



Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism

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MEDICAL CARE IN ARMED CONFLICT

International Humanitarian Law and State Responses to Terrorism

Dustin A. Lewis, Naz K. Modirzadeh, and Gabriella Blum

Harvard Law School Program on International Law and Armed Conflict

Legal Briefing + Compendium

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**MEDICAL CARE
IN ARMED CONFLICT:
INTERNATIONAL HUMANITARIAN
LAW AND STATE RESPONSES TO
TERRORISM**

EXECUTIVE SUMMARY

The global fight against terrorism has taken a turn that threatens to erode a foundational ethic of international humanitarian law (IHL): the protection of medical care for all wounded combatants, whether friend or foe. At the same time, aggressive state responses to terrorism illuminate how IHL medical-care protections, while extensive, are often fragmented and non-comprehensive. In short, contemporary counterterrorism policies contradict some of these IHL protections and expose the weakness of key others.

In 1864, states agreed to a pioneering IHL treaty on medical care. It required that the wounded and sick combatants of the warring states who are rendered *hors de combat* (out of the battle) be protected and cared for. Over time, those safeguards were extended to all wounded fighters *hors de combat* of all parties in all armed conflicts. Of course, protections for the wounded would be largely meaningless without access to medical personnel and supplies. So IHL also shields those engaged in medical care and the means they employ to do so. States thereby struck a balance—part practical, part moral—to keep medical care for the wounded and sick above the conflict.

None of these IHL protections is weakened for an enemy if she is defined as a terrorist. For instance, under IHL no wounded fighter may be denied medical care due to a terrorist designation.

Yet as part of their response to terrorist threats, some states attack medical caregivers or abuse, withhold, prevent, or punish medical care. Attacks directed at health-care facilities in terrorist-controlled areas and the use of health-care professionals in the

abusive treatment of alleged terrorists have been widely condemned. So, too, have denials of medicine to populations under the control of terrorist groups.

Our inquiry focuses on another element: how, often with the legal force and political backing of the United Nations Security Council, states penalize—during wartime (as well as peacetime)—diverse forms of support, sometimes including medical care, to terrorist organizations. These responses to terrorism reject two of the premises underlying the IHL protections for medical care.

First, counterterrorism policies recast medical care as a form of illegitimate support to the enemy. In comparison, according to the International Committee of the Red Cross (ICRC), the “dominant idea behind” the First Geneva Convention of 1949 is that “medical treatment, *even where given to enemies, is always legitimate*, and does not constitute a hostile act. *Medical personnel are placed above the conflict.*” Amid swelling concern, in 2011, the ICRC called for states to exclude from anti-terrorism legislations activities that are exclusively humanitarian and impartial in character and that are conducted without adverse distinction. Otherwise, prohibitions of medical services to persons rendered *hors de combat* as support to terrorism would “call into question the very idea behind the creation of the ICRC—and subsequently of National Red Cross and Red Crescent Societies—over 150 years ago.”

Second, counterterrorism policies reject the corollary proposition that a terrorist organization may assign a medical corps to work under its authority. Thus, domestic anti-terrorism legislations often prohibit medical caregivers from acting under the direction and control of terrorist groups. In comparison, the IHL system of protection of medical care hinges partly on mutual trust between the warring parties. The display of the Geneva Conventions’ distinctive emblems is perhaps the most visible manifestation of that trust. Displaying those emblems notifies the opposing side that the personnel and objects bearing them claim to benefit from special protections. IHL requires the warring parties—including organized armed groups—to safeguard that trust by overseeing and controlling their own medical

personnel, transports, and units.

As we demonstrate, however, IHL's own commitment to these premises remains incomplete and creates fault lines in the protective landscape. State responses to terrorism exacerbate these fault lines. And counterterrorism policies threaten to further weaken these ethical norms.

These are not mere abstract concerns. Across recent and current armed conflicts, state responses to terrorism have cast a spotlight on the scope and implementation of IHL protections for medical care:

- During its internal armed conflict, Peru prosecuted physicians in part for providing medical assistance to members of *Sendero Luminoso* (the Shining Path);
- Colombia penalized a medical professional who managed the longer-term specialized care of members of the *Fuerzas Armadas Revolucionarias de Colombia* (the Revolutionary Armed Forces of Colombia);
- Syria detained physicians who gave medical care to wounded opposition fighters designated as terrorists, and it attacked health-care facilities in terrorist-controlled areas;
- The United States prosecuted an American physician for agreeing to be an “on call” doctor for wounded members of al-Qaeda the next time that doctor travelled to Saudi Arabia; it penalized a different American for seeking to travel to Iraq and Syria to provide medical care to wounded members of the Islamic State of Iraq and al-Sham (ISIS) and in hospitals in ISIS-held territory; and it prosecuted a Canadian in part for providing English lessons in an al-Qaeda clinic in Afghanistan to assist nurses in reading medicine labels; and
- Australia and the United Kingdom are evaluating whether to penalize, upon their return, medics who have reportedly provided medical care in ISIS-held territory—including, potentially, to members of ISIS.

Over the last quarter-century, terrorists and other non-state actors have controlled access to civilian populations in a variety of armed conflicts. Consider Afghanistan, Chechnya, Colombia, Gaza, Iraq, Lebanon, Mali, Nepal, Nigeria, Pakistan, Peru, the Philippines, Somalia, Syria, and Yemen (among others). The number and effects of terrorist attacks are reportedly increasing around the world. And states are designating more organized armed groups as terrorists. We therefore expect that these questions will become more salient and more urgent in a growing number of theaters.

The surge in armed conflicts involving terrorism has brought to the fore the general question of medical care in armed conflict and the particular legal protections afforded to those providing such care to terrorists. Against this background, we evaluate IHL protections for wartime medical assistance concerning terrorists. Through that lens, we expose gaps and weaknesses in IHL. We also examine tensions between IHL and state responses to terrorism more broadly.

While those responses to terrorism highlight fault lines in the IHL landscape of medical-care measures, these ruptures are not new. But they are increasingly noticeable as terrorism is more frequently conceptualized as forming part of armed conflicts and as more states undertake aggressive responses to terrorist threats.

Part of the problem in the normative framework is that not all IHL medical-care measures are universally applicable to all armed conflicts. The oldest fault line is the disparate extent to which the legal regime protects medical care in the two types of armed conflict recognized under IHL: international armed conflicts (IACs) and non-international armed conflicts (NIACs). Traditionally, IHL imposed many more medical-care obligations in IACs than in NIACs. In the 1970s, states attempted to create a more uniform and comprehensive regime. Those efforts met success insofar as states opted into the resulting treaties flattening many of those distinctions. But because numerous states did not contract into the new treaties, those efforts simultaneously exacerbated the fragmentation between states

and across conflicts. Over all, selective participation in the legal regime has led to significant variance in states' medical-care obligations.

Meanwhile, an array of medical-care rules has crystallized into customary IHL (which binds all states, regardless of whether the state is a party to a relevant treaty). But a number of important customary IHL medical-care rules identified by the ICRC in a pioneering study lack, in our view, sufficient evidence of states' buy-in. Nor do developments in international human rights law and international criminal law fully resolve the fragmentation or fill the gaps in the IHL protections for medical care.

Furthermore, even the most extensive IAC and NIAC treaties do not exhaustively protect all facets of medical care. To date, for instance, under IHL states have not regulated the capture and retention of medical personnel in NIAC. Nor have they addressed independent caregivers seeking to travel to conflict areas to treat the wounded and sick in terrorist-controlled territory where civilian needs are often greatest.

Against the backdrop of this fragmented protective landscape, states are taking more aggressive approaches to preventing, intercepting, and punishing terrorism. The U.N. Security Council has been a key driver of these responses, requiring member states to take more and broader steps to obviate terrorist threats. Yet so far, the Council has not required that, in doing so, states fully exempt impartial wartime medical care, even in circumstances that would render such care protected under IHL. Rather, the Council seems to consider providing medical assistance and supplies to al-Qaeda and its associates as at least a partial ground for designating those who facilitate such care as terrorists themselves.

The overall result today is unsatisfactory. By prosecuting physicians for supporting terrorists in armed conflicts, some states are likely violating their IHL treaty obligations. But in certain other instances where states intentionally curtail

medical care there is no clear IHL violation. Both those *actual IHL violations* and the *lack of clear IHL violations*, we think, are cause for concern. The former represent failures to implement the legal regime. And the latter highlight the non-comprehensiveness—or, at least, the indeterminateness and variability—of the normative framework.

At first glimpse, the legal protections for medical care to an ISIS fighter or a member of the Shining Path may attract little sympathy. But those safeguards represent a fundamental thread that ties the larger tapestry of IHL protections together. Pulling that thread risks unraveling the broader wartime international law protective regime—a regime that aims, however imperfectly to date, to cover not only terrorists but all wounded people in armed conflict: military and civilian, terrorist and non-terrorist alike.

We first introduce some key concepts and sketch the relationship between the laws of armed conflict and state responses to terrorism. Then we trace the long history of the development of international legal protections for impartial medical assistance in armed conflict. We next illuminate the two major sets of IHL protections for impartial wartime medical care concerning terrorists: first, the entitlement to and the protection of medical care for the wounded and sick; and second, the most salient aspects of the corollary protections for medical caregivers, transports, units, and supplies.

We then discuss—alongside a broader analysis of the relationship between the laws of armed conflict and responses to terrorism—how states are attempting to prevent, disrupt, and punish terrorist threats. We focus on the relatively recent ascendance of the globally oriented anti-terrorism regime emanating from the U.N. Security Council. We also highlight the domestic jurisprudence of three states—Colombia, Peru, and the United States of America—where legal proceedings concerning wartime medical care to terrorists have been instituted.

We conclude by emphasizing that the Security Council's move to legislate global counterterrorism measures has occurred without due consideration—at least due public consideration—of the potential impact on the foundational ethic of IHL entailed in impartial medical care. Nor, in implementing those Council obligations and in devising their own additional anti-terrorism measures, have states sufficiently and publicly evaluated the potential consequences for that foundational ethic. Without duly considering what may be lost, these responses to terrorism risk unwittingly eroding a normative pillar of IHL.

CREDITS

ABOUT THE AUTHORS

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TABLE

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Fragmentation under IHL of Key Impartial Wartime Medical Care Norms

MAP

MAP 1, PAGE 107

Listed Locations of Security Council-designated Terrorist Organizations

WEB

This report is available free of charge online at <http://pilac.law.harvard.edu/mcac>.

ABBREVIATIONS

Treaties

ACHR	American Convention on Human Rights, November 22, 1969, 1144 U.N.T.S. 123
AP I	Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 3
AP II	Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-international Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 609
AP III	Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Adoption of an Additional Distinctive Emblem, December 8, 2005, 2404 U.N.T.S. 261
GC 1864	Convention for the Amelioration of the Wounded in Armies in the Field, August 22, 1864, 22 Stat. 940
GC 1906	Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, Geneva, July 6, 1906, 35 Stat. 1885
GC I	Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, August 12, 1949, 75 U.N.T.S. 31
GC II	Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, August 12, 1949, 75 U.N.T.S. 85
GC III	Convention (III) Relative to the Treatment of Prisoners of War, August 12, 1949, 75 U.N.T.S. 135
GC IV	Convention (IV) Relative to the Protection of Civilian Persons in Time of War, August 12, 1949, 75 U.N.T.S. 287
GC POW 1929	Geneva Convention Relative to the Treatment of Prisoners of War, July 27, 1929, 47 Stat. 2021
GC W&S 1929	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick of Armies in the Field, July 27, 1929, 47 Stat. 2074
HC (X) 1907	Convention (X) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention, October 18, 1907, 36 Stat. 2371
ICC RS	Rome Statute of the International Criminal Court, July 17, 1998, 2187 U.N.T.S. 90
ICCPR	International Covenant on Civil and Political Rights, December 16, 1966, 999 U.N.T.S. 171

UN Charter

Charter of the United Nations, June 26, 1945, 59 Stat. 1031

International Courts, Tribunals, and Other (quasi-) Judicial Bodies

ICC	International Criminal Court
ICTY	International Tribunal for the Prosecution of Persons Responsible for Serious Violations of International Humanitarian Law Committed in the Territory of the Former Yugoslavia since 1991
ICJ	International Court of Justice
IACtHR	Inter-American Court of Human Rights

Official Records

O.R.	Official Records of the Diplomatic Conference on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts, Geneva, 1974–1977, Volumes I–XVII (Swiss Federal Political Department, Bern, 1978)
CDDH	<i>Conference diplomatique sur la reaffirmation et le developpement du droit international humanitaire applicable dans les conflits armes</i> [Diplomatic Conference on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts], 1974–1977

ICRC Commentaries, Studies, and Submissions

ICRC, CE/7b	Conference of Government Experts on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts, Geneva, 24 May – 12 June 1971, Document CE/7b, Vol. VII, Protection of the Wounded and Sick Geneva, January 1971, submitted by the International Committee of the Red Cross
ICRC, CIHLS	Customary International Humanitarian Law, Henckaerts and Doswald-Beck eds. (2005) [Volume I: Rules; Volume II: Practice – Parts 1 and 2] (Also denominated ICRC, Customary IHL Study)
ICRC, <i>Commentary on GC I</i>	Commentary on the Geneva Conventions of 12 August 1949, Vol. I, Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Pictet ed. (1952)
ICRC, <i>Commentary on GC II</i>	Commentary on the Geneva Conventions of 12 August 1949, Vol. II, Geneva Convention for the for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, Pictet ed. (1960)
ICRC, <i>Commentary on GC III</i>	Commentary on the Geneva Conventions of 12 August 1949, Vol. III, Geneva Convention Relative to the Treatment of Prisoners of War, Pictet ed. (1960)

ICRC, <i>Commentary on GC IV</i>	Commentary on the Geneva Conventions of 12 August 1949, Vol. IV, Geneva Convention Relative to the Treatment of Civilians, Pictet ed. (1958)
ICRC, <i>Commentary on the APs</i>	Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949, Sandoz, Swinarski, and Zimmermann eds. (1987)

Journals and Yearbooks

<i>AJIL</i>	<i>American Journal of International Law</i>
<i>IRRC</i>	<i>International Review of the Red Cross</i>
<i>HSNJ</i>	<i>Harvard National Security Journal</i>
<i>RCADI</i>	<i>Recueil des Cours de l'Academie de Droit International</i>
<i>ILS</i>	<i>International Law Studies (Blue Book Series)</i>
<i>IYHR</i>	<i>Israel Yearbook of Human Rights</i>
<i>JICJ</i>	<i>Journal of International Criminal Justice</i>
<i>JNSLP</i>	<i>Journal of National Security Law and Policy</i>
<i>NYUJILP</i>	<i>New York University Journal of International Law and Politics</i>
<i>VJIL</i>	<i>Virginia Journal of International Law</i>
<i>YHIL</i>	<i>Yearbook of International Humanitarian Law</i>
<i>YILC</i>	<i>Yearbook of the International Law Commission</i>

Fields of International Law

ICL	International criminal law
IHL	International humanitarian law (also known as the laws of armed conflict or the <i>jus in bello</i>)
IHRL	International human rights law
IRL	International refugee law

Types of Armed Conflict

IAC	International armed conflict
NIAC	Non-international armed conflict

Types of Non-state Parties to an Armed Conflict

OAG	Non-state organized armed group
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Designated Terrorist Groups

FARC	<i>Fuerzas Armadas Revolucionarias de Colombia</i> (Revolutionary Armed Forces of Colombia)
GRF	Global Relief Foundation
ISIS	Islamic State of Iraq and Syria (also known as the Islamic State of Iraq and the Levant [ISIL]; the Islamic State [IS]; and <i>al-Dawla al-Islamiya fi al-Iraq wa al-Sham</i> [<i>Daesh</i>])
LeT/JuD	Lakshar-e-Tayyiba/Jamaat-ud-Dawa
LTTE	Liberation Tigers of Tamil Eelam

GLOSSARY¹

Civilian medical personnel	Anyone who is not a member of the military medical service and who meets the criteria laid down for medical personnel. ² (See <i>medical personnel</i> ; distinguish in part with <i>military medical personnel</i> ; distinguish with medical caregiver.)
Denunciation	Compulsory communication to national authorities of medical confidentiality in relation to information—not only health-related information but also other information such as on the activities, connections, position, or even the existence of the wounded—that caregivers may have obtained on the wounded and sick in their charge. ³
Distinctive emblem	The distinctive emblem of the red cross, the red crescent, the red lion and sun, and the red crystal on a white ground when used for the protection of medical equipment, personnel, supplies, or transports. ⁴
<i>Hors de combat</i>	A French locution for “out of the battle”: a person is <i>hors de combat</i> if (i) she is in a power of an adverse party, (ii) she clearly expresses an intention to surrender, or (iii) she has been rendered unconscious or is otherwise incapable of defending herself, provided that in any of these cases she abstains from any hostile act and does not attempt to escape; shipwrecked persons cannot be excluded from the construct of <i>hors de combat</i> . ⁵
Humanity	A principle of humanitarian action dictating that organizations focus on alleviating human suffering. ⁶

1. The definitions in this Glossary were crafted for, and are meant for use solely in, this report.

2. This definition is wider than the one set down in article 8(c) Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 3 (AP I). Note that this definition does not apply to all relevant IHL treaties. See *infra* Section 4: “Entitlement to and Protection of Medical Care for the Wounded and Sick *Hors de Combat* — Definition of the wounded and sick.”

3. Derived from Alexander Breitegger, “The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies,” 95 *IRRC* No. 889 (2013) 119 [citations omitted; hereinafter, Breitegger, “The legal framework”].

4. Derived from articles 8(1) AP I and 2(1) Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Adoption of an Additional Distinctive Emblem, December 8, 2005, 2404 U.N.T.S. 261 (AP III). See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Display of the distinctive emblems.”

5. Derived from article 41(2) AP I; see also, e.g., Yoram Dinstein, *Non-International Armed Conflicts in International Law* 164 (2014).

6. Derived from the Statutes of the International Red Cross and Red Crescent Movement (adopted by the 25th Int’l Conference of the Red Cross at Geneva in 1986, amended in 1995 and 2006), preamble.

Impartial	With respect to medical care: provided as required by the condition of the wounded, sick, and shipwrecked and on the basis of medical need, without any adverse distinction based on grounds other than medical ones. (See <i>medical care</i> ; distinguish with <i>neutral</i> .) ⁷
Impartiality	A principle of humanitarian action dictating that organizations be guided by needs, prioritizing those with the greatest need, and not discriminating adversely against those in need. ⁸ (Distinguish with <i>neutrality</i> .)
Independence	A principle of humanitarian action dictating that an organization be sufficiently autonomous from government(s) so that the organization can act in accordance with humanitarian principles. ⁹
Independent	Conforming to the humanitarian principle of independence. (See <i>independence</i> .)
Legislation	The constitutions of states, the enactments of their legislative organs, and the regulations and declarations promulgated by executive and administrative bodies. No form of regulatory disposition effected by a public authority is excluded. ¹⁰
<i>Lex lata</i>	The law as it currently stands.
<i>Lex scripta</i>	Law codified in treaties (written law).
Medical care	The search for, collection, transportation, diagnosis, or treatment, including

7. Impartial, in this context, does not mean “neutral” (in the sense of not taking sides in controversies of a political nature) but rather generally means that medical care is provided on a non-discriminatory basis—in other words, “without any adverse distinction based on grounds other than medical ones.” See, e.g., Alexander Breitegger, “The legal framework,” *supra* note 3, at p. 105 [citations omitted]. See also articles 3(2) and 12 Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, August 12, 1949, 75 U.N.T.S. 31 (GC I), 3(2) and 12 Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, August 12, 1949, 75 U.N.T.S. 85 (GC II), 3(2) Convention (III) Relative to the Treatment of Prisoners of War, August 12, 1949, 75 U.N.T.S. 135 (GC III), 3(2) Convention (IV) Relative to the Protection of Civilian Persons in Time of War, August 12, 1949, 75 U.N.T.S. 287 (GC IV), 10(2) AP I, and 7(2) Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-international Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 609 (AP II). Note that, throughout this report, despite the lack of express enumeration of the paragraphs in the relevant articles of GCs I–IV, we indicate the particular paragraph(s) of those articles by enumerating that paragraph or those paragraphs.

