rights. The duty to *respect* the rights implies a negative duty to refrain from infringing the core value that is protected by the right concerned (e.g. privacy, health, or housing). The duty to protect the right concerned implies an obligation on the part of the duty holder to protect the interest concerned against the unlawful acts of third parties (e.g., multinational corporations, healthcare institutions, or armed opposition groups). Lastly, the duty to fulfill is a positive duty on the part of the duty holder to take measures to ensure the availability of necessary services (e.g., medical care, housing, and adequate nutrition, but also access to legal recourse).

Based on this typology, States and potentially other parties have 'negative' obligations to respect the right to health (or not to harm health), as well as positive obligations to 'protect' the health of individuals in relation to others, and positive obligations to 'fulfil' health, i.e., providing or ensuring the availability of necessary health services. Altogether based on the right to health we can identify the following minimum obligations for States and other belligerent parties:

- 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[66]
- Protect:
  - Protect medical personnel and patients from attacks by third parties;
- Fulfill:
  - Provide necessary 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.

This framework of the right to health may apply to state parties in an NIAC or during situations that do not qualify as an IAC or a NIAC; and it may apply outside a state's national borders as long as States exercise 'effective control' over a certain territory. Furthermore, when it comes to NIACs, this framework may apply to the state party involved in the conflict, and potentially to non-state actors

[65] Shue 1980; Van Hoof 1984; Eide 2001.

[66] This obligation to 'respect' is explicitly mentioned in Committee on Economic, Social and Cultural Rights 2000, General Comment 14, para 34.

involved in the conflict, in particular if they exercise a certain amount of governmental control over a population.

Everything taken together, we see that IHL, medical-ethical standards, and the right to health oblige States and potentially other belligerent forces to respect the duty of care of military medical personnel and to support medical personnel in fulfilling their tasks. Clearly, HRL reinforces the duties that exist under IHL; and where IHL has limited applicability (i.e., during NIACs), HRL may provide an important additional framework of protection.

7.5.2 Obligations of Military Medical Personnel

As to the position of military medical personnel, the primary standards to look at are medical-ethical ones. An important point of departure for analyzing the duty of medical personnel is the Declaration of Geneva, the modern equivalent of the Hippocratic Oath, which 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.[67]

However, in medical-ethical circles there is much disagreement as to whether these and other standards should apply unconditionally during armed conflicts. 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 ones.[68] As was pointed out by Rascona:

> Line officers, who have far greater expertise and information than military physicians regarding the needs of the military mission, ultimately determine the ethical priorities military physicians must follow. If, for example, soldiers are ill but can fight, line officers (having been informed by military physicians regarding these soldiers' health) decide whether they still should fight under these conditions. This is what should occur. Those who are most capable of deciding what is necessary to best prevent such horrors as global genocide should be the ones to do so. The only other option would be to let persons with less expertise, such as physicians, make these decisions.[69]

Other groups have argued in favor of applying general medical-ethical standards unconditionally during armed conflicts. In 1965, the World Medical Association (WMA) adopted the above-mentioned *Regulations in Time of Armed Conflict*.[70] Article 1 of this document states that:

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[67] WMA Declaration of Geneva 1948, *supra* note 5.

[68] See, for example, Howe 2003; Madden and Carter 2003 and Gross 2006.

[69] See the reaction by D. R. Rascona to the views of Sidel and Levy 2003, p. 313.

[70] WMA Regulations in Times of Armed Conflict 1956, *supra* note 56.

> 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.[71]

Furthermore, the *Regulations* state that during an armed conflict, standard ethical norms apply, not only in regard to treatment but also to all other interventions (Article 3). As such, medical ethics standards in relation to doctors do not create a specific set of rules for health professionals that operate in an armed conflict; rather, the same ethical standards apply.

In addition, more specifically in relation to armed conflicts, it is deemed unethical to:

a. Give advice or perform prophylactic, diagnostic, or therapeutic procedures that are not justifiable for the patients' health care.
b. Weaken the physical or mental strength of a human being without therapeutic justification.
c. Employ scientific knowledge to imperil health or destroy life.
d. Employ personal health information to facilitate interrogation.[72]

And doctors have duties to:

- Treat people with humanity and respect applies to all patients and give the required care impartially and without discrimination[73];
- Preserve medical confidentiality (in circumstances where a patient poses a significant risk to other people physicians will need to weigh their obligation to the patient against their obligation to other individuals threatened)[74];
- Not use privileges and facilities afforded to them for other than healthcare purposes.[75]

Interestingly, the Regulations also contain a number of duties for physicians in relation to governments and other authorities to ensure that these:

– Provide the infrastructure that is a prerequisite to health, including potable water, adequate food and shelter; and
– Are planning for the repair of the public health infrastructure in the immediate post-conflict period.[76]

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[71] WMA 1956, *supra* note 56, Regulation 1.
[72] WMA 1956, Ibid., Regulation 2.
[73] WMA 1956, Ibid., Regulation 4.
[74] WMA 1956, Ibid., Regulation 6.
[75] WMA 1956, Ibid., Regulation 7.
[76] WMA 1956, Ibid., Regulations 9 and 10.