8. Derived from the Statutes of the International Red Cross and Red Crescent Movement (adopted by the 25th Int’l Conference of the Red Cross at Geneva in 1986, amended in 1995 and 2006), preamble.

9. *Id.*

10. Derived from Ways and Means for Making the Evidence of Customary International Law More Readily Available, Report of the International Law Commission on its Second Session, UN doc. A/CN.4/34, *YILC* 1950, Vol. II, p. 370, para. 60.

	first-aid treatment, of the wounded, sick, and shipwrecked, or the prevention of disease of such persons. Unless expressly indicated otherwise, in this report we assume that such care is provided on an impartial basis. (See <i>impartial</i> .)
Medical caregiver	A person who provides, or attempts to provide, medical care or attention to a wounded, sick, shipwrecked, or otherwise <i>hors de combat</i> person in an armed conflict. (See <i>medical care</i> .)
Medical confidentiality	As a general rule, the discretion that a physician must observe with respect to third parties regarding the state of health of her patients and the treatment she has administered or prescribed for them. ¹¹
Medical ethics	A set of rules and moral duties incumbent on those in the medical profession and on others engaged in medical care (even if the latter are not, strictly defined, members of the former); such rules and duties are typically defined by municipal authorities or by professional medical bodies (or by both). ¹² In general, medical ethical duties are inspired by the overarching concern for the best interests of the wounded and sick. ¹³ (See <i>medical care</i> .)

11. Derived from ICRC, *Commentary on the APs*, para. 670 fn 21 (referring to CE/7b, p. 22).

12. Drawn in part from Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* 4 (2015); ICRC, *Commentary on the APs*, para. 4688. The term *medical ethics* is introduced, but not defined, in AP I and AP II. While they do not have force under international law, certain guidelines adopted by the World Medical Association have been said by Alexander Breitegger, an ICRC Legal Adviser, to “constitute an important point of reference for interpretation what the notion of medical ethics entails.” Breitegger, “The legal framework,” supra note 3, at p. 119 (citing to World Medical Association (WMA), International Code of Medical Ethics, adopted by the 3rd General Assembly of the WMA, London, England, 1949 (last revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006); WMA, Declaration of Geneva, adopted by the 2nd General Assembly of the WMA, Geneva, Switzerland, 1948 (last revised by the 173rd WMA Council Session, Divonne-les-Bains, France, 2006); WMA, Regulations in Times of Armed Conflict, adopted by the 10th World Medical Assembly, Havana, Cuba, 1956 (last editorially revised by the 173rd WMA Council Session, Divonne-les-Bains, France). Note that the views expressed by Breitegger in that article do not necessarily reflect the position of the ICRC. *Id.* at 83. For a more recent (but also non-legally-binding) set of ethical principles concerning health care in armed conflict and other emergencies agreed to by five major non-governmental organizations, International Committee of the Red Cross, International Pharmaceutical Federation, World Medical Association, ICMH, and International Council of Nurses, “Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies,” June 2015, available at <https://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies>.

13. Breitegger, “The legal framework,” supra note 3, p. 119. Breitegger submits that medical ethics therefore would require medical personnel to strive to use health-care resources in the best way to benefit the wounded and sick; to respect the rights and preferences of the wounded and sick, including the right to accept or refuse treatment and the right to confidentiality of health-related information, unless there is a real and imminent threat of harm to the patient or others and this threat can only be removed by a breach of confidentiality; and not to allow their professional judgement to be influenced by personal profit or discrimination.

Medical personnel	Those persons assigned, by a party to an armed conflict, exclusively to provide medical care, or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary. ¹⁴ Unassigned persons do not qualify as medical personnel; they may qualify for other protections (such as those pertaining to civilians). (See <i>civilian medical personnel</i> , <i>medical care</i> , <i>medical transport</i> , <i>medical unit</i> , <i>military medical personnel</i> , and <i>wounded and sick</i> ; partially distinguish with <i>medical caregiver</i> .)
Medical transports	Any means of transportation, whether military or civilian, permanent or temporary, assigned exclusively to medical transportation and under the control of a competent authority of a party to an armed conflict. ¹⁵
Medical unit	Establishments and other units, whether military or civilian, organized to provide medical care and authorized by a party to the conflict to do so. The term includes, for example, hospitals and other similar units, blood-transfusion centers, preventive-medicine centers and institutes, medical depots, and the medical and pharmaceutical stores of such units. Medical units may be fixed or mobile, permanent or temporary. ¹⁶ (See <i>medical care</i> .)
Military medical personnel	Members of the military service meeting the criteria laid down for medical personnel. (See <i>medical personnel</i> ; distinguish in part with <i>civilian medical personnel</i> ; distinguish with <i>medical caregiver</i> .)
Neutral	Conforming to the humanitarian principle of neutrality. (See <i>neutrality</i> ; distinguish with <i>impartial</i> .)
Neutrality	A principle of humanitarian action dictating generally that an organization not take sides in hostilities or in ideological, racial, religious, or political controversies. ¹⁷

Id. [citations omitted]. At the same time, again according to Breitegger, “medical ethics also require medical personnel to observe IHL and IHRL;” thus, medical personnel should not “condone, facilitate or participate in practices of torture or other ill-treatment.” Id. [citation omitted].

14. Derived from article 8(c) and (e) AP I. Note that this definition does not apply to all relevant IHL treaties. See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Definition of caregivers, transports, and units.”

15. Derived from article 8(g) AP I. Note that this definition does not apply to all relevant IHL treaties. See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Definition of caregivers, transports, and units.”

16. Derived from articles 8(e) and 12(2) AP I. Note that this definition does not apply to all relevant IHL treaties. See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Definition of caregivers, transports, and units.”

17. Derived from the Statutes of the International Red Cross and Red Crescent Movement (adopted by the 25th Int’l Conference of the Red Cross at Geneva in 1986, amended in 1995 and 2006), preamble.

Offenses	Crimes at common law or enacted through legislative organs, as well as particularly serious violations of regulations and declarations promulgated by executive and administrative bodies.
Terrorist	Those persons, entities, or conduct meeting a relevant legal definition of terrorist. That definition must be found in domestic law or international law. ¹⁸
(Act of) Terrorism	An act meeting a relevant legal definition of terroristic conduct. That definition must be found in domestic law or international law. ¹⁹
Wartime	The period during which an armed conflict (though not necessarily a “war” in the technical sense) exists as defined in international law.
Wounded and sick	Persons, whether military or civilian, who—because of trauma, disease, or other physical or mental disorder or disability—are in need of medical assistance or care and who refrain from any act of hostility; these terms also cover maternity cases, new-born babies, and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility. ²⁰

18. Our use of the term *terrorist* is not meant to weigh in on the validity of those definitions; nor do we mean to characterize the actual legal status of any particular individual or entity.

19. Our use of the terms *acts of terrorism* and *terrorist act* is not meant to weigh in on the validity of those definitions; nor do we mean to characterize the actual legal status of any particular individual or entity.

20. Derived from article 8(a) AP I. See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* para. 3.1.2 (2006). Note that this definition does not apply with respect to the wounded and sick protected in all relevant IHL treaties. See *infra* Section 4: “Entitlement to and Protection of Medical Care for the Wounded and Sick *Hors de Combat* — Definition of the wounded and sick.”

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Wounded or sick combatants, to whatever nation they may belong, shall be collected and cared for.

—Geneva Convention (1864), Article 6(1)

No one may ever be molested or convicted for having nursed the wounded or sick.

—Geneva Convention I (1949), Article 18(3)

Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.

—Additional Protocol I (1977), Article 16(1), and Additional Protocol II (1977), Article 10(1)

[The defendants] were members of the Peruvian Community Party [a terrorist organization], and had provided medical attention, treatment and operations, supply of medicines and medical instruments for the care of criminal terrorist[s]; acts [that] constitute the crime established and penalized in Article 4 of Decree Law No. 25,475 [crime of terrorism in the category of acts of collaboration].

— Fourteenth Criminal Court of Lima, File No. 94-95, Peru (Sept. 16, 1995)

[The U.N. Security Council] *[d]ecides* [...] that all States shall [...] [e]nsure that any person who participates [...] in supporting terrorist acts is brought to justice [...].

— U.N. Security Council Resolution 1373 (2001), para. 2(e) (Sept. 28, 2001)

[Dr.] Sabir is not charged merely for being a doctor or for performing medical services. Here, [Dr.] Sabir is alleged essentially to have volunteered as a medic for the al Qaeda military, offering to make himself available specifically to attend to the wounds of injured fighters. Much as a military force needs weapons, ammunition, trucks, food, and shelter, it needs medical personnel to tend to its wounded.

— U.S. v. Shah, 474 F.Supp.2d 492, 498–499 (2007)

In July 2012, the Syrian government passed an anti-terrorism law that effectively made it a crime to provide medical care to anyone suspected of supporting the rebels. Ahmed was caught between the Hippocratic oath—a doctor’s promise to treat every patient—and the growing pressure to take sides. “The regime said ‘Why are you helping the Free Army?’ and the Free Army said ‘Why are you helping the regime?’”

— Aryn Baker, “Syria’s Health Crisis Spirals As Doctors Flee,” *Time Blog* (Feb. 4, 2014)

1

INTRODUCTION



For over 150 years, international humanitarian law (IHL) has protected medical care for wounded combatants, whether friend or foe.¹ These protections inject a vital dose of humanity into the devastation of war. The global fight against terrorism has taken a turn that threatens to erode this foundational ethic of IHL.² At the same time, aggressive state responses to terrorism illuminate how IHL medical-care protections, while extensive, are often fragmented and non-comprehensive.

In 1864, states agreed to a pioneering IHL treaty on medical care. It required that the wounded and sick combatants of the warring states who are rendered *hors de combat* (out of the battle) be protected and cared for. Over time, those safeguards were extended to all wounded fighters *hors de combat* of all parties in all armed conflicts. So long as they refrain from any act of hostility and do not attempt to escape, those fighters must be given all feasible medical attention.³ And the parties must provide that care impartially: that is, as required by the condition of the wounded, on the basis of medical need, and without any adverse distinction based on grounds other than medical ones.⁴

Protections for the wounded would be largely meaningless without access to

1. In this report, in referring to the body of international law applicable in armed conflict, we primarily use the term international humanitarian law (IHL); this body of law is also known as the laws of armed conflict and the *jus in bello*. See, e.g., the brief discussion in Yoram Dinstein, *The Conduct of Hostilities under the Law of International Armed Conflict* 13–14 (2d ed., 2004).

2. Throughout this report, we use the terms *terrorist* and *terrorism* as defined *infra* (Section 2: “Definitions and Incidence of Terrorism”). In doing so, we do not seek to weigh in on the legal status (under IHL, other fields of international law, or domestic law) of any of the individuals or groups potentially falling within those definitions.

3. See *infra* Section 4: “Entitlement to and Protection of Medical Care for the Wounded and Sick *Hors de Combat* — All feasible medical care as soon as practicable and on an impartial basis guided by medical grounds.” See also article 41(2) AP I. Further on the *hors de combat* construct, see, e.g., Michael N. Schmitt, “Targeting in Operational Law,” in *The Handbook of the International Law of Military Operations* 268 (eds. Terry D. Gill and Dieter Fleck, 2010) (“A person is *hors de combat* if as a result of wounds or sickness he is no longer able to continue to fight. Merely being wounded is insufficient, for many wounded combatants can and do continue fighting. The key, therefore, is that the individual concerned be unconscious or otherwise incapacitated. The incapacitation does not have to result from hostile action. Combatants who are ill may also be incapacitated.”); Yoram Dinstein, *Non-International Armed Conflicts in International Law* 164 (2014).

4. See *infra* Section 4: “Entitlement to and Protection of Medical Care for the Wounded and Sick *Hors de Combat* — All feasible medical care as soon as practicable and on an impartial basis guided by medical grounds.”

medical personnel and supplies. So IHL also shields those engaged in medical care and the means they need to do so. Where assigned by a party to the conflict exclusively to provide such care, medical personnel, transports, and units benefit from a special status (beyond that conferred on combatants, civilians, and civilian objects) under IHL.⁵ They may not be knowingly attacked, fired upon, or unnecessarily prevented from discharging their proper functions. That protection may not cease unless those personnel commit or those transports or units are used to commit—outside their humanitarian function—acts harmful to the enemy. Even then, that special protection for units and transports may cease only after a warning has been given, setting, whenever appropriate, a reasonable time limit, and where that warning has gone unheeded. Moreover, at least in conflicts between states, certain medical personnel may not be detained but rather only retained—and then only if the condition and numbers of prisoners of war merit it. Nor may medical personnel be punished for having provided medical care, even to the enemy wounded.

The rationale underlying these norms arose out of the experience of interstate wars in Europe in the mid-nineteenth century. States have reaffirmed the basic reasoning fairly regularly since. The short version is that as legally recognized participants in hostilities, able combatants may be targeted at anytime during an armed conflict. Yet once incapacitated—such as through wounds, sickness, or capture—they are considered *hors de combat* and thus no longer present an active threat. So long as they refrain from any act of hostility, they may not knowingly be attacked, fired upon, or unnecessarily interfered with. Not only that, they must also be cared for impartially and to the greatest extent feasible. States thereby struck a balance—part practical, part moral—to keep medical care for the wounded and sick above the conflict.

A lynchpin of this normative structure is that the warring parties need to assign,

5. For more on the technical scope of the protections outlined in this paragraph, see *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Respect and protection of medical personnel, units, and transports: prohibition on knowingly attacking, firing upon, or unnecessarily preventing them from discharging their proper functions” and *id.* at “Capture, detention, and retention.”

recognize, and authorize—in a word, *control*—their medical personnel, transports, and units. That is because states were willing to opt in to protections for the enemy wounded in part by requiring that all parties effectively oversee their respective medical personnel and objects. Feigning the special legal status gravely undermines the protections for the wounded. Falsely claiming that protection is therefore a serious breach of the law.

Strikingly, since 1864, states have also established legal protections for *unassigned medical caregivers* (those *not* authorized and controlled by a party to the conflict).⁶ Those caregivers may, on their own initiative, assist the wounded and sick. And while doing so the warring parties may not knowingly direct attacks against them, either. Moreover, at least in conflicts between states, these caregivers may never be convicted or mistreated for having nursed the wounded of any party. Yet in keeping with the system of control underlying the balance struck by states, the protections for these unassigned caregivers are more limited than those for the authorized medical personnel of a party to the conflict.

Today, some state responses to terrorism reject two of the premises underlying the IHL protections for medical care.

First, counterterrorism policies recast medical care as a form of illegitimate support to the enemy. In comparison, according to the International Committee of the Red Cross (ICRC), the “dominant idea behind” the First Geneva Convention of 1949 is that “medical treatment, *even where given to enemies, is always legitimate, and does not constitute a hostile act. Medical personnel are placed above the conflict.*”⁷

Second, counterterrorism policies reject the corollary proposition that a terrorist organization may assign a medical corps to work under its authority. Thus, domestic anti-terrorism legislations often prohibit medical caregivers from acting under the direction and control of terrorist groups. In comparison, the IHL system

6. For more on the technical scope of the protections outlined in this paragraph, see *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies.”

7. ICRC, *Commentary on GC I*, p. 192 [italics added].

of protection of medical care hinges partly on mutual trust between the warring parties. The display of the Geneva Conventions' distinctive emblems is perhaps the most visible manifestation of that trust. Displaying those emblems notifies the opposing side that the personnel and objects bearing them claim to benefit from special protections. IHL requires the warring parties—including non-state organized armed groups (OAGs)—to safeguard that trust by overseeing and controlling their own medical personnel, transports, and units.⁸

These IHL protections are deeply rooted. Yet despite their lineage they do not fully cohere across all states and all conflicts. Nor are those IHL protections exhaustive.

In short, the *lex lata* (the law as it currently stands), while extensive, is fragmented and non-comprehensive. Some important IHL medical-care protections apply only to some states or to some categories of armed conflict. And certain aspects of the contemporary practice of wartime medical care have little to no effective protection under IHL whatsoever.

This fragmentation and these gaps would exist irrespective of whether the relevant armed conflict involves terrorism. But prosecutions of physicians for wartime medical care to terrorists—coupled with an expanding United Nations Security Council counterterrorism framework—cast a spotlight on these issues.

Mixing Counterterrorism Frameworks with Varying Applicability and Non-comprehensive Coverage of IHL

The U.N. Security Council anti-terrorism framework marks a growing worldwide effort to standardize the fight against terrorism. Powerful states have elevated the suppression of support to terrorism at home and abroad, as well as sanctions based on terrorist group membership or affiliation, to the status of essential international goals.

8. ICRC, *Commentary on APs*, para. 736 [italics added].

Since 1999, the Council has adopted a growing set of counterterrorism decisions. Through them, states are required to impose sanctions against hundreds of individuals and dozens of groups as well as to suppress and prevent terrorism more generally. These Security Council counterterrorism obligations and the domestic measures implementing them efface the line—already often difficult to draw—between peacetime and wartime. They also graft additional complexity onto the intricate international law regime applicable to armed conflict.

To fulfill these Council obligations and to safeguard their national-security interests, states are implementing increasingly forceful and multi-faceted approaches to preventing, disrupting, and punishing terrorism. In general, neither these Council resolutions nor many of the domestic legislations implementing them fully exempt impartial wartime medical care—even in circumstances where such care would be protected under IHL.

For their part, none of those IHL protections is weakened for an enemy if she is defined as a terrorist. For instance, under IHL no wounded fighter may be denied medical care due to a terrorist designation.

Yet state responses to terrorism highlight already existing fault lines in the IHL landscape of medical-care measures. A threshold problem is that some states refuse to recognize the existence of an armed conflict involving terrorists at all. Or, where they do recognize one, states may not indicate when they consider the conflict to have begun, by what criteria it will end, its geographic scope, and whom it encompasses.

Moreover, not all IHL medical-care measures are universally applicable to all armed conflicts. The oldest fault line is the disparate extent to which the legal regime protects medical care in the two types of armed conflict recognized under IHL: international armed conflicts (IACs) and non-international armed conflicts (NIACs). Traditionally, IHL imposed many more medical-care obligations in IACs than in NIACs. In the 1970s, states attempted to create a more uniform and comprehensive

regime. Those efforts met success insofar as states opted into the resulting treaties flattening many of those distinctions. But because numerous states did not contract into the new conventions, those efforts simultaneously exacerbated the fragmentation between states and across conflicts. Over all, selective participation in the legal regime has led to significant variance in states' medical-care obligations.

Meanwhile, an array of medical-care rules has crystallized into customary IHL (which binds all states, regardless of whether the state is a party to a relevant treaty⁹). But a number of important customary IHL medical-care rules identified by the ICRC in a pioneering study lack, in our view, sufficient evidence of states' buy-in. Nor do developments in international human rights law (IHRL) or international criminal law (ICL) fully resolve the fragmentation or fill the gaps in the IHL protections for medical care.

The upshot is that, even in the same conflict, different parties may be subject to different medical-care obligations. Consider the following examples. Both parties in an IAC are obliged to care for the enemy wounded and sick *hors de combat*. Yet one party may be obliged additionally to care for all wounded and sick civilians, while the other party may be required only to facilitate steps to assist civilian authorities in doing so.¹⁰ Moreover, in one NIAC the state may be prohibited from punishing anyone who provided medical care compatible with medical ethics to the enemy. While in a separate NIAC even that same state could have no IHL obligation that would preclude such punishment. Finally, in an IAC a state party may retain certain captured medical personnel only in limited circumstances. Yet in a NIAC IHL imposes no such limitations on the detention or retention of medical personnel.

Furthermore, even the most extensive IAC and NIAC treaties do not exhaustively protect all facets of contemporary wartime medical-care practices. To date, for

9. But see the so-called "persistent objector" rule. See, e.g., Olufemi Elias, "Persistent Objector," *Max Planck Encyclopedia of Public International Law*, Online version, last updated: September 2006.

10. On the technical scope of obligations in this paragraph, see *infra* Section 4.

instance, IHL does not address independent caregivers seeking to travel to conflict areas to treat the wounded and sick in terrorist-controlled territory where the needs of civilians and fighters *hors de combat* are often greatest.

Practical Stakes

As part of their response to terrorist threats, some states attack medical caregivers and some abuse, withhold, prevent, or punish medical care. Attacks directed at health-care facilities in terrorist-controlled areas and the use of health-care professionals in the abusive treatment of alleged terrorists have been widely condemned.¹¹ So, too, have denials of medicine to populations under the control of terrorist groups.¹² Our

11. On attacks on health-care facilities, see, e.g., Ben Hubbard, “ISIS-Imposed Fuel Embargo Threatens Syria’s Medical Centers,” *New York Times*, June 18, 2015, available at <http://www.nytimes.com/2015/06/19/world/middleeast/isis-imposed-fuel-embargo-threatens-syrias-medical-centers.html> [<https://perma.cc/3BVK-VPEF>] (reporting that “[i]nternational aid groups sounded the alarm on Thursday about Syrian government attacks on medical facilities in opposition-controlled areas.”); on the use of health-care professionals in the abusive treatment of alleged terrorists, see, e.g., International Committee of the Red Cross, *Report on the Treatment of Fourteen “High-Value Detainees” in CIA Custody*, February 2007, pp. 21–23, available at <http://assets.nybooks.com/media/doc/2010/04/22/icrc-report.pdf> [<http://perma.cc/G6MX-C7AQ>]; U.N. Commission on Human Rights, *Situation of Detainees at Guantánamo Bay* (Report of the Chairperson-Rapporteur of the Working Group on Arbitrary Detention, Leila Zerrougui; the Special Rapporteur on the independence of judges and lawyers, Leandro Despouy; the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak; the Special Rapporteur on freedom of religion or belief, Asma Jahangir; and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt), U.N. doc. E/CN.4/2006/120, February 27, 2006, paras. 66–82, 92–94. See also the discussion and citations in Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* 49–67 (2015) [hereinafter Mehring, *Medical Ethics in IHL*].

12. U.N. Human Rights Council, *Report of the independent international committee of inquiry on the Syrian Arab Republic*, U.N. doc. A/HRC/28/69, Feb. 5, 2015, Annex II, “Violations documented between 15 July 2014 and 15 January 2015,” para. 264, p. 60 (stating that “Government forces instrumentalise the basic needs of civilians, including access to medical care and food, as part of a military strategy to erode civilian support in areas under non-State armed group control and punish those perceived to be affiliated with armed groups. By refusing to permit humanitarian delivery of medical supplies to the civilian population, the lives of women, men and children are put at grave risk. Civilians are indiscriminately targeted by a systematic policy to prevent access to medical assistance. [...] The denial of medicine has no military justification and is used as part of a punitive strategy.”); see also S.C. Res. 2139 (2014), para. 6 (the Security Council, in relation to the armed conflict in Syria, “[d]emands that all parties, in particular the Syrian authorities, promptly allow rapid, safe and unhindered humanitarian access for UN humanitarian agencies and their implementing partners, including across conflict lines and across borders, in order to ensure that humanitarian assistance reaches people in need through the most direct routes”).

inquiry focuses on another element: how, often with the legal force and political backing of the U.N. Security Council, some states penalize—during wartime (as well as peacetime)—diverse forms of support, including medical care, to terrorist organizations.¹³

Across recent and current armed conflicts, state responses to terrorism have cast a spotlight on the scope and implementation of IHL protections for medical care:

- During its internal armed conflict, Peru prosecuted physicians for providing medical assistance to members of *Sendero Luminoso* (the Shining Path);¹⁴
- Colombia penalized a medical professional who managed the longer-term specialized care of members of the *Fuerzas Armadas Revolucionarias de Colombia* (Revolutionary Armed Forces of Colombia, or FARC);¹⁵
- Syria detained physicians who gave medical care to wounded opposition fighters designated as terrorists,¹⁶ and it attacked health-care facilities in terrorist-controlled areas;¹⁷

13. See Leonard S. Rubenstein, “Punishing Health Care Providers for Treating Terrorists,” *Hastings Center Report* 45, no. 4 (2015), 13–16.

14. *De La Cruz-Flores v. Peru*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 115 (Nov. 18, 2004).

15. Court of Justice of Colombia, Criminal Cassation Chamber, Case No. 27227, May 21, 2009, p. 3.

16. U.N. Human Rights Council, Report of the independent international committee of inquiry on the Syrian Arab Republic, U.N. doc. A/HRC/25/65, Feb. 12, 2014, para. 111 (“Medical staff suspected of treating or providing medical supplies to the opposition were detained and tortured, as in the case of Dr. Abbas Khan, who died in government detention on 17 December.”) and Annex VII, “Assaults on Medical Care,” para. 21 (concluding that “[a]nti-terrorism laws issued on 2 July 2012 effectively criminalised medical aid to the opposition. Laws 19, 20 and 21 contravene the customary international humanitarian law rule that under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.”); Aryn Baker, “Syria’s Health Crisis Spirals As Doctors Flee,” *Time Blog*, February 4, 2014, available at <https://time.com/3968/syrias-health-crisis-spirals-as-doctors-flee/> [<https://perma.cc/D3JW-98ZD>] (reporting that, “In July 2012, the Syrian government passed an anti-terrorism law that effectively made it a crime to provide medical care to anyone suspected of supporting the rebels. Ahmed was caught between the Hippocratic oath—a doctor’s promise to treat every patient—and the growing pressure to take sides. “The regime said ‘Why are you helping the Free Army?’ and the Free Army said ‘Why are you helping the regime?’”).

17. Ben Hubbard, “ISIS-Imposed Fuel Embargo Threatens Syria’s Medical Centers,” *New York Times*, June 18, 2015, available at <http://www.nytimes.com/2015/06/19/world/middleeast/isis-imposed-fuel-embargo-threatens->

- The United States prosecuted an American physician for agreeing to be an “on call” doctor for wounded members of al-Qaeda the next time he travelled to Saudi Arabia;¹⁸ it penalized a different American seeking to travel to Iraq and Syria to provide medical care to wounded members of the Islamic State of Iraq and al-Sham (ISIS) and in hospitals in ISIS-held territory;¹⁹ and it prosecuted a Canadian in part for providing English lessons in an al-Qaeda clinic in Afghanistan in order to assist nurses in reading medicine labels;²⁰ and
- Australia and the United Kingdom are evaluating whether to penalize, upon their return, medics who have reportedly provided medical care in ISIS-held territory, including, potentially, to members of ISIS.²¹

Over the last quarter-century, terrorists and other non-state actors have controlled access to civilian populations in a variety of armed conflicts. Consider

syrias-medical-centers.html [https://perma.cc/3BVK-VPEF] (reporting that “[i]nternational aid groups sounded the alarm on Thursday about Syrian government attacks on medical facilities in opposition-controlled areas.”).

18. U.S. v. Shah, 474 F.Supp.2d 492, 498–499 (2007); U.S. v. Farhane, 634 F.3d 127, 140–141 (2011); id., partial dissent of Chief District Judge Dearie, at 175, 181 fn 8.

19. See, e.g., U.S. v. Conley, “Plea Agreement and Statement of Facts relevant to Sentencing,” Criminal Action No. 14-cr-00163-RM, D. Colo., September 10, 2014; U.S. v. Conley, Criminal Complaint and Affidavit, Case No. 14-mj-01045-KLM, D. Colo., April 9, 2014.

20. U.S. v. Warsame, 537 F.Supp.2d 1005, 1019 (2008). See *infra* Section 5: “Domestic Proceedings against Medical Caregivers — United States of America.”

21. Marga Zambrana and Emma Graham-Harrison, “American and Canadian among group of medics in Isis stronghold,” *The Guardian*, March 23, 2015, available at www.theguardian.com/world/2015/mar/23/american-canadian-maleeh-hamdoun-among-medics-group-isis-syria (quoting the Home Office as saying, in respect of 11 medical school students—of American, British, and Canadian nationalities—who crossed into ISIS-controlled parts of Syria and who were believed to be working in hospitals there, that “even if they were in areas under Isis [sic] control, the medics would not automatically face prosecution under anti-terror laws if they tried to return to the UK, as long as they could prove they had not been fighting.”); Tim Williams and Sheradyn Holderhead, “Former Adelaide doctor Tareq Kamleh joins terror group ISIS, releases propaganda video,” *Sunday Herald Sun*, April 26, 2015, available at <http://www.adelaidenow.com.au/news/south-australia/former-adelaide-doctor-tareq-kamleh-joins-terror-group-isis-releases-propaganda-video/story-fni6uo1m-1227321062787> [http://perma.cc/K8M6-4U9W] (reporting that an Australian physician who travelled to Raqqa to provide medical care and who appeared in an “Islamic State video urging other medical professionals to travel to Syria and join the holy war against the West” could face up to 25 years’ imprisonment).

Afghanistan, Chechnya, Colombia, Gaza, Iraq, Lebanon, Mali, Nepal, Nigeria, Pakistan, Peru, the Philippines, Somalia, Syria, and Yemen (among others). The number and effects of terrorist attacks are reportedly increasing around the world. And states are designating more organized armed groups as terrorists. We therefore expect that these questions will become more salient and more urgent in a growing number of theaters.²²

Normative Inquiries

To better understand contemporary practices and controversies, we explore IHL and potential trends in state responses to terrorist threats. Five sets of normative questions frame our inquiry:

- Most fundamentally, in an armed conflict involving terrorism, should impartial medical care remain “above” the conflict, or should such care be seen as an impermissible form of support to terrorism? Is there something different about situations of armed conflict involving terrorism and “traditional” interstate wars for which the key humanitarian protections were first legally enshrined? What about the notion of a “global” war on terrorism in comparison to internal civil wars?
- Should the position on punishment matter if the medical caregiver takes sides in the hostilities? What if she aligns with the terrorist group’s ideology or swears an oath of allegiance to the group but still impartially provides care to all in need of medical attention? How much should membership in or affiliation with the adverse party matter, if at all, for protections for medical caregivers in war?
- Does the calculus shift where a terrorist group controls access to a

22. See, e.g., Katherine H. A. Footer and Leonard S. Rubenstein, “A human rights approach to health care in conflict,” 95 *IRRC* No. 889 (2013) 176 (noting that “in many places around the world, including Chechnya, Kosovo, Burma, and Syria, health workers have been threatened, arrested, prosecuted, or killed for having adhered to their ethical obligation to provide care impartially, regardless of the affiliation or political belief of the patient.”).

civilian population? What if the health-care facilities available to the former are the same as those available to the latter?

- In light of modern developments, such as the relative ease of international travel and the proliferation of large multinational humanitarian organizations, do the theories underlying legal distinctions crafted in earlier eras—especially on assigned versus unassigned medical caregivers—retain their normative salience today?
- What costs are inflicted on the normative regime when a state focuses on punishing their citizens and foreign nationals who have travelled to conflict areas to provide impartial medical care upon their return? What about when a state focuses on preventing them from doing so in the first place?

Humanitarian Principles in a Counterterrorism World

IHL treaties lay down extensive protections for military and civilian personnel assigned exclusively to medical duties by a party to the conflict. Those conventions also provide protections (though far fewer) for medical caregivers who are *not* assigned by a party. International and local humanitarian non-governmental organizations (NGOs), as well as unaffiliated individuals, may thus be at greater risk.²³ Yet due to the nature of many armed conflicts involving terrorists, it is precisely those unassigned humanitarian NGOs and individuals who are often most likely to provide medical assistance to terrorists.

Generally, engaging in “principled” humanitarian action—including where it encompasses providing medical care to the wounded and sick *hors de combat* in

23. Because they are part of the state armed forces, military medical personnel seem unlikely—or, at least, far less likely—to face these challenges; in addition, National Red Cross or Red Crescent Societies, for example, which are typically recognized and authorized by the relevant state, similarly seem to be less susceptible to anti-terrorism measures than would private humanitarian medical providers who are not so recognized and authorized.

armed conflict—means adhering to the principles of humanity, impartiality, and independence.²⁴ The principle of *humanity* dictates that organizations must focus on alleviating human suffering.²⁵ The principle of *impartiality* means being guided by needs, prioritizing those with the greatest need, and not discriminating adversely against those in need.²⁶ And the principle of *independence* means being sufficiently autonomous from governments so that the organization can act in accordance with humanitarian principles. Many humanitarian organizations are also guided by a fourth principle: *neutrality*. That principle generally means not taking sides in hostilities or in ideological, racial, religious, or political controversies.

Adhering to these principles, which are referenced in an IHL treaty,²⁷ is meant to distinguish humanitarians from other actors on the battlefield. The perception among warring parties of whether an organization adheres to these principles is often central, as a matter of practice, to obtaining and maintaining access to deliver humanitarian relief.²⁸

States regularly endorse these humanitarian principles. The December 2014

24. Those principles may be seen in a number of ways: as stand-alone moral concepts; as attributes of some organizations; as a quality of humanitarian assistance; as duties binding on some organizations; or as a justificatory claim for obtaining and maintaining access to populations in need.

25. Our definitions of these principles are drawn from the Statutes of the International Red Cross and Red Crescent Movement (adopted by the 25th Int'l Conference of the Red Cross at Geneva in 1986, amended in 1995 and 2006), preamble.

26. “Impartial,” in terms of medical ethics, has been said to mean “that health-care workers must treat patients on the basis of need and not on the basis of ethnicity, religion, gender, age, or any other factor that might lead to unfair discrimination. It also overlaps with medical neutrality, as referring to the non-involvement of health-care workers in political parties and issues related to the conflict within their workplaces.” Vivienne Nathanson, “Medical ethics in peacetime and wartime: the case for a better understanding,” 95 *IRRC* No. 889 (2013) 195–96. According to that author, “The ethical rule is clear and simple. Care should be offered based upon need; the person most in need is treated first. This is the basis of triage in both wartime and peacetime.” *Id.* at p. 196.

27. Article 63(1)(a) GC IV (“Subject to temporary and exceptional measures imposed for urgent reasons of security by the Occupying Power: (a) recognized National Red Cross (Red Crescent, Red Lion and Sun) Societies shall be able to pursue their activities *in accordance with Red Cross principles, as defined by the International Red Cross Conferences*. Other relief societies shall be permitted to continue their humanitarian activities under similar conditions [...].”) [italics added].

28. For a critical view of the principles from within the humanitarian community, see, e.g., Rony Brauman, “Médecins Sans Frontières and the ICRC: matters of principle,” 94 *IRRC* No. 888 (2012).

U.N. General Assembly resolution concerning attacks on health workers is a recent example. The General Assembly reaffirmed those four humanitarian principles as well as the need for all actors engaged in providing humanitarian assistance in armed conflicts to promote and fully respect them.²⁹

Yet despite states' support for principled humanitarian action, the rationale underlying certain humanitarian principles—especially neutrality—runs into the with-us-or-against-us logic underpinning many anti-terrorism agendas. While neutrality means not taking sides, those counterterrorism approaches require it.

As a legal expert at the ICRC, Jean Pictet was an architect of the Geneva Conventions and their Protocols. In 1979, he foregrounded this dilemma from a classical humanitarian perspective:

If anyone presents the Red Cross with the well known and destructive dilemma embodied in the phrase, “whoever is not with me is against me”, may it always reply, “I am with all those who suffer, and that is sufficient”.³⁰

Today, Pictet's argument must confront counterterrorism policies head-on.

Indeed, for principled humanitarian organizations like the ICRC, counterterrorism framings present an existential threat. Amid swelling concern, in 2011, the ICRC called for states to exclude from anti-terrorism legislations activities

29. U.N. General Assembly, “Resolution adopted by the General Assembly on 11 December 2014: Global health and foreign policy,” U.N. doc. A/RES/69/132, January 9, 2015, preamble (similarly reaffirming the need for all actors engaging in the provision of humanitarian assistance in situations of humanitarian emergencies and natural disasters, as well, to promote and fully respect these four principles); see also *id.* at paras. 6 and 9 (calling for member states to respect the integrity of medical personnel in carrying out their duties in line with their codes of ethics; and stressing the obligation, in accordance with IHL and applicable national laws and regulations, to respect and protect medical personnel exclusively engaged in medical duties). In a related vein, in August 2011, the ICRC launched the Health Care in Danger Project to “develop, promote and implement measures safeguarding health care delivery.” ICRC, Annual Report 2013, Volume 1, May 2014, p. 61. States parties to the Geneva Conventions expressed their support for the goals of the project. ICRC, 31st International Conference of the Red Cross and Red Crescent Movement, Geneva, Switzerland, November 28–December 1, 2011, Resolution 5.

30. Jean Pictet, *The Fundamental Principles of the Red Cross Proclaimed by the Twentieth International Conference of the Red Cross, Vienna, 1965: Commentary* (1979), available at <https://www.icrc.org/eng/resources/documents/misc/fundamental-principles-commentary-010179.htm> [<https://perma.cc/4XCU-UJD4>].

that are exclusively humanitarian and impartial in character and are conducted without adverse distinction.³¹ Otherwise, prohibitions of medical services to persons rendered *hors de combat* as support to terrorism would “*call into question the very idea behind the creation of the ICRC—and subsequently of National Red Cross and Red Crescent Societies—over 150 years ago.*”³²

Outline

The surge in armed conflicts involving terrorism has brought to the fore the general question of medical care in armed conflict and the particular legal protections afforded to those providing such care to terrorists. Against this backdrop, we evaluate IHL protections for wartime medical assistance concerning terrorists. Through that lens, we expose gaps and weaknesses in IHL. We also examine tensions between IHL and state responses to terrorism more broadly.