This shows that the WMA is of the opinion that doctors also have professional duties in relation to governments and other authorities. So in addition to medical neutrality what is also required is a certain amount of 'political activism' (i.e., reporting on human rights abuses).[77]

Another group that has more recently argued in favor of the unconditional application of medical-ethical standards is the Dual Loyalty Working Group, a joint initiative by Physicians for Human Rights and the University of Cape Town.[78] The Group proposes a set of ten guidelines in total, 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.[79]

Like the Regulations of the WMA, these guidelines stress that general medical-ethical standards apply during armed conflicts. There is also a duty to respect confidentiality, and a similar duty to report human rights violations. As was already observed in the introduction, it is interesting to note that the Dual Loyalty Working Group stresses the importance of the protection of human rights by medical professionals.

The next step is to see how these medical-ethical principles are reflected by IHL and HRL. IHL is not so much directed at regulating the conduct of medical personnel in relation to the wounded and sick directly: rather it provides for their protection in the exercise of their duties. Nonetheless, as state agents, military medical personnel have to respect the rules that have been set out for the belligerent parties. Article 10 of Additional Protocol I states that the wounded and sick

[77] See also List 2008, p. 243.

[78] International Dual Loyalty Working Group 2002, in Allhoff 2008, pp. 33–37; See also London et al. 2006.

[79] International Dual Loyalty Working Group 2002, in Allhoff 2008, pp. 33–37; The other guidelines concern the issues of chemical weapons, torture, capital punishment, and human experimentation, issues that are left aside in this contribution. ICRC 2012a, Customary IHL, Rule 25.

of any party to the conflict 'shall be respected and protected'. We may assume that this duty to protect the wounded and sick and of all the parties to the conflict also falls upon military medical personnel, as employees of the armed forces.[80]

When it comes to HRL, we see that human rights are increasingly mentioned as an important framework for medical professionals.[81] It provides the health professional with an agreed upon, legally binding and universally applicable set of rules on the basis of which he can weigh his ethical dilemmas.[82] Human rights norms, in particular the right to health, should therefore obtain a more solid role when it comes to solving the moral difficulties that arise during armed conflicts.

Above I have suggested that military medical personnel may bear direct responsibilities under a 'right to health'. Based on this assumption, I argue that the notion of a 'right to health' can have some important implications for military medical personnel. The above-mentioned 'AAAQ', stipulating the principles of availability, accessibility, and acceptability under the right to health, can also be of specific importance in the patient-doctor relationship. 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' can be of some guidance during battlefield situations. Acceptability means that health services must be respectful of medical ethics and culturally appropriate. 'Respectful of medical ethics' includes, according to General Comment 14, respecting the confidentiality of patients.[83] By referring to patients' rights, the General Comment establishes a link between the right to health and 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.[84]

Furthermore, in relation to the belligerent forces, a distinction was made between three types of human rights obligations: obligations to respect, to protect, and to fulfill human rights. I argue that similar obligations can be defined in

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[80] Article 10 Additional Protocol I, *supra* note 9; See also Article 11, Additional Protocol I, *supra* note 9, which prohibits physical mutilations, the carrying out of medical experimentations, and the removal of tissue or organs for transplantation.

[81] *Inter alia*, Rubenstein 2009.

[82] International Dual Loyalty Working Group 2002, see the quote in the intro.

[83] Committee on Economic, Social and Cultural Rights 2000, General Comment 14, para 12.

[84] *Inter alia,* Article 6 Universal Declaration on Bioethics and Human Rights (UNESCO, 2005), *supra* note 23, and Articles 5–9 Convention on Human Rights and Biomedicine (Oviedo Convention, 1997; Council of Europe), *supra* note 23.

relation to military medical professionals. Based on the above military medical personnel have the following human rights obligations:

- Respect:
  - Respect for equal access to available medical services;
  - Refrain from discrimination between patients;
  - Refrain from prioritizing between patients on considerations other than medical ones;
- Protect:
  - Protect patients from attacks by third parties;
  - Protect the confidentiality of patients;
- Fulfill:
  - Provide medical services ('duty of care');
  - Report allegations of 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.