In studying the IHL regime applicable to medical care, substantive fragmentation and gaps in legal protection between states and across types of conflict emerge. These ruptures are not new. But they are increasingly noticeable as terrorism is more frequently conceptualized as forming part of armed conflicts and as more states undertake aggressive responses to terrorist threats.

The U.N. Security Council has been a key driver of these responses, requiring member states to take more and broader steps to obviate terrorist threats. Yet, as noted above, so far the Council has not required that, in doing so, states fully exempt impartial wartime medical care, even in circumstances that would render such care protected under IHL. Rather, the Council seems to consider providing medical assistance and supplies to al-Qaeda and its associates as at least a partial ground for

31. International Committee of the Red Cross, International Humanitarian Law and the challenges of contemporary armed conflicts, doc. 31IC/11/5.1.2, October 2011, Geneva, p. 53 [hereinafter, “ICRC, *Challenges Report*”].

32. ICRC, *Challenges Report*, supra note 31, at p. 53. The ICRC and National Red Cross and Red Crescent Societies benefit from certain particular protections under IHL beyond those for unassigned international humanitarian organizations or independent caregivers. See infra Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Definition of caregivers, transports, and units” and “Display of the distinctive emblems.”

designating those who facilitate such care as terrorists themselves.

The overall result today is unsatisfactory. By prosecuting physicians for supporting terrorists through medical care in armed conflicts, some states are likely violating their IHL treaty obligations. But in certain other instances where states intentionally curtail impartial medical care there is no clear IHL violation. Both those *actual IHL violations* and the *lack of clear IHL violations*, we think, are cause for concern. The former represent failures to implement the legal regime. And the latter highlight the non-comprehensiveness—or, at least, the indeterminateness and variability—of the normative framework.

At first glimpse, the legal protections for medical care to an ISIS fighter or a member of the Shining Path may seem relatively unimportant. But those safeguards represent a fundamental thread that ties the larger tapestry of IHL protections together. Pulling that thread risks unraveling the broader wartime international law protective regime—a regime that aims, however imperfectly to date, to cover not only terrorists but all wounded people in armed conflict: military and civilian, terrorist and non-terrorist alike.

Following this **Introduction**, in **section 2** we summarize key relevant concepts in the laws of armed conflict and state responses to terrorism. We put forward working definitions of *terrorist* and *terrorism* for purposes of the report. We also outline contemporary definitions of *armed conflict* found in international law. And we briefly discuss the distinctions and overlaps between IHL and the frameworks in which states respond to terrorism, including the potential statuses of terrorists under IHL.

In **section 3**, we trace the long history of the development of international legal protections for impartial medical assistance in armed conflict. We show how—as a corollary to the care for wounded combatants, prisoners of war, and civilians—states agreed to IHL treaties requiring respect and protection for those who provide

wartime medical care. Yet we note a problem in the normative framework: not all IHL medical-care measures are universally applicable to all armed conflicts. We trace the oldest fault line: the extent to which the legal regime protects medical care in the two types of armed conflict recognized under IHL—international armed conflicts (IACs) and non-international armed conflicts (NIACs). Such protections in IAC treaties have been regulated for over a century and a half. Yet for a long time there were no international legal protections for medical care in internal conflicts or civil wars. In 1949, Common Article 3 introduced basic provisions, but those did not come close to the extensive medical-care protections found in IAC treaties. As states attempted to create a more uniform and comprehensive regime in the 1970s, the resulting treaties flattened many of those distinctions for contracting states. But because numerous states did not become party to the new treaties, those efforts simultaneously exacerbated the fragmentation between states and across conflicts. The result is that the scope of IHL protections for medical care may be vastly different between states and across types of armed conflict—or even for the same state between types of NIACs.

Next we discuss how, in principle, customary international law—those rules of international law deriving from and reflecting a general practice accepted as law³³—could fill those gaps in the *lex scripta*: between states party and those not party to the Additional Protocols; between IACs and NIACs more generally; and between different types of NIACs. With respect to some elements of wartime medical care, the most extensive evidence accumulated to date (the ICRC’s pioneering *Customary IHL Study*) does not, in our view, meet the necessary criteria for customary law: It does not reflect sufficiently uniform, extensive, and representative state practice; nor does it reflect dense enough evidence of such practice being undertaken due to a

33. Michael Wood, Special Rapporteur, “Second report on identification of customary international law,” International Law Commission, 66th Session, U.N. doc. A/CN.4/672, May 22, 2014, p. 7, para. 20; see generally *id.* at pp. 7–14, paras. 21–30 (discussing state practice, decisions of international courts and tribunals, and literature in arguing in favor of this “two-element” approach).

legal conviction. Meanwhile, some important facets of the contemporary practice of wartime medical care remain lightly regulated or even unaddressed in IHL. Finally, we highlight complementary developments in the related fields of IHRL and ICL. But we note that those developments in IHRL and ICL, while buttressing protections already recognized in IHL, do not fully resolve the fragmentation or fill the gaps in the protections for medical care.

In **section 4**, we spotlight the two major sets of IHL protections for impartial wartime medical care concerning terrorists. Since IHL does not contemplate the status of terrorist as such, we explain what types of protections exist across the various statuses terrorists may have under IHL (having sketched those statuses in section 2).

We first outline the entitlement to and the protection of medical care for the wounded and sick *hors de combat* and for wounded and sick civilians. These protections cut across such categories as the search for, collection, and evacuation of the wounded; the provision of all feasible medical care to them impartially; respecting and protecting the wounded, including against attacks; protecting them against ill-treatment and pillage; and treating them humanely. This set of protections also encompasses prohibitions on certain medical, scientific, and biological experiments and related procedures. We include protections for civilians in our analysis for two reasons. First, certain terrorists may have civilian status under IHL. And second, attempts to curtail care specifically for terrorists may significantly diminish civilians' access to medical attention more generally.

We then sketch the second set of protections: the most salient aspects of the corollary protections for medical caregivers, transports, units, and supplies. This category includes protections ranging from the respect and protection due to medical personnel, transports, and units—including against direct attack—as well as protections for certain medical personnel in IACs who, upon capture, may be retained but not detained. It also encompasses, under some treaties, prohibitions on punishing medical caregivers. Lastly, this subsection discusses the IHL provisions

establishing the terms of use of the protective emblems of the Geneva Conventions.

Throughout, we note areas of overlap, but also areas of divergence, between various sets of IHL treaties and rules put forward in the *Customary IHL Study*. The resulting portrait is of a somewhat fragmented, intricate, fact-dependent normative regime—one marked by many areas of substantive agreement but also important protective gaps.

In **section 5**, we discuss how states are attempting to prevent, disrupt, and punish terrorist threats. We briefly note that, despite the proliferation of international anti-terrorism treaties, states have yet to agree on a general anti-terrorism convention. We also quickly outline developments concerning customary international law. We then focus in more depth on the relatively recent ascendance of the globally oriented anti-terrorism regime emanating from the U.N. Security Council. Through these Council resolutions, states are required to impose sanctions against hundreds of individuals and dozens of groups as well as to suppress and prevent terrorism more generally. In imposing these obligations, as noted above, the Security Council has not fully exempted impartial wartime medical care, even in circumstances that would render such care protected under IHL. By potentially inviting states to ignore IHL obligations regarding medical care for terrorists, the Council's approach may indirectly jeopardize access to medical care for wounded civilians in conflict areas.

Finally, we discuss the domestic jurisprudence of three states—Colombia, Peru, and the United States of America—where legal proceedings concerning wartime medical care to terrorists have been instituted.

In the **Conclusion**, we emphasize that states and international organizations should more consciously and more deliberately weigh the costs and benefits of weakening medical-care protections through their counterterrorism frameworks.

Finally, in the **Compendium**, we provide verbatim excerpts of medical-care

protections in the *lex scripta* of IHL.

A few caveats: The research was conducted primarily in English and thus generally does not comprehensively take into account secondary sources in other languages.³⁴ While it reflects research into numerous jurisdictions spanning every continent (except Antarctica), our analysis is nonetheless non-comprehensive in terms of its survey of domestic counterterrorism legislations. We do not focus on attacks on medical caregivers. Nor do we focus on the use of health-care professionals in the abusive treatment of detained (alleged) terrorists,³⁵ or on the role of military medical service members in providing terrorists with medical care.³⁶ We limit our study to those, outside of the military medical service, generally dedicated to medical care in armed conflict. We thus omit caregivers who actively participate in hostilities or who (also) knowingly and intentionally provide non-medical forms of assistance to fighters. Nor does our analysis address protections for health-care professionals in situations not arising to an armed conflict under international law. Due to the relative rarity of warfare at sea involving terrorists, we generally do not address protections for shipwrecked wounded and sick persons. Lastly, none of us is a physician (nor otherwise professionally medically trained). The report therefore does not reflect the insights of those who have faced the normative and operational dilemmas identified in this report.

One of our chief aims in this report is to provide key reference points for further exploration as well as an initial analytical framing of the main considerations. We also hope that this report will spark debate on how to safeguard impartial medical care for all wounded and sick persons in armed conflict.

34. PILAC Research Assistants provided some research support with respect to Arabic, Chinese, French, Russian, and Spanish materials. One of the report authors checked the translations of the only authentic (French) text of the pre-1949 IHL treaties discussed herein against his own translation of those texts.

35. See, e.g., the discussion and citations in Mehring, *Medical Ethics in IHL*, supra note 11, at pp. 49–62.

36. Concerning the so-called “dual loyalty” of members of the military medical service, who may face competing loyalties due to their dual positions—as members of the armed forces subject to command hierarchy and as health-care practitioners subject to professional ethics—see, e.g., id. at pp. 22–26.

2

KEY CONCEPTS IN THE LAWS OF ARMED CONFLICT AND COUNTERTERRORISM FRAMEWORKS



To foreground the discussions of medical care in IHL and states' responses to terrorism, this section outlines key concepts in IHL and counterterrorism frameworks.¹ We first briefly note the definitions of *terrorist* and *terrorism* we use in this report. We then describe and discuss challenges concerning the classification of armed conflicts involving terrorists under IHL. Finally, we outline the potential status of terrorists under IHL.

Definitions and Incidence of Terrorism

As discussed in more detail in section 5, there are no generally agreed-upon definitions of *terrorism*, *terrorist*, or *terrorist act* in international law. However, states have developed, at the multilateral and regional levels, numerous anti-terrorism treaties. Examples include those aiming to prevent and punish certain terrorist acts—such as hijacking airplanes or hostage taking—and to suppress terrorism financing.² The U.N. Security Council has considered terrorism a threat to international peace and security and has sanctioned individuals and groups associated with al-Qaeda.³ And at the domestic level, states have promulgated wide-ranging anti-terrorism legislations.⁴

Due to the lack of definitional consensus between states, for the purposes of this report we defer to definitions of (*acts of*) *terrorism*, *terrorist*, and *terrorist act* found in any of the relevant jurisdictions where such terroristic conduct may be committed, especially—due to our focus here—those with a sufficient nexus to an armed conflict. Thus, the term *terrorist* is used here to denote persons, entities, or conduct meeting a relevant legal definition of terrorist. Similarly, the terms *terrorist act* and (*acts of*) *terrorism* are used here to denote those acts meeting a relevant legal definition of terroristic conduct.⁵ The relevant legal definition of *terrorist*, *terrorist act*, or (*acts of*)

1. There is no shortage of scholarly attention to various aspects of the relationship between IHL and terrorism. See generally, e.g., Andrea Bianchi and Yasmin Naqvi, *International Humanitarian Law and Terrorism* (2011).

2. See *infra* Section 5: “Conventional and Customary Definitions of Terrorism.”

3. See *infra* Section 5: “Security Council Anti-Terrorism Frameworks.”

4. See *infra* Section 5: “Domestic Proceedings against Medical Caregivers.”

5. Unless stated otherwise, each preceding and subsequent reference in this report to *terrorist*, *terrorist act*, and *act(s)*

terrorism must be found in domestic law or international law.⁶ Our use of these terms is not meant to weigh in on the validity of any of those definitions. Nor do we mean to characterize the actual legal status of any particular individual or entity.

The lack of definitional consensus among states makes it difficult to quantify terrorist attacks. Some commonly used statistics, however, suggest that terrorist attacks are on the rise. In 2014, according to statistics used by the U.S. State Department, 13,463 terrorist attacks resulted in 32,727 fatalities, in 34,791 injuries, and in 9,428 people taken hostage or kidnapped.⁷ Compared to 2013, these figures reflect a 35% increase in attacks and 81% increase in fatalities. Terrorist attacks took place in 95 states in 2014. More than 60% of those attacks occurred in five countries (Iraq, Pakistan, Afghanistan, India, and Nigeria). And 78% of all fatalities due to terrorist attacks that year took place in five countries (Iraq, Nigeria, Afghanistan, Pakistan, and Syria).

Definition and Classification of Armed Conflicts under IHL

Nearly a decade and a half after the attacks of 9/11, state officials, scholars, and civil society actors continue to disagree about an array of legal, policy, and strategic issues at the intersection of armed conflict and terrorism. One of the primary questions is the

of terrorism conforms to these meanings.

6. The Terrorism Prevention Branch of the United Nations Office of Drugs and Crime maintains electronic databases of certain international provisions and domestic terrorism legislations, available at <http://www.unodc.org/tldb/> [<http://perma.cc/3NHH-QP3H>]. Acts of terrorism are proscribed in certain IHL treaties; see, e.g., *infra* Section 2: “Definition and Classification of Armed Conflicts under IHL.”

7. The dataset used a definition of terrorist acts that included violent acts carried out by non-state actors meeting three cumulative criteria:

1. The violent act was aimed at attaining a political, economic, religious, or social goal; 2. [t]he violent act included evidence of an intention to coerce, intimidate, or convey some other message to a larger audience (or audiences) other than the immediate victims; and [t]he violent act was outside the precepts of International Humanitarian Law insofar as it targeted non-combatants.

National Consortium for the Study of Terrorism and Responses to Terrorism, *Country Reports on Terrorism 2014: Annex of Statistical Information*, June 2015, available at <http://www.state.gov/j/ct/rls/crt/2014/239416.htm> [<http://perma.cc/UMM3-2X2E>]. All of the statistics used in this paragraph are from this Annex.

definition of armed conflict—its *geographic, temporal, material, and personal* scope—under international law. A related question is whether certain acts of terrorism may *give rise to or form part of* a situation of armed conflict.

IHL applies only in relation to situations of armed conflict. There are two main sources of IHL: treaties and customary law.⁸ Treaties are international agreements between two or more states.⁹ In the recent formulation of Special Rapporteur Michael Wood, customary international law “means those rules of international law that derive from and reflect a general practice accepted as law.”¹⁰

IHL generally recognizes two categories of armed conflict: international armed conflict (IAC) and non-international armed conflict (NIAC).¹¹ Terrorist acts and other forms of involvement by terrorists in armed conflict may arise in relation to either category. (Some anti-terrorism treaties, however, exclude from their scope of application the conduct of forces in an armed conflict.¹²) The applicability of IHL to

8. On the construct of *strata*, rather than *sources*, of international law, see Yoram Dinstein, “The Interaction between Customary International Law and Treaties,” 322 *RCADI* 243 (2006) 260–1.

9. See, e.g., article 2(1)(a) Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 133; Restatement (Third) of the Foreign Relations Law of the United States § 301(1) (1987).

10. Michael Wood, Special Rapporteur, “Second report on identification of customary international law,” International Law Commission, 66th Session, U.N. doc. A/CN.4/672, May 22, 2014, p. 7, para. 20; see generally *id.* at pp. 7–14, paras. 21–30 (discussing state practice, decisions of international courts and tribunals, and literature in arguing in favor of this “two-element” approach). Under the so-called “traditional” view, customary international law crystallizes when there exists a general and consistent practice of states followed from a sense of legal obligation (or *opinio juris sive necessitatis*). James P. Benoit, “Mistreatment of the Wounded, Sick and Shipwrecked by the ICRC Study on Customary International Humanitarian Law,” 11 *YIHL* (2008) 179 (citing to the Restatement (Third) of Foreign Relations Law of the United States § 102, cmts. b, c (1987); ICJ, *North Sea Continental Shelf* (West Germany v. Denmark and the Netherlands) (Merits) [1969] ICJ Rep. p. 3, pp. 42–46).

11. At its inception, IHL generally regulated interstate conflicts involving two or more sovereigns, with few exceptions. On the “recognition of belligerency” and the “recognition of insurgency,” see, e.g., Yoram Dinstein, *Non-International Armed Conflicts in International Law* 108–14 (2014) [hereinafter, Dinstein, *NIACs in International Law*]; Sandesh Sivakumaran, *The Law of Non-International Armed Conflict* 9–20 (2012).

12. E.g., article 19(2) International Convention for the Suppression of Terrorist Bombings, 2149 U.N.T.S. 256 (“The activities of armed forces during an armed conflict, as those terms are understood under international humanitarian law, which are governed by that law, are not governed by this Convention, and the activities undertaken by military forces of a State in the exercise of their official duties, inasmuch as they are governed by other rules of international law, are not governed by this Convention.”); article 26(5) Convention on the Prevention of Terrorism, Council of Europe, Treaty Series No. 196, 2005.

an armed conflict is not predicated on the (un)lawfulness of the resort to force, which is governed by a different field of public international law: the *jus ad bellum*.¹³ IHL applies to all parties to armed conflict: states and, where relevant, dissident armed forces or organized armed groups. It also applies, where relevant, to neutral states and to individuals.

Of course, terrorist acts may also be conducted outside of the context of an armed conflict. Those acts of terrorism are subject to domestic law-enforcement regimes and IHRL.¹⁴ We do not treat those cases here; we focus only on terrorism that has a sufficient nexus to an armed conflict to implicate IHL.¹⁵

The application of IHL to a specific situation of armed conflict turns on an assessment of the facts. It does not require a declaration of war.¹⁶ The majority of contemporary armed conflicts involving terrorists appear to be non-international in character. Below, we therefore elaborate in more detail the NIAC classification considerations than the IAC considerations.¹⁷

Application challenges

It can be difficult to determine whether a particular situation of violence or political enmity amounts to an armed conflict under international law—and, if so, whether that conflict is an IAC or a NIAC. The practical application of IHL may be made more difficult by the behavior of the state responding to a terrorist threat.

13. Hans-Peter Gasser and Daniel Thürer, “Humanitarian Law, International” *Max Planck Encyclopedia of Public International Law*, Online version, para. 2, last updated: March 2011.

14. Those acts may (also) fall within the scope of an international anti-terrorism convention. See, e.g., *infra* Section 5: “Conventional and Customary Definitions of Terrorism.”

15. See *infra* Section 2: “Nexus to Armed Conflict.”

16. See Common Article 2(1) GCs I–IV. See generally Jelena Pejic, “Extraterritorial targeting by means of armed drones: Some legal implications,” *IRRC* early online version (2015) 12, available at <https://www.icrc.org/en/document/jelena-pejic-extraterritorial-targeting-means-armed-drones-some-legal-implications> [hereinafter Pejic, “Extraterritorial targeting”].

17. Nonetheless, as explained below, impartial medical care to terrorists may arise in relation either to an IAC or to a NIAC.

Some states try to avoid the application of IHL altogether by arguing that their counterterrorism activities are undertaken outside of a situation of armed conflict. States may invoke the rhetoric of war but not consider themselves bound by certain IHL treaties or particular customary IHL rules. States may also—out of a sense of legal obligation or as a policy preference—apply IHL alongside other legal frameworks to an armed conflict involving terrorists.

In sum, whether an IHL treaty provision or a customary IHL rule applies turns on such factors as:

- Whether the state is a party to the relevant treaty;
- Whether the rule reflects customary IHL;
- Whether the terrorist acts and the states' response to them have a sufficient nexus to the armed conflict; and
- Whether that armed conflict is international or non-international in character.¹⁸

A case-by-case assessment of the facts in light of the legal criteria is often required to discern if terrorist acts give rise to or form part of an armed conflict under IHL.

International armed conflict

The four Geneva Conventions of 1949 (GCs I–IV) are:

- The *Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field* (GC I),¹⁹
- The *Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea* (GC II),²⁰

18. Scholars disagree on whether, for example, the use of force by a foreign state directed against a non-state armed group on the territory of another state without that territorial state's consent should be characterized as a non-international or an international armed conflict. See, e.g., the discussion in Dapo Akande, "Classification of Armed Conflicts: Relevant Legal Concepts," in *International Law and the Classification of Conflicts* 70–79 (ed. Wilmschurst, 2012) [hereinafter Akande, "Classification of Armed Conflicts"].

19. Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, August 12, 1949, 75 U.N.T.S. 31 (GC I).

20. Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed

- The *Convention Relative to the Treatment of Prisoners of War* (GC III),²¹ and
- The *Convention Relative to the Protection of Civilian Persons in Time of War* (GC IV).²²

These treaties apply not only to all cases of declared war but also to “any other armed conflict which may arise between two or more” state parties, “even if the state of war is not recognized by one of them.”²³ GCs I–IV “shall also apply to all cases of partial or total occupation of the territory” of a state party, even if the “occupation meets with no armed resistance.”²⁴ An IAC may also exist where a state deploys irregular forces against another state so long as those forces “belong” (in IHL terms) to the state and the state exercises sufficient control over them.²⁵ For its part, the *Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts* (AP I) applies, in addition to the same situations as GCs I–IV, to “armed conflicts in which peoples are fighting against

Forces at Sea, August 12, 1949, 75 U.N.T.S. 85 (GC II).

21. Convention (III) Relative to the Treatment of Prisoners of War, August 12, 1949, 75 U.N.T.S. 135 (GC III).

22. Convention (IV) Relative to the Protection of Civilian Persons in Time of War, August 12, 1949, 75 U.N.T.S. 287 (GC IV).

23. Common Article 2(1) GCs I–IV. States parties to GCs I–IV “undertake to respect and to ensure respect for the [relevant] Convention in all circumstances,” including, where applicable, in peacetime. Common Article 1 GCs I–IV. Certain provisions of GCs I–IV shall be implemented in peacetime as well. Common Article 2(3) GCs I–IV contained a so-called *si omnes* clause: “Although one of the Powers in conflict may not be a party to the present Convention, the Powers who are parties thereto shall remain bound by it in their mutual relations. They shall furthermore be bound by the Convention in relation to the said Power, if the latter accepts and applies the provisions thereof.” *Id.* In light of the universal ratification of GCs I–IV, this clause bears no practical legal weight concerning the application of the conventions today.

24. Common Article 2(2) GCs I–IV. Pursuant to Article 42 Regulations Respecting the Laws and Customs of War on Land, Annex to Convention (IV) Respecting the Laws and Customs of War on Land, October 18, 1907, 36 Stat. 2295, “territory is considered occupied when it is actually placed under the authority of the hostile army.” See ICJ, *Armed Activities on the Territory of the Congo* (Democratic Republic of the Congo v. Uganda), ICJ Rep 2005, 168, paras. 172–73. Questions have arisen as to whether “occupation” and “occupied territory” in GC IV mean the same thing as “belligerent occupation” under customary international law and under article 42 Hague IV 1907 Annex. See, e.g., Akande, “Classification of Armed Conflicts,” *supra* note 18, at pp. 45–46.

25. Article 4(A)(2) GC III. This standard is “overall control” in the view of the Appeals Chamber of the ICTY. ICTY, *Prosecutor v. Tadić*, Appeals Chamber, Judgment, Case No IT-94-1-A, July 15, 1999, paras. 122 and 131. See also ICJ, *Application of the Convention on the Prevention and Punishment of the Crime of Genocide* (Bosnia and Herzegovina v. Serbia and Montenegro), ICJ Rep 43, 2007, p. 210, paras. 404–405.

colonial domination and alien occupation and against racist régimes in the exercise of their right of self-determination [...].”²⁶

The degree and kind of military force necessary to trigger the application of IHL to an IAC is a matter of dispute in jurisprudence and scholarship. The Appeals Chamber of the International Criminal Tribunal for the former Yugoslavia (ICTY) has held that an IAC “exists whenever there is a resort to armed force between States [...]”.²⁷ The ICRC’s *Commentaries* on GC I–IV state that “[a]ny difference arising between two States and leading to the intervention of members of the armed forces is an armed conflict within the meaning of article 2 [GCs I–IV], even if one of the Parties denies the existence of a state of war.”²⁸ The alternative view is that an IAC comes into effect only when the use of force between states reaches a minimal level of intensity.²⁹

Finally, where a state uses force directed at an organized armed group in the territory of a host state without that host state’s consent, a double classification cannot be excluded.³⁰ That is, both an IAC between the two states *and* a NIAC between the attacking state and the OAG may arise.

Non-international armed conflict

On its terms, article 3 GCs I–IV (Common Article 3) applies “[i]n the case of armed

26. As enshrined in the Charter of the United Nations and the Declaration on Principles of International Law concerning Friendly Relations and Co-operation among States in accordance with the Charter of the United Nations. Article 1(4) AP I. Article 3 AP I governs the temporal scope of application.

27. ICTY, Prosecutor v. Tadić, Appeals Chamber, Decision on the Defence Motion for Interlocutory Appeal on Jurisdiction, Case No. IT-94-1-AR72, Oct. 2, 1995, para. 70 [hereinafter, *Tadić*, Interlocutory Appeal].

28. ICRC, *Commentary on GC I*, p. 32; accord ICRC, *Commentary on GC II*, p. 28; ICRC, *Commentary on GC III*, p. 23; ICRC, *Commentary on GC IV*, p. 20.

29. International Law Association, “Final Report of the Meaning of Armed Conflict in International Law,” 2010, p. 32, available at <http://www.ila-hq.org/en/committees/index.cfm/cid/1022>. This approach has been criticized on the grounds (among others) that “[t]o import an intensity requirement into the definition of international armed conflicts is effectively to assert that no law governs the conduct of military operations below that level of intensity, including the opening phase of hostilities.” Akande, “Classification of Armed Conflicts,” supra note 18, at p. 41; see also Pejic, “Extraterritorial targeting,” supra note 16, at p. 11.

30. See Akande, “Classification of Armed Conflicts,” supra note 18, at p. 75; Pejic, “Extraterritorial targeting,” supra note 16, at pp. 11–12.

conflict not of an international character occurring in the territory of one of the High Contracting Parties [...].”³¹ And for its part, the *Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-international Armed Conflicts* (AP II) applies expressly

to all armed conflicts which are not covered by Article 1 of [AP I] and which take place in the territory of a [state party] 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 [AP II].³²

Commentators generally consider AP II to impose a higher threshold of application than Common Article 3.³³ AP II expressly does “not apply to situations of internal disturbances and tensions, such as riots, isolated and sporadic acts of violence and other acts of a similar nature, as not being armed conflicts.”³⁴ According to the ICTY Appeals Chamber, a NIAC “exists whenever there is [...] protracted armed violence between governmental authorities and organized armed groups or between such groups within a State.”³⁵ International jurisprudence and examinations of state practice in legal literature reveal three cumulative criteria for classifying a situation of violence as a NIAC: the existence of sufficiently organized parties, protracted violence, and the intensity of the fighting.³⁶

To activate the application of AP II in the territory of a contracting state, the terrorist OAG would need to be “under responsible command” and to “exercise such

31. Even prior to the advent of Common Article 3, international law provided for the recognition of belligerency to a civil war between a state and a rebel group. The laws of war were brought into effect between the parties where the belligerent government recognized the belligerent insurgent group. Akande, “Classification of Armed Conflicts,” *supra* note 18, at pp. 49–50.

32. Article 1(1) Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-international Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 609 (AP II).

33. See Akande, “Classification of Armed Conflicts,” *supra* note 18, at pp. 54–56.

34. Article 1(2) AP II. See also article 8(2)(c), (d), (e), and (f) ICC RS.

35. *Tadić*, Interlocutory Appeal, *supra* note 27, at para. 70.

36. See, e.g., Dinstein, *NLACs in International Law*, *supra* note 11, at pp. 20–21, 28–36.

control over a part of [the state party's] territory as to enable [the group] to carry out sustained and concerted military operations and to implement" AP II.³⁷ Examples of organized armed groups designated as terrorists that have controlled territory during protracted hostilities arising to the level of NIACs include the FARC in Colombia³⁸ and the Liberation Tigers of Tamil Eelam (LTTE) in Sri Lanka.

The AP II threshold, however, is generally less likely to be met by many designated terrorist groups. As a matter of international law, NIACs that do not fall under AP II are nonetheless still governed by Common Article 3 and customary IHL rules applicable to NIACs. And, where applicable, the Rome Statute of the International Criminal Court may impose (additional) medical-care legal obligations in situations meeting that instrument's threshold of application for NIACs.³⁹

Jelena Pejic, a leading IHL scholar and practitioner, has identified seven types of Common Article 3 conflicts under IHL, some only "arguably" so.⁴⁰ All of those potential types of Common Article 3 conflicts may in principle involve terrorism. Some of the variation is based on the extraterritorial nature of the relevant conflict, which may affect the scope and applicability of certain medical-care obligations.

Nexus to Armed Conflict

The only terrorist acts that IHL applies to are those that have a sufficient connection to an armed conflict. In other words, "not all acts of terrorism in a territory affected by armed conflict will comprise part of that conflict."⁴¹ Instead, "[i]t remains

37. Article 1(1) AP II.

38. See generally Felicity Szesnat and Annie R. Bird, "Colombia," in *International Law and the Classification of Conflicts* 214–228 (ed. Wilmschurst, 2012).

39. Articles 8(2)(c)–(f) Rome Statute of the International Criminal Court, July 17, 1998, 2187 U.N.T.S. 90 (ICC RS). In principle, in a NIAC involving a state party that is not a contracting party to AP II but that is subject to the jurisdiction of the Rome Statute, the state would be bound—with respect to medical-care protections—not only by Common Article 3 and customary rules applicable in NIAC but also by relevant provisions of the Rome Statute (such as articles 8(2)(e)(ii) and (iv) ICC RS).

40. Jelena Pejic, "The protective scope of Common Article 3: more than meets the eye," 93 *IRRC* No. 881 (2011) 5–9; see also Pejic, "Extraterritorial targeting," *supra* note 16, at pp. 14–18.

41. Ben Saul, "Terrorism and international humanitarian law," in *Research Handbook on International Law and*

necessary to distinguish ordinary criminal acts of terrorism committed by other individuals or organisations from violence committed by the parties to the conflict or which has a ‘nexus’ to the conflict.”⁴² The response to the former—an “ordinary” criminal act of terrorism—is not governed by IHL. Rather, it is subject to the application of domestic law-enforcement measures compatible with other relevant fields of international law, such as IHRL.⁴³

So long as they are conducted with a sufficient nexus to an armed conflict, many terrorist acts—such as attacks directed against civilians⁴⁴—would also constitute a violation of IHL.⁴⁵ Yet a number of the acts that may be penalized in domestic law as terrorism offenses are not prohibited under IHL. (Nor, however, are those acts necessarily authorized under IHL.⁴⁶) For instance, unlike domestic anti-terrorism-financing measures, IHL does not expressly prohibit the provision of financial resources to terrorist OAGs. Moreover, so long as they comport with law-of-armed-conflict rules governing the conduct of hostilities, attacks carried out by OAGs against government armed forces are not prohibited in IHL. (Nor does

Terrorism 214 (ed. Saul, 2014) [hereinafter Saul, “Terrorism and international humanitarian law”].

42. *Id.*

43. *Id.*

44. *Id.* at pp. 225–226.

45. For example, pursuant to article 51(2) AP I, “[a]cts or threats of violence the primary purpose of which is to spread terror among the civilian population are prohibited” and according to article 4(2)(d) AP II,

[w]ithout prejudice to the generality of the foregoing, the following acts against [all persons who do not take a direct part or who have ceased to take part in hostilities, whether or not their liberty has been restricted] are and shall remain prohibited at any time and in any place whatsoever: [...] acts of terrorism.

They may also constitute a violation of international criminal law and domestic law; see, e.g., ICTY, *Prosecutor v. Galić*, Appeals Chamber, Judgment, Case No IT-98-29-A, November 30, 2006, pp. 39–44, paras. 87–90 (finding that “the prohibition of terror against the civilian population as enshrined in Article 51(2) of Additional Protocol I and Article 13(2) of Additional Protocol II clearly belonged to customary international law from at least the time of its inclusion in those treaties”). See, e.g., Hans Gasser, “Acts of terror, ‘terrorism’ and international humanitarian law,” 84 *IRRC* No. 847 (2002) 554–62; Dinstein, *NLACs in International Law*, *supra* note 11, at p. 34.

46. For instance, pursuant to article 3(1) AP II, states parties agreed that “[n]othing in this Protocol shall be invoked for the purpose of affecting the sovereignty of a State or the responsibility of the government, by all legitimate means, *to maintain or re-establish law and order in the State* or to defend the national unity and territorial integrity of the State.” *Italics added.*

IHL directly authorize them.⁴⁷⁾ Meanwhile, domestic legislations may penalize those attacks as violent crimes, treason, support for terrorism, and the like.⁴⁸

Potential Status of Terrorists under IHL

IHL does not expressly recognize the status of *terrorist* as such: “[t]here is neither any special legal status for ‘terrorists’, nor any lacuna excluding them, in IHL.”⁴⁹ In this subsection, we identify some examples of how allegations of terrorist violence may arise in IAC or in NIAC and what the corresponding status under IHL of those engaging in such conduct may be. That status—which can be highly fact-dependent—is important here because the scope of protections for a terrorist may turn on her status or function under IHL.⁵⁰

Two prefatory notes are in order. First, an individual may have a dual legal status: one under a source of counterterrorism law and another under IHL. For example, someone may be considered a terrorist under domestic legislation but also a member of the state armed forces or of an organized armed group under IHL. The two statuses are not mutually exclusive.⁵¹

Second, in situations of armed conflict, civilians enjoy significant protections under IHL. Most importantly, they are generally immune from direct attack. That immunity lasts, under AP I and AP II, unless and for such time as they take a direct

47. Dinstein subdivides violence during NIAC into three categories: hostilities, ordinary crimes, and war crimes. Dinstein, *NIACs in International Law*, supra note 11, at pp. 11–17.

48. See, e.g., *R v. Mohammed Gul* [2012] EWCA Crim 280 [60] (concluding that “[t]hose who attacked the military forces of a government or the Coalition forces in Afghanistan or Iraq with the requisite intention set out in the Act are terrorists. There is nothing in international law which either compels or persuades us to read down the clear terms of the 2000 Act to exempt such persons from the definition in the Act.”); U.S. Department of Defense, *Law of War Manual* § 17.4 (2015).

49. *Id.* at p. 222.

50. With respect to the IHL considerations concerning who may be targeted, see, e.g., Pejic, “Extraterritorial targeting,” supra note 16, at pp. 20–23.

51. Saul, “Terrorism and international humanitarian law,” supra note 41, at p. 213. As noted above, however, certain anti-terrorism conventions exclude from their scope of application armed forces in situations of armed conflict. See supra Section 2: “Definition and Classification of Armed Conflicts under IHL.”

part in hostilities.⁵² Thus, while IHL does not prohibit civilians from conducting hostilities (so long as they do so in accordance with the laws of war), under IHL civilians forfeit their immunity against direct attack while directly participating in hostilities. One of the most pressing and disputed questions in contemporary IHL practice and scholarship concerns the exact definitional contours of such direct participation in hostilities.⁵³

International armed conflict

Under IHL, in IAC “a person is generally either a combatant or a civilian,”⁵⁴ and “[g]enerally speaking, members of the armed forces (other than medical personnel and chaplains) are combatants.”⁵⁵ (The so-called “special” status of medical personnel who are authorized by a party to a conflict is highlighted in section 4.) The distinction matters chiefly because combatants “cannot be prosecuted for lawful acts of war in the course of military operations even if their behaviour would constitute a serious crime in peacetime. [...] Once captured, combatants are entitled to prisoner-of-war status and to benefit from the protection of” GC III.⁵⁶

A state may also deploy “irregular” forces in an IAC,⁵⁷ and those forces may be

52. Articles 51(3) AP I and 13(3) AP II. Pursuant to Common Article 3(1), in NIAC “[p]ersons taking no *active* part in the hostilities” shall be treated in accordance with the protections laid down therein. *Italics added.* The United States does not seem to accept the qualifying phrase “for such time.” See U.S. Department of Defense, *Law of War Manual* §§ 2.9.1.2 and 2.9.4 (2015). Nor apparently does Israel; see Yoram Dinstein, “The ICRC Customary International Humanitarian Law Study,” 82 *ILS* (2006) 107 [citations omitted] (originally published in 36 *IYHR* 2006).

53. See, e.g., 42 *NYUJILP* 3 (2010); Michael N. Schmitt, “The Interpretive Guidance on the Notion of Direct Participation in Hostilities: A Critical Analysis,” 1 *HNSJ* (2010) 5.

54. *Id.* See article 4(A) GC III; article 43 AP I.

55. Knut Dörmann, “The legal situation of ‘unlawful/unprivileged combatants,’” 85 *IRRC* No. 849 (2003) 45–46. Note the distinct legal position of members of a *levée en masse*, who, pursuant to article 4(A)(6) GC III, are not combatants but are entitled to prisoner-of-war status upon falling into the hands of the enemy. Under IHL, religious personnel have a particular protected status; we do not discuss or address that status in this report. Where an IHL provision includes protections for both medical and religious personnel, we focus only on those pertaining to the former and elide those pertaining to the latter.

56. *Id.* at p. 45. Combatants “can be prosecuted only for violations of international humanitarian law, in particular for war crimes.” *Id.* See also article 43(2) AP I.