7.6 Conclusions

This contribution has touched upon an important aspect of the overall theme of this volume, i.e., the 'human face' of armed conflicts. If we want to 'humanize' armed conflict, we need to strengthen and consolidate the position of those who work with the wounded and sick. I have attempted to demonstrate how the interconnected fields of IHL, medical ethics, and human rights come together when it comes to the regulation of the position of military medical personnel. The core principle underlying this framework is the principle of 'medical neutrality', which defines the position of all health workers, including military medical personnel. Generally speaking, all norms emphasize the importance of an undisturbed, fair, and equal distribution of health-related services, as well as the duty to treat patients equally, and not to give priority to military considerations when deciding which patient to treat first.

Everything taken together, we can identify two dimensions in connection with these norms: (1) duties on the part of the belligerent forces to allocate health services in an appropriate and fair manner, while respecting the undisturbed delivery of military medical personnel and their medical neutrality; and (2) duties on the part of military medical personnel to provide medical services in a neutral fashion, respectful of medical ethics, and giving priority to medical considerations above military ones.

While these are important starting points, the practical realities are still very much removed from these positions. Governments, non-state actors, and the military medical profession should therefore make a stronger commitment to the framework so defined. This commitment should lead to a strong affirmation and articulation of the importance of these standards, making it clear that they should be adhered to by everyone involved in the conflict. It should be stressed that these standards are legally binding and that non-compliance can lead to accountability under IHL and HRL. In addition, this commitment should result in the training of the military forces as well as in investigations of alleged violations.[85] International organizations can play an important role in strengthening the role and position of military medical professionals. It is therefore promising that the ICRC has placed the matter firmly on its agenda,[86] while there is also potential at the WHO to explore this issue further.[87]

References

Documents

Committee on Economic, Social and Cultural Rights (1990) The nature of States Parties Obligations, 14 Jan 1990, General Comment 3., UN Doc. E/1991/23, Article 2, para 1. http://www.unhchr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664?Opendocument. Accessed June 2012

Committee on Economic, Social and Cultural Rights (2000) The right to the highest attainable standard of health, 11 Aug 2000, UN General Comment No. 14, UN Doc. E/C12/200/4. http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En. Accessed June 2012

Committee on Economic, Social and Cultural Rights (2001) Concluding observations on the additional information submitted by Israel, 31 Aug 2001, UN Doc. E/C.12/Add.69. http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/19b934142bfa843ac1256abc003095cb?Opendocument. Accessed June 2012

Committee on Economic, Social and Cultural Rights (2003) Concluding observations on the second periodic report of Israel, 23 May 2003, UN Doc. E/C.12/1/Add. 90. http://www.unhchr.ch/tbs/doc.nsf/0/b313a3503107f1e6c1256d33002cea38?Opendocument. Accessed June 2012

ICRC (2004) What is International Humanitarian Law? Advisory Service on International Humanitarian Law. http://www.icrc.org/eng/assets/files/other/what_is_ihl.pdf. Accessed Feb 2011

ICRC (2011) Health care in danger: making the case, ICRC Resource Centre. http://www.icrc.org/eng/resources/documents/publication/p4072.htm. Accessed June 2012

ICRC (2012a) Customary International Law (updated version of the Study on Customary International Humanitarian Law conducted by the International Committee of the Red Cross

[85] See also Rubenstein and Bittle 2010, p. 337.

[86] ICRC 2011.

[87] Rubenstein and Bittle 2010, p. 337; See WHO, Health Action in Crisis unit, at http://www.who.int/hac/en/. Accessed 27 January 2013.

(ICRC) and originally published by Cambridge University Press). http://www.icrc.org/customary-ihl/eng/docs. Accessed June 2012
ICRC (2012b) Health care in danger: questions and answers, ICRC Resource Centre. http://www.icrc.org/eng/resources/documents/faq/health-care-in-danger-faq-2011-08-05.htm. Accessed May 2012
ICRC (2012c) Video Series. http://www.icrc.org/eng/what-we-do/safeguarding-health-care/index.jsp. Accessed May 2012
Sidel V, Levy B (2003) Physician-soldier: a moral dilemma? In: Military medical ethics, vol 1. Borden Institute, US Army Medical Department. http://www.bordeninstitute.army.mil/published_volumes/ethicsVol1/ethicsVol1.html. Accessed June 2012