57. As defined in article 4(A)(2) GC III.

accused of terrorist conduct. The key questions as to the status of those persons are whether the terrorists serving as such irregular forces “belong” in IHL terms to the relevant state party to the conflict and whether they comply with the four minimum conditions of combatancy.⁵⁸ International law scholar Ben Saul explains that “[w]hile autonomous terrorist groups (such as Al-Qaeda) do not ‘belong’ to any state, it is conceivable for a terrorist group to be sufficiently connected to and commanded by state authorities in a given situation.”⁵⁹

Also in IAC, the conduct of “guerilla” forces who fall under article 44(3) AP I (by carrying their arms openly preceding and during a hostile act⁶⁰)— and thus who also qualify as combatants under that regime—may give rise to terrorism allegations.⁶¹

In addition to combatants and irregular forces, a number of other actors’ conduct may elicit allegations of terrorist violence during an IAC. For example, accusations of terrorist violence may arise “where civilians spontaneously resist the invading forces of a foreign state (a *levée en masse*).”⁶²

58. Article 4(A)(2) GC III.

59. Saul, “Terrorism and international humanitarian law,” *supra* note 41, at p. 210.

60. More specifically, pursuant to article 44(3) AP I, an armed combatant

shall retain his status as a combatant, provided that, in [situations of armed conflicts where, owing to the nature of the hostilities, he cannot distinguish himself from the civilian population while he is engaged in an attack or in a military operation preparatory to an attack], he carries his arms openly: (a) during each military engagement, and (b) during such time as he is visible to the adversary while he is engaged in a military deployment preceding the launching of an attack in which he is to participate.

61. Article 44(3) is one of the grounds on which the U.S. has elected not to become a party to AP I. *Detailed Analysis of Provisions*, Attachment 1 to George P. Shultz, Letter of Submittal, December 13, 1986, *Message from the President Transmitting AP II*, p. IX (stating that “Article 44(3), in a single subordinate clause, sweeps away years of law by ‘recognizing’ that an armed irregular ‘cannot’ always distinguish himself from non-combatants; it would grant combatant status to such an irregular anyway. As the essence of terrorist criminality is the obliteration of the distinction between combatants and noncombatants, it would be hard to square ratification of this Protocol with the United States’ announced policy of combatting terrorism.”)

62. Saul, “Terrorism and international humanitarian law,” *supra* note 41, at p. 211. Article 4(A)(6) GC III defines a *levée en masse* as “[i]nhabitants of a non-occupied territory, who on the approach of the enemy spontaneously take up arms to resist the invading forces, without having had time to form themselves into regular armed units, provided they carry arms openly and respect the laws and customs of war.” Members of a *levée en masse*, despite not technically belonging to or forming part the armed forces of a party to the IAC, are entitled to prisoner-of-war status if they fall into the hands of the enemy. Article 4(A)(6) GC III.

Terrorism allegations may also arise “where a state occupies another state’s territory without initially meeting armed resistance, whether from the military or irregular forces of the occupied state or a *levée en masse*.”⁶³ In that case, according to Saul, “[s]ubsequent ‘terrorist’ violence by civilian resistance forces of occupied territory may still be classified as part of the international conflict brought about by occupation.”⁶⁴ In a similar vein, terrorist violence may form part of an IAC “involving civilian resistance forces which succeed any national armed forces that resisted an invading military but dissolved upon the establishment of the occupation.”⁶⁵ Finally, terrorist violence may form part of an IAC where a so-called national liberation movement is recognized pursuant to AP I.⁶⁶

Non-international armed conflict

Terrorist violence may also form part of a NIAC.⁶⁷ Such violence may, for instance,

63. Saul, “Terrorism and international humanitarian law,” supra note 41, at p. 211. See also Akande, “Classification of Armed Conflicts,” supra note 18, at p. 47 (arguing that “it is the law of occupation and other rules of international armed conflict (including the law of targeting) that conditions how the occupier may respond to an uprising in the foreign territory of which it has temporary occupation.”). But see Marko Milanovic, “Lessons for human rights and humanitarian law in the war on terror: comparing *Hamdan* and the Israeli *Targeted Killings* case,” 89 *IRRC* No. 866 (2007) 381–385.

64. Saul, “Terrorism and international humanitarian law,” supra note 41, at p. 211.

65. *Id.* Saul identifies “Israel’s conflict against Palestinian terrorist organisations” as one such IAC, “albeit with *sui generis* characteristics.” *Id.* [citation omitted]. In relation to that form of IAC, according to Saul, “a distinction should be drawn between non-state groups comprised of inhabitants of occupied territory and foreign terrorist groups which fight an occupying power; only the latter may be characterised as part of an international conflict, while the former may form part of a separate non-international conflict.” *Id.*

66. Article 1(4) AP I. Saul, “Terrorism and international humanitarian law,” supra note 41, at p. 211. Saul argues that that states not party to AP I

(relevantly including Israel, occupying Palestine, and Morocco, occupying Western Sahara) remain free to treat liberation fighters as domestic rebels, including to criminalise them as ‘terrorists’ under domestic law (for attacks on the state’s own territory) or the military law applicable in occupied territory (to the extent that the prior domestic law of the occupied territory has been displaced for security reasons).

Id. at p. 212.

67. In a 1997 judgment, the Trial Chamber of the ICTY added the precondition of the intensity of violence to help distinguish armed conflicts from “banditry, unorganized and short-lived insurrections, or *terrorist activities*.” ICTY, *Prosecutor v. Tadić*, Trial Chamber, Opinion and Judgment, Case No IT-94-1-T, May 7, 1997, para. 562 [citations omitted; italics added]. However, according to Dinstein, that reference to *terrorist activities* should “be taken as relating not to the nature of the acts but to their sporadic incidence. It is only when terrorist activities do not meet the required

be committed by:

- A member of the state armed forces;
- A member of the dissident armed forces;
- A member of an organized armed group; or
- A civilian directly participating in hostilities.

(AP II also contemplates the “special” status of medical personnel in NIAC. Among the conditions to obtain that status is that those assigned personnel do not commit acts, outside their humanitarian function, harmful to the enemy.⁶⁸)

States have not agreed in NIAC treaties to extend the “combatant’s privilege”—and, upon capture, the corresponding status of prisoner of war—to members of organized armed groups or to civilians directly participating in hostilities.⁶⁹ Parties to a NIAC may, however, extend POW status to captured fighters as a policy matter.⁷⁰

preconditions of a NIAC that they would move into another legal arena [i.e., one other than IHL].” Dinstein, *NIACs in International Law*, supra note 11, at p. 34.

68. See infra Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Respect and protection of medical personnel, units, and transports: prohibition on knowingly attacking, firing upon, or unnecessarily preventing them from discharging their proper functions” and id at. “Prohibition on illegitimate compulsion.”

69. See Dinstein, *NIACs in International Law*, supra note 11, at pp. 58–63. The IHL criteria for membership in an organized armed group are a matter of dispute. See, e.g., Kenneth Watkin, “Opportunity Lost: Organized Armed Groups and the ICRC ‘Direct Participation in Hostilities’ Interpretive Guidance,” 42 *NYUJILP* 641 (2010).

70. Pursuant to Common Article 3(2), “[t]he Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention.”; pursuant to article 6(5) AP II, “[a]t the end of hostilities, the authorities in power shall endeavour to grant the broadest possible amnesty to persons who have participated in the armed conflict, or those deprived of their liberty for reasons related to the armed conflict, whether they are interned or detained.”

A black and white photograph showing a group of soldiers in a field. One soldier in the foreground is kneeling, attending to a person lying on the ground. Other soldiers are visible in the background, some standing and some crouching. The scene appears to be a medical aid station or a battlefield triage area. The number '3' is overlaid on the left side of the image.

3

THE RISE OF
INTERNATIONAL
LEGAL PROTECTIONS
FOR WARTIME
MEDICAL CARE

In this section, we trace how—beginning a century before the first anti-terrorism treaty came into force—states developed international instruments protecting wartime medical care. Over time, states established that wounded and sick combatants, then prisoners of war, and then civilians must be protected and cared for.¹ States also established that those providing medical care must be respected and protected.² Today, certain key IHL medical-care obligations are incumbent on all parties to all armed conflicts. But seen in aggregate, the current legal regime is somewhat fragmented and marked by protective gaps.

IHL Treaties

Antecedents to the Geneva Conventions of 1949

The international legal framework governing armed conflict is frequently couched in terms of reflecting states' attempts to balance military necessity with concerns for humanity.³ At its inception, IHL primarily created obligations of states in relation to other states.⁴ Nationality largely determined whether a person was considered a friend, foe, or neutral.

States intentionally designed IHL in part to infuse humanitarian concern into the cruelty of war. It was the horrifying images of the languishing wounded soldiers on the battlefield of Solferino that prompted a chance traveler, the Swiss businessman Henri Dunant, to envision the creation of what would become the ICRC.⁵

1. Concerning medical care for wounded and sick combatants under treaty-based IHL, see, e.g., Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* 91–94 (2015) [hereinafter Mehring, *Medical Ethics in IHL*]; concerning medical care for prisoners of war under treaty-based IHL, see, e.g., id. at pp. 94–98; concerning medical care for the civilian population under treaty-based IHL, see, e.g., id. at pp. 98–102.

2. Regarding protection of physicians and other medical care providers under treaty-based IHL, see, e.g., id. at 106–118.

3. Michael N. Schmitt, “Military Necessity and Humanity in International Humanitarian Law: Preserving the Delicate Balance,” 50 *VJIL* No. 4 (2010) 795.

4. Reparation claims, for instance, are addressed not by the individual harmed but rather by her government to the other sovereign. Silja Vöneky, “Implementation and Enforcement of International Humanitarian Law,” in *The Handbook of International Humanitarian Law* 683–85 (3d ed., ed. Fleck, 2014).

5. Baptiste Rolle and Edith Lafontaine, “The emblem that cried wolf: ICRC study on the use of the emblems,” 91

Medical care for enemy forces was the subject of one of the first modern international instruments on war: the *Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, 1864* (GC 1864).⁶ Prompted by the forerunner to the ICRC to convene in Geneva, states were animated in part by self-interest: they wanted their *own* wounded or sick soldiers to be treated humanely. As a condition for taking the somewhat radical step of ensuring medical care to the enemy, states were keen to *maintain control* over the terms and conditions of such care.

The regime pivoted in part on mutual trust between the parties. A practical manifestation of that trust was the introduction of the distinctive sign that each party was responsible for controlling. Hospitals and ambulances adopted a uniform flag, which was to be accompanied in all circumstances by the national flag.⁷ And military medical personnel could wear an armlet, which could be assigned only by military authorities.⁸ Both the uniform flag and the armlet featured a red cross on a white background.⁹

Applicable to IACs, GC 1864 rested on three broad sets of principles. First, it established the fundamental obligation of states to collect and care for wounded or sick combatants irrespective of their nationality.¹⁰ Second, it regulated the “neutrality” of certain medical personnel, establishments, units, and equipment, as well as inhabitants of the country who bring help to the wounded.¹¹ “Neutrality,” in this context, meant a form of inviolability: states party to GC 1864 could not take adverse action against such medical personnel or inhabitants bringing help to the

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6. Convention for the Amelioration of the Wounded in Armies in the Field, August 22, 1864, 22 Stat. 940 (GC 1864).

7. Article 7(1) GC 1864.

8. Article 7(2) GC 1864.

9. Article 7(3) GC 1864.

10. Article 6 GC 1864.

11. Articles 1–5 GC 1864.

wounded.¹² And third, it introduced the distinctive and uniform sign of the red cross on a white background.¹³

In sum, GC 1864 established the responsibilities of states parties to wounded and sick enemy soldiers in their care. It thus laid down the principles of relief to the wounded without adverse distinction between enemy and ally and of the “neutrality” of medical personnel.

In The Hague in 1899 and 1907 and in Geneva in 1906, states convened again to further develop international law applicable to war. The *1899 Convention (III) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention of 22 August 1864*, for instance, clarified some of the provisions of GC 1864 and adapted its principles to sea warfare.¹⁴

The 33 articles of the *Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, Geneva, 6 July 1906* (GC 1906) replaced the ten articles of GC 1864 in relations among the contracting states.¹⁵ GC 1906 broadened the scope of application to include, in addition to combatants, other persons who were officially attached to the armies and who were wounded or sick.¹⁶

GC 1906 also discarded the principle of “neutrality” of medical personnel and units, and replaced it with the broader and more onerous duty of “respect and protection.”¹⁷ That two-fold duty remains the term of art today—though one

12. GC 1864. The notion of neutrality entailed in articles 2 and 5 GC 1864 (concerning medical personnel and inhabitants) is not synonymous with the modern humanitarian principle of neutrality, discussed *supra* (Introduction: “Humanitarian Principles in a Counterterrorism World”) and defined in the Glossary. Rather, the notion of neutrality as used in articles 2 and 5 GC 1864 relates to the concept of what would later be phrased “protect and respect.” Mehring, *Medical Ethics in IHL*, *supra* note 1, at p. 84.

13. Article 7 GC 1864.

14. 1899 Convention (III) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention of August 22, 1864, 32 Stat. 1827. See Jann K. Kleffner, “Protection of the Wounded, Sick, and Shipwrecked,” in *The Handbook of International Humanitarian Law* 322 (3d ed., ed. Fleck, 2014) [hereinafter, Kleffner, “Protection of the Wounded, Sick, and Shipwrecked”].

15. Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, Geneva, July 6, 1906, 35 Stat. 1885.

16. Article 1 GC 1906. Whereas GC 1864 entailed the notion of *protection*, GC 1906 added the notion of *respect*.

17. Articles 6 and 9(1) GC 1906. The concept of “protection and respect” [*protégés et respectés*]—note the inverse

that appears, to a certain extent, to lack a definitional consensus¹⁸—not only for medical personnel, transports, and units but also for the wounded and sick hors de combat. Thus this “respect and protection” duty seems to entail slightly different sets of obligations for the respective categories of persons and objects to which it applies. The respect prong appears to mean that both the wounded and sick hors de combat and medical personnel, transports, and units may not knowingly be attacked or fired upon. The protection prong differs slightly between these sets of persons and objects: the wounded and sick hors de combat may not knowingly be unnecessarily interfered with, while medical personnel, transports, and units may not knowingly be unnecessarily prevented from discharging their proper functions.¹⁹ The “respect and protection” duty does not exempt the wounded and sick hors de combat nor medical personnel from capture, detention, or search. Moreover, this special status

order of the terms—was already included in article 1(1) GC 1864, which, as mentioned above, couched the protection due to ambulances and military hospitals in terms of “neutrality.” (The only authentic language of the 1864–1929 treaties discussed in this report is French, and thus where relevant we reference the authoritative language.) In the authentic text, the phrasing used in article 6 GC 1906 is “Les formations sanitaires mobiles (c’est-à-dire celles qui sont destinées à accompagner les armées en campagne) et les établissements fixes du service de santé seront respectés et protégés par les belligérants.” The authentic text phrasing used in article 9(1) GC 1906 is

Le personnel exclusivement affecté à l’enlèvement, au transport et au traitement des blessés et es malades, ainsi qu’à l’administration des formations et établissements sanitaires, les aumôniers attachés aux armées, seront respectés et protégés en toute circonstance ; s’ils tombent entre les mains de l’ennemi, ils ne seront pas traités comme prisonniers de guerre.

18. According to an ICRC *Commentary* on a subsequent treaty, the concept of “protection” is broader: it purportedly imposes an obligation (of means) to come to the qualifying person’s aid and give her any care of which she stands in need. See generally ICRC, *Commentary on GC IV*, at p. 134; see also *id.* at pp. 133–134 (explaining, in relation to the development of the concept of *respect and protection*—as entailed, for example, in articles 6 and 9 GC 1906, article 12(1) GC I, articles 12(1), 22(1), 27(1), 36 and 37(1) GC II, and articles 16(1), 18(1), 20(1) and (3), and 21 GC IV—that

[t]he word ‘respect’ (‘respecter’) means according to the Dictionary of the French Academy, ‘to spare, not to attack’ (épargner, ne point attaquer), whereas ‘protect’ (protéger) means ‘to come to someone’s defence, to give help and support’. These words make it unlawful to kill, ill-treat or in any way injure an unarmed enemy, while at the same time they impose an obligation to come to his aid and give him any care of which he stands in need.

Id.

19. U.S. Department of Defense, *Law of War Manual* §§ 7.3.3, 7.8.2, 17.14.1.2, and 17.15.1.2 (2015). The section of the *Manual* on civilian hospital personnel—who, under article 20 GC IV, also are entitled to respect and protection—does not define “respect and protection” in that context, though it can be reasonably assumed that it has the same definition as used elsewhere in the *Manual*. *Id.* at § 7.17.4.2.

is forfeited when the wounded and sick engage in a hostile act or when medical personnel commit, or medical units or transports are used to commit, outside their humanitarian duties, acts harmful to the enemy.²⁰ (A subsequent IHL treaty exempts certain medical personnel in IAC from detention and instead contemplates that the adverse party may retain them if the number and condition of prisoners of war so require.²¹)

GC 1906 also expressly recognized, for the first time in an international treaty, volunteer aid societies.²² So long as they were subject to military laws and regulations and were duly recognized and authorized by their own government, the personnel of those societies would fall under the same type of protection as military medical personnel.²³ These requirements were part of the system of mutual trust between the warring parties. Again, states were willing to take on obligations to respect and protect medical personnel partly if the other party was willing to exercise sufficient control over their medical personnel, too.

The *Convention (X) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention, The Hague, 18 October 1907* (HC (X) 1907) adapted the protective regime entailed in GC 1906 concerning armed conflicts on land to maritime warfare.²⁴ And the 1907 *Hague Convention (V) on Rights and Duties of Neutral Powers and Persons in Case of War on Land* extended the protective principles to neutral states.²⁵

20. See infra Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Respect and protection of medical personnel, units, and transports: prohibition on knowingly attacking, firing upon, or unnecessarily preventing them from discharging their proper functions.”

21. See infra Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Capture, detention, and retention.”

22. Article 10(1) GC 1906.

23. Id.

24. Thereby broadening the protections entailed in 1899 Convention (III) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention of August 22, 1864, 32 Stat. 1827. Convention (X) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention, October 18, 1907, 36 Stat. 2371 (HC (X) 1907).

25. See, e.g., Articles 14–15 Convention (V) Respecting the Rights and Duties of Neutral Powers and Persons in Case of War on Land, October 18, 1907, 36 Stat. 2310.

A decade after the end of World War I, in 1929, states developed two additional conventions relating to medical care in armed conflict. The *Geneva Convention for the Amelioration of the Wounded and Sick in Armies in the Field*, 27 July 1929 (GC W&S 1929) represented the third version of the Geneva Convention, following GC 1864 and GC 1906.²⁶ GC W&S 1929 established the protection of medical aircraft and recognized the use of the emblems of the red crescent and of the red lion and sun (thus expanding the options beyond the red cross for certain states).²⁷ Building on instruments developed decades earlier, states also developed a treaty on the treatment of prisoners of war: the *Geneva Convention Relative to the Treatment of Prisoners of War*, 27 July 1929 (GC POW 1929).²⁸ The new instrument required that “[e]ach camp shall possess an infirmary, where prisoners of war shall receive attention of any kind of which they may be in need.”²⁹

The Geneva Conventions of 1949

During World War II (WWII), the existing legal protections for medical assistance proved drastically insufficient.

Fragmentation in the legal landscape contributed to protection gaps. Two of the major parties—Japan and the Union of Soviet Socialist Republics (U.S.S.R.)—had not ratified GC POW 1929. Among many others, prisoners of war of the Soviet Union in Germany and German POWs captured or detained in the Soviet Union suffered.³⁰

26. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick of Armies in the Field, July 27, 1929, 47 Stat. 2074 (GC W&S 1929).

27. Articles 18 and 19(2) GC W&S 1929. Note that article 19(2) GC W&S 1929 restricts the use of the red crescent and the red lion and sun on a white background to states that already used one of those two emblems before the adoption of the treaty. See generally Jean-François Quéguiner, “Commentary on the Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III),” 89 *IRRC* No. 865 (2007) 177.

28. Articles 14–15 Geneva Convention Relative to the Treatment of Prisoners of War, July 27, 1929, 47 Stat. 2021 (GC POW 1929).

29. Article 14(1) GC POW 1929 [italics added]. In the authentic text: “Chaque camp possédera une infirmerie, où les prisonniers de guerre recevront les soins de toute nature dont ils pourront avoir besoin.”

30. Mehring, *Medical Ethics in IHL*, supra note 1, at p. 87 [citations omitted].

During the war, “[m]en were killed or molested for having taken care of partisans or parachutists.”³¹ Along the same lines, “doctors and orderlies who had worked in the Medical Service or Red Cross Society of an occupying country were subjected at the close of hostilities to laws which treated any form of service in an enemy army as high treason.”³² They “were regarded purely and simply as individuals who had taken up arms against their country.”³³

In addition, without any international legal protection addressing them, thousands of civilians in the hands of parties to the conflict died.³⁴

To help ameliorate these and other problems, on August 12, 1949 states signed the four Geneva Conventions.

International armed conflicts

GC I supersedes GC W&S 1929³⁵ and extensively elaborates obligations concerning wounded and sick members of the armed forces in the field.

To strengthen the respect and protection due to military medical units and establishments, the drafters added a warning requirement. GC W&S 1929 had laid down that the protection against attack for medical units could not cease unless the units were used to commit, outside their humanitarian duties, acts harmful to the enemy.³⁶ GC I requires, in addition, that *even then* such protection could not cease for those units unless the adverse party had given a due warning, setting, in all appropriate cases, a reasonable time limit, and that warning had gone unheeded.³⁷

31. ICRC, *Commentary on GC I*, p. 192.

32. Id.

33. Id.

34. Mehring, *Medical Ethics in IHL*, supra note 1, at p. 87 [citations omitted].

35. Preamble GC I (stating that “[t]he undersigned Plenipotentiaries of the Governments represented at the Diplomatic Conference held at Geneva from April 21 to August 12, 1949, *for the purpose of revising the Geneva Convention for the Relief of the Wounded and Sick in Armies in the Field of July 27, 1929*, have agreed as follows”) [italics added].

36. Article 7 GC W&S 1929.

37. Article 21 GC I. See generally ICRC, *Commentary on GC I*, pp. 201–202.

In GC I, states also regulated the position of *auxiliary* and *permanent medical personnel* of a party to the conflict.³⁸ Included in the former are members of the armed forces trained for employment (if the need arose) as hospital orderlies, nurses, or auxiliary stretcher-bearers. In the latter are military medical service members, as well as recognized and authorized members of National Red Cross Societies and voluntary aid agencies (including those of neutral states).

In addition, GC I extends (albeit in a more limited fashion) the protections, which first emerged in GC 1864, for *unassigned* caregivers. For instance, under GC I military authorities must “permit the inhabitants and relief societies, even in invaded or occupied areas, spontaneously to collect and care for the wounded or sick whatever their nationality.”³⁹ And, in response to the “painful problems” of ill-treatment against medical caregivers in WWII,⁴⁰ the drafters of GC I promulgated a rule stipulating that “[n]o one may ever be molested or convicted for having nursed the wounded or sick.”⁴¹

GC I also helps clear up the confusion that arose during WWII concerning the situation of captured medical personnel. Under GC W&S 1929, medical personnel falling into the hands of the enemy could not be retained.⁴² In the absence of an agreement between the parties, they had to be sent back to the belligerent to which they belonged as soon as a route for their return opened up and military considerations permitted.⁴³ Pending their return, they were to carry out their medical duties under the enemy’s direction. While they were “preferably” to be engaged in the care of the wounded and sick of their party, fulfilling that preference was not a legal obligation under GC W&S 1929.⁴⁴ GC I puts matters on a different footing. It provides that, while they may not be detained, certain

38. Articles 24–27 GC I.

39. Article 18(2) GC I.

40. *Id.*

41. Article 18(3) GC I [*italics added*].

42. Article 12(1) GC W&S 1929.

43. *Id.* at article 12(2).

44. *Id.* at article 12(3).

medical personnel may be *retained* by the adverse party—but only if the number and condition of POWs require it.⁴⁵

Perhaps the most innovative aspect of GC I was the establishment of a “grave breaches” regime for certain acts committed against particular persons or certain property.⁴⁶ States parties undertake to give effect to this regime through various suppression and punitive measures. One key element is the requirement to enact necessary legislation to provide penal sanctions for persons committing, or ordering to be committed, grave breaches.⁴⁷ Among the persons against whom such breaches could be committed are the wounded and sick as well as medical personnel protected under GC I.⁴⁸ Acts constituting grave breaches against protected persons include (among others) willful killing; torture or inhuman treatment, including biological experiments; and willfully causing great suffering or serious injury to body or health.⁴⁹

GC II, which replaced HC (X) 1907, further extends the protective regime to wounded, sick, and shipwrecked members of the armed forces at sea.⁵⁰ And GC III, which replaced GC POW 1929, extensively regulates the status and treatment of—including the medical care and attention due to—prisoners of war.⁵¹

Finally, GC IV deals unevenly with the protection of civilians, including in occupied territories.⁵² As outlined below, the bulk of GC IV relates to “protected persons” and civilians in occupied territory. Yet a key part of the convention applies to the whole population of the countries in conflict.⁵³ In that part, GC IV establishes

45. Article 28(1) GC I.

46. Articles 50–51 GC I, 50–51 GC II, 129–30 GC III, and 146–47 GC IV.

47. Article 49(1) GC I.

48. ICRC, *Commentary on GC I*, p. 371.

49. Article 50 GC I.

50. See, e.g., Kleffner, “Protection of the Wounded, Sick, and Shipwrecked,” *supra* note 14, at p. 322. GC I applies with respect to wounded and sick (while GC II applies with respect to wounded, sick, and shipwrecked) persons who are entitled to prisoner-of-war status in accordance with article 4(A) GC III. Common Article 13 GC I and GC II.

51. E.g., articles 15 and 30 GC III.

52. Kleffner, “Protection of the Wounded, Sick, and Shipwrecked,” *supra* note 14, at p. 322.

53. Articles 13–26 (Part II) GC IV.

protections for (among other things) civilian hospitals organized to give care to the wounded and sick, the infirm, and maternity cases.⁵⁴ Those hospitals must be respected and protected by the parties at all times.⁵⁵ As with military medical units and establishments protected in GC I, under GC IV the protections for these civilian hospitals may not cease unless they are used to commit, outside their humanitarian functions, acts harmful to the enemy.⁵⁶ Also as with their military analogues, that protection for civilian hospitals may not cease until after due warning is given, setting, in all appropriate circumstances, a reasonable time limit, and only after that warning remains unheeded.⁵⁷ The personnel of civilian hospitals have similar protections.⁵⁸ As do civilian transports on land or sea conveying the wounded and sick, the infirm, and maternity cases.⁵⁹

Moreover, each state party to GC IV shall, subject to certain control measures, “allow the free passage of all consignments of medical and hospital stores [...] intended only for civilians of another [state party], even if the latter is its adversary.”⁶⁰ Likewise, it shall “permit the free passage of all consignments of essential [...] tonics [that is, pharmaceutical products] intended for children under fifteen, expectant mothers and maternity cases.”⁶¹

In its section that applies to the whole population of the countries in conflict, GC IV also expressly makes the wounded and sick—as well as the “infirm” and expectant mothers—the object of “particular protection and respect.”⁶² In addition, each party is obliged to facilitate steps to search for the killed and wounded, to

54. Article 18(1) GC IV.

55. *Id.*

56. Article 19(1) GC IV.

57. *Id.*

58. Article 20 GC IV.

59. Article 21 GC IV. On the protections for certain medical aircraft, see article 22 GC IV.

60. Article 23 GC IV.

61. Article 23(1) GC IV. See also ICRC, *Commentary on GC IV*, p. 181 (“The term ‘tonics’ covers any pharmaceutical products which are intended to restore normal vitality to the human organism.”) [citation omitted].

62. Article 16(1) GC IV.

assist the shipwrecked and others exposed to grave danger, and to protect them against pillage and ill-treatment.⁶³ Yet—unlike the analogous provisions in GCs I–III covering combatants and prisoners of war—these GC IV obligations generally have been interpreted not to require the military parties to provide medical care to wounded and sick civilians. In the words of the ICRC, “saving civilians is the responsibility of the civilian authorities rather than of the military.”⁶⁴ Similarly, the obligations to evacuate the wounded and sick from besieged or encircled areas and to allow medical personnel and equipment into those areas are couched in GC IV in relatively hortatory terms: the parties “shall endeavour” to conclude such local agreements.⁶⁵

Much of the rest of GC IV relates to the protection for a relatively narrow category of civilians, namely “protected persons.” They are defined as “those who, at a given moment and in any manner whatsoever, find themselves, in case of a conflict or occupation, in the hands of a Party to the conflict or Occupying Power of which they are not nationals.”⁶⁶ GC IV stipulates that, in general, such persons “shall, if their state of health so requires, receive medical attention and hospital treatment to the same extent as the nationals of the State concerned.”⁶⁷ Where a protected person is interned due to security concerns,⁶⁸ the interning party is bound to (among other

63. Article 16(2) GC IV.

64. ICRC, *Commentary on GC IV*, p. 135.

65. Article 17 GC IV.

66. Article 4(1) GC IV. The ICTY Appeals Chamber purported to expand the definition of “protected persons” by reference to the object and purpose of the treaties, whereby nationality or affiliation is irrelevant. ICTY, *Prosecutor v. Tadić*, Appeals Chamber, Judgment, Case No IT-94-1-A, July 15, 1999, paras. 163–166.

67. Article 38(2) GC IV. Note that this provision is in the section on aliens in the territory of a party to the conflict. Article 40 GC IV lays down provisions concerning compelling protected persons to work, including, potentially, medical caregivers. Pursuant to article 40(2) GC IV, “[i]f protected persons are of enemy nationality, they may only be compelled to do work which is normally necessary to ensure the feeding, sheltering, clothing, transport and health of human beings and which is not directly related to the conduct of military operations.” In that case, “protected persons compelled to work shall have the benefit of the same working conditions and of the same safeguards as national workers in particular as regards wages, hours of labour, clothing and equipment, previous training and compensation for occupational accidents and diseases.” Article 40(3) GC IV.

68. Articles 41–43 GC IV. See also ICRC, *Commentary on GC IV*, p. 256 (noting that “[i]nternment is also a form of assigned residence, since internees are detained in a place other than their normal place of residence. Internment is the

things) grant her the medical attention required by her state of health.⁶⁹ Medical inspections of those internees must occur at least once a month.⁷⁰

GC IV also elaborates a detailed protective regime concerning medical attention for civilians in occupied territory. For example, the occupying power has the duty—to the fullest extent of the means available to it—of “ensuring the [...] medical supplies of the population.”⁷¹ The occupying power also has the duty of ensuring and maintaining—again, to the fullest extent of the means available to it, but this time also with the cooperation of national and local authorities—“the medical and hospital establishments and services, public health and hygiene in the occupied territory [...].”⁷² Moreover, in occupied territory, “[m]edical personnel of all categories shall be allowed to carry out their duties.”⁷³

more severe, however, as it generally implies an obligation to live in a camp with other internees.”).

69. Article 81(1) GC IV. See also, e.g., articles 81(2), 85(1), 91–92, 109(1), and 127(2)–(3) GC IV. Article 109(1) GC IV pertains in part to medical relief supplies.

70. Article 92 GC IV.

71. Article 55(1) GC IV. In particular, the occupying power should “bring in the necessary [...] medical stores [...] if the resources of the occupied territory are inadequate.” *Id.* The occupying power may requisition medical supplies available in the occupied territory only “for use by the occupation forces and administration personnel, and then only if the requirements of the civilian population have been taken into account.” Article 55(2) GC IV. The occupying power shall make—subject to the provisions of other international conventions—arrangements to ensure that fair value is paid for any requisitioned goods. *Id.* Furthermore, “[t]he Protecting Power shall, at any time, be at liberty to verify the state of the [...] medical supplies in occupied territories, except where temporary restrictions are made necessary by imperative military requirements.” Article 55(3) GC IV. In addition, the occupying power—in adopting health and hygiene measures and in implementing them—“shall take into consideration the moral and ethical susceptibilities of the population of the occupied territory.” Article 56(3) GC IV.

72. Article 56(1) GC IV. In that connection, GC IV makes a “particular reference to the adoption and application of the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics.” *Id.* Moreover, “[t]he Occupying Power shall not hinder the application of any preferential measures in regard to [...] medical care [...] which may have been adopted prior to the occupation in favour of children under fifteen years, expectant mothers, and mothers of children under seven years.” Article 50(5) GC IV.

73. Article 56(1) GC IV. Note, however, that such personnel are distinct from (and do not benefit from the special status provided to) those medical personnel assigned by a party to the conflict pursuant, for example, to articles 24, 26–27 GC I or to hospital staff pursuant to article 20 GC IV. See ICRC, *Commentary on GC IV*, p. 314 (“Medical personnel of all categories’ should be taken to mean all people engaged in a branch of medical work: doctors, surgeons, dentists, pharmacists, midwives, medical orderlies and nurses, stretcher bearers, ambulance drivers, etc., whether such persons are or are not attached to a hospital. On that point the provision differs from Article 20 of [GC IV], which refers only to hospital staff, who are alone authorized to wear the armlet bearing the red cross emblem.”).

GC IV anticipates that the competent organs of the occupied state may not be operating in a particular part of occupied territory. Where that occurs, the occupying authorities shall, if necessary, grant new hospitals set up in those territories the recognition provided to civilian hospitals, hospital personnel, and transport vehicles under the part of GC IV applicable to the whole population.⁷⁴ Finally with respect to medical attention in occupied territories, GC IV establishes a number of obligations concerning relief schemes⁷⁵ and relief societies.⁷⁶

Non-international armed conflicts

After WWII, states began in earnest to allow the veil of sovereignty to be pierced in armed conflicts involving a government's armed forces fighting an armed opposition group.⁷⁷ In adopting Common Article 3, states agreed to subject NIACs to international treaty law. They did not, however, confer legal status on non-state armed groups in NIACs.⁷⁸ The resulting scope of Common Article 3—the so-called “Convention in miniature”⁷⁹—is significantly narrower than the web of treaty laws binding states parties in IACs governed by the rest of the Geneva Conventions of 1949.

Nonetheless, Common Article 3 expressly requires, in general terms, that “[t]he wounded and sick shall be collected and cared for.”⁸⁰ In addition, it imposes humane-treatment obligations concerning all persons *hors de combat*.⁸¹ And Common Article 3 also expressly provides a basis for “[a]n impartial humanitarian

74. Article 56(2) GC IV.

75. Articles 59–62 GC IV.

76. Article 63 GC IV.

77. Or between such groups, in line with the *Tadić* formulation. *Tadić*, Interlocutory Appeal, *supra* note 27, at para. 70.

78. Common Article 3(2). See generally Sandesh Sivakumaran, *The Law of Non-International Armed Conflict* 205–207 (2012). As noted in the ICRC's *Commentary on GC IV*, Common Article 3 “is strictly humanitarian in character. It does not limit in any way a State's essential right to suppress an insurrection, nor its powers of trial and sentence, nor, again, its right to appraise aggravating or attenuating circumstances.” ICRC, *Commentary on GC I*, p. 56.

79. ICRC, *Commentary on GC IV*, p. 34.

80. Common Article 3(2) [italics added].

81. Common Article 3(1).

body, such as the International Committee of the Red Cross,” to offer its services to all of the parties to the conflict.⁸²

Review

With respect to IACs, GCs I–IV reaffirm and expand legal protections for impartial wartime medical care for wounded and sick combatants and prisoners of war and establish important similar protections for wounded and sick civilians. But the drafters also left some areas of significant concern arising from WWII totally unregulated under IHL. One example was the experience of occupying forces ordering “inhabitants, including doctors, to denounce the presence of any presumed enemy, under the threat of grave punishment.”⁸³ States did not agree to extend international legal protections to those who conceal the wounded from authorities.

With respect to NIACs, Common Article 3 represents a vital step in expanding protections for wartime medical assistance. Yet, as states quickly recognized, that step was relatively modest.

The 1977 and 2005 Additional Protocols to the Geneva Conventions

Soon after the Geneva Conventions of 1949 came into force, there was a push to further develop and expand their protections. In the eyes of many, the Conventions did not go far enough. In the GCs, for instance, “the position of civilian medical personnel had been dealt with in a somewhat incomplete fashion.”⁸⁴ And, as noted by the ICRC in 1971, while Common Article 3 “has already rendered signal service [...] *it cannot be denied that it has loopholes and shortcomings*. Its promoters themselves considered it only as the *first step*.”⁸⁵ The article is silent on “the protection to be

82. That paragraph also provides that “[t]he Parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention.” Common Article 3(2) GCs I–IV.

83. ICRC *Commentary on the APs*, paras. 670–674.

84. ICRC, *CE/7b*, p. 1.

85. *Id.* at p. 30 [italics added].

granted to doctors and other medical personnel, on medical establishments and transports and on the respect due to the sign of the red cross.”⁸⁶ While those protections may be *implied* in Common Article 3, “it must be admitted that there would be considerable advantage in stating expressly, among the provisions to be confirmed, principles which have never been contested.”⁸⁷

In part to strengthen the protective regime for medical care, from the 1950s through the early 1970s states and the ICRC took a series of steps at International Conferences of the Red Cross and elsewhere. Those efforts culminated in a series of events in Geneva: Conferences of Government Experts, in 1971 and 1972, and a Diplomatic Conference, in 1974–1977.⁸⁸

Ultimately, out of the Diplomatic Conference two new treaties emerged. Additional Protocol I applies to IACs, as well as a particular type of NIAC: so-called wars of national liberation, which are treated as IACs for purposes of AP I.⁸⁹ And Additional Protocol II applies to certain NIACs.

International armed conflicts

AP I significantly strengthens protections for impartial wartime medical care. For instance, it broadens the legal protections to include expressly all wartime wounded, sick, and shipwrecked persons, whether military *or* civilian.⁹⁰ AP I also extends

86. *Id.*

87. *Id.*

88. Issues relating to medical care discussed in the lead up to the Diplomatic Conference included the possibility of extending the use of the distinctive emblems of the Geneva Conventions to civilian medical personnel; elaborating additional regulations concerning medical aircraft; and the potential introduction of a new emblem (a red staff of Aesculapius on a white background) as a means to identify doctors and nurses who are not members of the state medical service (a proposal that was ultimately rejected). *Id.* at pp. 2, 17, 25–26.

89. The scope of material application of AP I also expressly includes “armed conflicts in which peoples are fighting against colonial domination and alien occupation and against racist regimes in the exercise of their right of self-determination, as enshrined in the Charter of the United Nations and the Declaration on Principles of International Law concerning Friendly Relations and Co-operation among States in accordance with the Charter of the United Nations.” Article 1(4), AP I. Regarding the temporal scope of AP I, see article 3 AP I.