Literature

Allhoff F (2008) Physicians at war: the dual-loyalties challenge. International library of ethics, law, and the new medicine, vol 41. Springer, Dordrecht
Beam T, Spracino L (2003) Military medical ethics, vol I. Office of the Surgeon General, Falls Church
Bellal A, Giacca G, Stuart C-M (2001) International law and armed non-state actors in Afghanistan. Int Rev Red Cross 93(881):1–33
British Medical Association (2001) The medical profession and human rights. Handbook for a changing agenda. Zed Books, London
Bloche M, Gregg and Marks JH (2005) When doctors go to war. N Engl J Med 352(1):3–6
Coomans F (2011) The extraterritorial scope of the international covenant on economic, social and cultural rights in the work of the United Nations Committee on Economic, Social and Cultural Rights. Hum Rights Law Rev 11(1):1–35
Eide A (2001) Economic, social and cultural rights as human rights. In: Eide A, Krause C, Rosas A (eds) Economic, social and cultural rights: a textbook. Martinus Nijhoff Publishers, Dordrecht/Boston/London, pp 21–41
Frisina M (2008) Guidelines to prevent malevolent use of physicians at war. In: Allhoff F (ed) Physicians at war: the dual-loyalties challenge. International Library of Ethics, Law, and the New Medicine, vol 41. Springer, Dordrect, pp 39–52
Gross M (2006) Bioethics and armed conflict: moral dilemmas of medicine and war. MIT Press, Cambridge
Hartlev M (2012) Patients' rights. In: Toebes B, Hartlev M, Hendriks A, Rothmar Herrmann J (eds) Health and human rights in Europe. Intersentia/Hart, Cambridge/Antwerp/Portland, pp 111–144
Howe E (2003) Mixed agency in military medicine: ethical roles in conflict. In: Beam T, Spracino L (eds) Military medical ethics, vol I. Office of the Surgeon General, Falls Church, pp 331–365
International Dual-Loyalty Working group (2002) Dual-loyalty and human rights in health professional practice: proposed guidelines and institutional mechanisms, physicians for human rights. Washington/University of Cape Town. https://s3.amazonaws.com/PHR_Reports/dualloyalties-2002-report.pdf. Accessed Feb 2013. Also in Allhoff (2008), pp 15–38
Jägers N (2002) Corporate human rights obligations: in search of accountability. Intersentia, Antwerp
Letnar Černič J (2010) Human rights law and business. Europa Law Publishing, Groningen
List J (2008) Medical neutrality and political activism: physicians' roles in conflict situations. In: Allhoff F (ed) Physicians at war: the dual-loyalties challenge. International Library of Ethics, Law, and the New Medicine, vol 41. Springer, Dordrect, pp 237–255

London L, Rubenstein L, Baldwin-Ragaven L, Van Es A (2006) Dual loyalty among military health professionals: Human rights and ethics in times of armed conflict. Cambr Q Healthc Ethics 15:381–39

Lubell N (2005) Challenges to applying human rights law to armed conflict. Int Rev Red Cross 87(860):737–754

Madden W, Carter B (2003) Physician-soldier: a moral profession. In: Beam T, Spracino L (eds) Military medical ethics, vol I. Office of the Surgeon General, Falls Church, pp 269–291

McDonald A, Kleffner J, Toebes B (eds) (2008) Depleted Uranium Weapons and international law. T.M.C. Asser Press, The Hague

Mottershaw E (2008) Economic, social and cultural rights in armed conflict: International Human Rights Law and International Humanitarial Law. Int J Hum Rights 12(3):449–470

Rubenstein L (2009) Physicians and the right to health. In: Clapham A, Robinson M (eds) Realizing the right to health, Swiss Human Rights Book, vol 3. Rüffer & Rub, Zürich, pp 381–392

Rubenstein L, Bittle M (2010) Responsibility for protection of medical workers and facilities in armed conflict. The Lancet 375:329–340

Shue H (1980) Basic rights: subsistence, affluence and U.S. Foreign Policy. Princeton University Press, Princeton

Solis G (2010) The law of armed conflict. Cambridge University Press, Cambridge

Toebes B (2008) The use of depleted uranium as a potential violation of human rights. In: McDonald A, Kleffner J, Toebes B (eds) Depleted uranium weapons and international law. T.M.C. Asser Press, The Hague, pp 187–216

Toebes B (2012) The right to health and other health-related rights. In: Toebes B, Hartlev M, Hendriks A, Rothmar Herrmann J (eds) Health and human rights in Europe. Intersentia, Cambridge, pp 83–110

Toebes B, Hartlev M, Hendriks A, Rothmar Herrmann J (eds) (2012) Health and human rights in Europe. Intersentia, Cambridge

van Hoof G (1984) The legal nature of economic, social and cultural rights: a rebuttal of some traditional views. In: Alston P, Tomaševski K (eds) The right to food. SIM, Utrecht, pp 97–111

World Medical Association (WMA) Regulations in time of armed conflict, adopted by the 10th World Medical Assembly, Havana, Cuba, Oct 1956, last amended by the World Medical Association General Assembly, Tokyo, 2004. http://www.wma.net/en/30publications/10policies/a20/. Accessed Feb 2013