90. See, e.g., Kleffner, “Protection of the Wounded, Sick, and Shipwrecked,” *supra* note 14, at p. 322; Mehring, *Medical Ethics in IHL*, *supra* note 1, at pp. 90–91 (calling the inclusion of both combatants and civilians a “significant development as it closes the gap between the protection of wounded and sick combatants and wounded and sick

medical-attention protections to mental-health aspects of care.⁹¹ AP I further supplements GCs I–IV by defining, for purposes of the protocol, wounded and sick persons,⁹² as well as a host of other medically related personnel and objects.⁹³ The Protocol maintains the requirement that the status of medical personnel, transports, and units—even so-called *civilian medical personnel*—be predicated on the recognition and authorization of a party to the conflict.⁹⁴ (Even though AP I retains the authorization requirement to obtain that special status, unassigned caregivers benefit from important protections—though fewer than their medical-personnel counterparts—under the Protocol.)

AP I introduces the concept of, but does not define, “medical ethics” as a bulwark against illegitimate compulsion.⁹⁵ For instance, the Protocol prohibits the

civilians.”) *Id.* at 91.

91. Article 8(a) AP I.

92. *Id.*

93. Article 8(c), (e)–(j) AP I.

94. ICRC *Commentary on the APs*, para. 349 (noting generally that “civilian medical personnel are also covered [under article 8(c) AP I, defining “medical personnel”], *provided that they are assigned to medical tasks by a Party to the conflict*, in order to ensure in a better way the protection of all the wounded and sick, whether civilian or military.”) [italics added]; *id.* at para. 354 (clarifying that “[n]ot every civilian doctor is protected by the Conventions. Indeed, there is no *a priori* reason why a plastic surgeon, for example, should be protected. On the other hand, if the Party to the conflict in the territory in which he works assigns him to tasks mentioned above, i.e., if he becomes useful for the protection of the wounded and sick, he deserves to be protected. This is an example of the derivative character of the protection of medical personnel, which is relevant only when such personnel is engaged in the protection of the wounded and sick. Moreover, *it is essential that the Party to the conflict*, which is responsible for preventing the misuse of the protective emblem, *retains the power to decide who is entitled to the protection reserved for medical personnel.*”) [italics added]; *id.* at para. 610 (confirming, with respect to article 15(1) AP I, that “it should be remembered that *not all civilian medical and nursing personnel is covered here, but only those who have been assigned to medical tasks by the Party to the conflict on which they depend.*”) [italics added; citation omitted].

95. The ICRC *Commentary on the APs* states that *medical ethics* “refers to the moral duties incumbent upon the medical profession. Such duties are generally decreed by the medical corps of each State in the form of professional duties.” ICRC, *Commentary on APs*, p. 200, para. 655. See generally Mehring, *Medical Ethics in IHL*, *supra* note 1, at pp. 306–344. For a recent (non-legally-binding) list of ethical principles of health care in armed conflict and other emergency situations to which five major NGOs subscribe, International Committee of the Red Cross, International Pharmaceutical Federation, World Medical Association, ICMH, and International Council of Nurses, “Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies,” June 2015, available at <https://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies>. See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Prohibition on illegitimate compulsion” and “Prohibition on punishment.”

punishment of anyone who carries out medical activities compatible with medical ethics.⁹⁶ It also prohibits compelling physicians to act in a way that does not conform with medical ethics or with other medical rules designed for the benefit of the wounded and sick.⁹⁷

AP I expands the grave breaches regime introduced in GCs I–IV and expressly regards grave breaches as war crimes.⁹⁸ Many of the grave breaches laid down in AP I relate to medical care. For instance, AP I stipulates that certain willful acts or omissions⁹⁹ that seriously endanger the physical or mental health or integrity of a person in the power of a party other than the one on which she depends constitute grave breaches.¹⁰⁰ AP I also includes the wounded and sick—including civilians—protected by the Protocol as persons against whom grave breaches may be committed.¹⁰¹ The Protocol expressly recognizes that certain acts committed against medical personnel, units, and transports may constitute grave breaches.¹⁰² And under certain conditions a number of additional acts related to medical care also constitute grave breaches under AP I.¹⁰³ Those acts include making a person the object of attack in the knowledge that she is *hors de combat*, as well as the perfidious use of the distinctive emblems or other protective signs of GCs I–IV and AP I.¹⁰⁴

Non-international armed conflicts

Earlier drafts of AP II included far more provisions than the version that states ultimately agreed to at the end of the Diplomatic Conference in 1977. The 28 articles

96. Article 16(1).

97. Article 16(2) AP I. See also article 11(3) AP I.

98. Article 85 AP I; see also article 11(4) AP I.

99. Those that violate article 11(1) or (2) AP I or that fail to comply with the requirements of article 11(3) AP I.

100. Article 11(4) AP I.

101. Article 85(5) AP I.

102. So long as they are under the control of the adverse party and are protected by the Protocol. Article 85(5) AP I.

103. When committed willfully, in violation of the relevant provision of AP I, and where they cause death or serious injury to body or health. Article 85(3) AP I.

104. Article 85(3)(e) and (f) AP I. The perfidious use must be in violation of article 37 AP I to constitute a grave breach under the Protocol.

of AP II nonetheless expand the treaty provisions—including those related to medical care—applicable to NIACs meeting the Protocol’s threshold of application.

AP II mirrors many of the medical-care provisions laid down in AP I. For instance, AP II imposes obligations to search for, collect, and care for wounded or sick—whether military *or* civilian.¹⁰⁵ It regulates the use of the distinctive emblems.¹⁰⁶ It stipulates respect for and protection of medical personnel and requires they be granted all available help.¹⁰⁷ And it lays down the same type of respect-and-protect obligations—and the corresponding protections against attack—for medical transports and units that previously applied to such objects only in IACs.¹⁰⁸ As does AP I, AP II also prohibits punishing anyone who carries out medical activities compatible with medical ethics, regardless of who benefits.¹⁰⁹

Yet some medical-care measures are less exhaustive in AP II than in AP I. For instance, AP I and AP II both prohibit subjecting certain persons to any medical procedure that is not indicated by the state of health of the person concerned and that is not consistent with generally accepted medical standards.¹¹⁰ Yet unlike AP II, AP I also expressly prohibits—with certain exceptions—carrying out on such persons,

105. Article 7 AP II.

106. Article 12 AP II.

107. Article 9(1) AP II.

108. Article 11 AP II.

109. Article 10(1) AP II. During the Conference of Government Experts preceding the Diplomatic Conference, it was agreed that the purpose of this provisions “was to protect the *performance of medical activities and should cover all persons who were engaged in such activities, regardless of whether they were in protected institutions or not.*” Conference of Government Experts on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts, Second Session, 3 May - 3 June 1972, Report on the Work of the Conference, Submitted by the International Committee of the Red Cross, July 1972, Geneva, Volume 1, p. 39, para. 1.49. (stating further that “[i]n order to make this clear, the words ‘medical personnel’ were changed to ‘any person engaged in medical activities’.”) [italics added]. The dispositive element regarding what falls under the broad expression “medical activities” may, in the view of the ICRC, be discerned by ascertaining whether “the activities are at improving health or alleviating the suffering of the wounded.” ICRC, *Commentary on the APs*, para. 652.

110. The latter standard is framed in slightly different terms in article 11(1) AP I (“generally accepted medical standards which would be applied under similar medical circumstances to persons who are nationals of the Party conducting the procedure and who are in no way deprived of liberty”) than in article 5(2)(e) AP II (“generally accepted medical standards applied to free persons under similar medical circumstances”).

even with their consent, physical mutilations, medical or scientific experiments, or removal of tissue or organs for transplantation.¹¹¹

Finally, AP II—like Common Article 3—contains no grave breaches regime.

Review

Both Additional Protocols increase the amount and breadth of protections for medical care. But AP I contains more such measures than AP II. Perhaps more importantly, AP II does not make up for the relatively fewer *combined* set of medical-care measures across all relevant treaties for NIAC compared to IAC.

Adding to the fragmented character of the legal regime is the fact that, unlike the Geneva Conventions of 1949, the Additional Protocols have not been universally ratified. Indeed, it was with the Additional Protocols that the “Great Schism” was born.¹¹² Today, over two-dozen states are not party to AP I nor to AP II. Some states engaged in armed conflicts involving terrorists are party to neither Protocol, such as Israel, Pakistan, Somalia, Turkey, and the United States.¹¹³

The thumbnail version of this dissonance is that some states think key provisions of the Protocols, especially AP I, do not reflect good law or sound policy. Even more, the thinking goes, AP I could potentially *subvert* foundational IHL norms. Some non-contracting states are especially concerned that AP I could operate in a way that supports terrorism. Part of the reason the United States, for instance, has declined to become a party was its concern that AP I weakens the distinction between combatants and noncombatants and thereby supports a rationale underlying terrorist violence.¹¹⁴

111. Article 11(1)–(3) AP I.

112. Yoram Dinstein, “International Humanitarian Law and Modern Warfare,” in *International Expert Conference on Computer Network Attacks and the Applicability of International Humanitarian Law* 17, 18–19 (ed. Boström, 2014).

113. Pakistan and the United States have signed but not ratified AP I and AP II.

114. Article 44(3) is one of the grounds on which the United States has elected not to become a party to AP I. See, e.g., Letter of Transmittal from the White House to the Senate, January 29, 1987, Annexed Letter of Submittal, Washington, December 13, 1986, George Schultz, p. IX (stating that “Article 44(3) [AP I], in a single subordinate clause, sweeps away years of law by ‘recognizing’ that an armed irregular ‘cannot’ always distinguish himself from non-

Zooming out, the results are fragmentation in the *lex scripta*: between the medical-care treaty protections for states party to the Protocols and those not party to them; between those protections for IAC versus those for NIAC; and between those protections across different types of NIACs.

In principle, customary IHL could resolve that fragmentation and fill in the corresponding gaps in the *lex scripta*. Our research suggests that, so far, it has not—at least not fully.

Customary IHL

In the words of Special Rapporteur Michael Wood, as noted above, customary law comprises those rules of international law deriving from and reflecting a general practice accepted as law.¹¹⁵ There is no universally agreed-upon quantitative formula or mathematical equation to discern customary international law. But, in general, to be established, a customary rule needs to reflect (1) sufficiently uniform, extensive, and representative *state practice* alongside (2) dense enough evidence of such practice being undertaken due to a legal conviction (so-called *opinio juris sive necessitatis*, or *opinio juris*).¹¹⁶

combatants; it would grant combatant status to such an irregular anyway. As the essence of terrorist criminality is the obliteration of the distinction between combatants and noncombatants, it would be hard to square ratification of this Protocol with the United States' announced policy of combatting terrorism.") The United States does consider some elements of AP I to reflect customary IHL; see, e.g., U.S. Department of Defense, *Law of War Manual* § 8.1.4.2 (2015) (stating that "[a]lthough not a Party to AP I, the United States has stated that the U.S. Government will choose out of a sense of legal obligation to treat the principles set forth in Article 75 as applicable to any individual it detains in an international armed conflict, and expects all other nations to adhere to these principles as well. This statement was intended to contribute to the crystallization of the principles contained in Article 75 as rules of customary international law applicable in international armed conflict.") [citations omitted].

115. Michael Wood, Special Rapporteur, "Second report on identification of customary international law," International Law Commission, 66th Session, U.N. doc. A/CN.4/672, May 22, 2014, p. 7, para. 20; see generally *id.* at pp. 7–14, paras. 21–30.

116. ICJ, *North Sea Continental Shelf* (West Germany v. Denmark and the Netherlands) (Merits) [1969] ICJ Rep. p. 3, pp. 42–46. On the so-called "persistent objector" rule, see, e.g., Olufemi Elias, "Persistent Objector," *Max Planck Encyclopedia of Public International Law*, Online version, last updated: September 2006.

Potential scope

Discerning the scope of customary IHL may be especially important for wartime medical care—including for terrorists—for three reasons.

First, in principle, customary IHL could fill gaps in the *lex scripta* between contracting states to the respective Additional Protocols and non-contracting states. In this way, customary IHL has the potential to help address the lack of universal ratification of AP I and AP II. If the medical-care provisions of AP I and AP II reflect customary IHL, then states would be bound—irrespective of whether they were party to the relevant treaty—to adhere in IACs to those rules flowing from AP I and in NIACs to those rules flowing from AP II.¹¹⁷

Second, in principle, customary IHL could help fill gaps in the *lex scripta* between medical-care measures for IAC and those for NIAC. Customary IHL may be particularly salient in this respect due to the much denser cluster of such measures applicable in IAC treaties compared to the thinner set of provisions found in NIAC treaties.

And third, in principle, customary IHL could bind parties to rules and principles even if states had not codified those protections in treaties. Medical care is one of the most highly regulated aspects of the *lex scripta*. But that does not foreclose the possibility that additional binding medical-care rules of international law could arise outside of those treaties. This type of customary IHL formation may be most useful in this context regarding internationally recognized legal protections for wartime medical care that states have not (yet) inked in international agreements.

But *does* customary IHL concerning medical care fill any of the gaps in the *lex scripta* or impose any rules that have not been codified in IHL treaties?

We do not aim to answer those specific questions. Instead, we raise two related sets of considerations. First, we discuss the medical-care aspects of the most extensive

117. Customary IHL rules may also bind non-state armed groups.

(though, on its terms, non-comprehensive) attempt to date to discern the scope of customary IHL: the ICRC's *Customary IHL Study*. And second, we highlight five aspects of the contemporary practice of impartial wartime medical care that are not—at least not yet—captured in treaties or, in our view, in customary IHL.

ICRC's *Customary IHL Study*

In 1995, the International Conference of State Parties requested the ICRC to undertake a study on customary IHL.¹¹⁸ A decade later, the ICRC published its *Customary IHL Study*, which identifies an array of purported rules, the vast majority of which it said applied in both IAC and NIAC.¹¹⁹

By design, the *Customary IHL Study* was ambitious but not comprehensive. The authors did not seek to “to determine the customary nature of each treaty rule” of IHL.¹²⁰ As a result, the *Customary IHL Study* “does not necessarily follow the structure of existing treaties.”¹²¹ Instead, it “sought to analyse issues in order to establish what rules of customary international law can be found inductively on the basis of State practice in relation to these issues.”¹²² Thirteen of the rules identified in this way relate, at least in part, to impartial wartime medical care for the wounded and sick *hors de combat*.¹²³

118. 26th International Conference of the Red Cross and Red Crescent, Geneva, December 3–7, 1995, Resolution 1, *International humanitarian law: From law to action*; Report on the follow-up to the International Conference for the Protection of War Victims, *IRRC* No. 310, 1996, p. 58. The request coincided with the development of jurisprudence by international criminal tribunals that purported to flatten, largely through customary IHL, many of the legal distinctions between IAC and NIAC. *Tadić*, Interlocutory Appeal, *supra* note 27, at paras. 96–127.

119. ICRC, *CIHLS* Vol. I: Rules.

120. *Id.* at p. xxxvi.

121. *Id.*

122. *Id.*

123. *Id.* at Rule 25, pp. 79–86 (“Medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. They lose their protection if they commit, outside their humanitarian function, acts harmful to the enemy.”); Rule 26, *id.* at pp. 86–88 (“Punishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited.”); Rule 28, *id.* at pp. 91–97 (“Medical units exclusively assigned to medical purposes must be respected and protected in all circumstances. They lose their protection if they are being used, outside their humanitarian function, to commit acts harmful to the enemy.”); Rule 29, *id.* at pp. 98–102 (“Medical transports assigned exclusively to medical

In its attempt to establish the existence of the customary IHL rules on medical care, the ICRC had to overcome two main challenges.¹²⁴ The first was that some of the rules purportedly applicable in both IAC and NIAC are based in the *lex scripta* set down primarily—or, at times, exclusively¹²⁵—in IAC treaties. To establish those rules in both types of conflict, the ICRC would therefore need to demonstrate a sufficient alternative basis of state practice and *opinio juris*.

The second (and, at times, related) challenge is that a large amount of the putative rules are rooted in the *lex scripta* set down more exhaustively in AP I and less comprehensively in AP II. In principle, therefore, with respect to those rules the

transportation must be respected and protected in all circumstances. They lose their protection if they are being used, outside their humanitarian function, to commit acts harmful to the enemy.”); Rule 30, *id.* at pp. 102–104 (“Attacks directed against medical [...] personnel and objects displaying the distinctive emblems of the Geneva Conventions in conformity with international law are prohibited.”); Rule 35, *id.* at pp. 119–120 (“Directing an attack against a zone established to shelter the wounded, the sick and civilians from the effects of hostilities is prohibited.”); Rule 47, *id.* at pp. 164–170 (“Attacking persons who are recognized as hors de combat is prohibited. A person hors de combat is: [...] (b) anyone who is defenceless because of unconsciousness, shipwreck, wounds or sickness; [...] provided he or she abstains from any hostile act and does not attempt to escape.”); Rule 59, *id.* at pp. 207–209 (“The improper use of the distinctive emblems of the Geneva Conventions is prohibited.”); Rule 88, *id.* at pp. 308–311 (“Adverse distinction in the application of international humanitarian law based on race, colour, sex, language, religion or belief, political or other opinion, national or social origin, wealth, birth or other status, or on any other similar criteria is prohibited.”); Rule 92, *id.* at pp. 320–323 (“Mutilation, medical or scientific experiments or any other medical procedure not indicated by the state of health of the person concerned and not consistent with generally accepted medical standards are prohibited.”); Rule 109, *id.* at pp. 396–399 (“Whenever circumstances permit, and particularly after an engagement, each party to the conflict must, without delay, take all possible measures to search for, collect and evacuate the wounded, sick and shipwrecked without adverse distinction.”); Rule 110, *id.* at pp. 400–403 (“The wounded, sick and shipwrecked must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. No distinction may be made among them founded on any grounds other than medical ones.”); Rule 111, *id.* at pp. 403–405 (“Each party to the conflict must take all possible measures to protect the wounded, sick and shipwrecked against ill-treatment and against pillage of their personal property.”).

124. We focus here on medical-care rules in the *Customary IHL Study*. The United States and some prominent commentators have critiqued certain methodological components of, the evidence offered in, and some of the conclusions of the *Customary IHL Study*. See, e.g., John B. Bellinger, III and William J. Haynes, II, “A US government response to the International Committee of the Red Cross study *Customary International Humanitarian Law*,” 89 *IRRC* No. 866 (2007); Yoram Dinstein, “The ICRC Customary International Humanitarian Law Study,” 82 *ILS* (2006) (originally published in 36 *IYHR* (2006)).

125. For example, the primary basis in the *lex scripta* for Rule 35 (“Directing an attack against a zone established to shelter the wounded, the sick and civilians from the effects of hostilities is prohibited.”) is found in treaties applicable to IAC, such as article 23 GC I and article 14 GC IV. No treaty provisions governing NIAC expressly regulate such hospital and safety zones.

ICRC would need to demonstrate that states *not* party to the relevant Protocol(s) nonetheless consider the relevant rules in those treaties binding: in respect of IACs for those rules deriving from AP I, and in respect of NIACs for those rules deriving from AP II. Where the rule purportedly applied in both IAC and NIAC but the rules in AP I and AP II on which the putative norm are based *differed*, the authors would need to demonstrate states' buy-in for how the ICRC fashioned the resulting *hybrid* rule.

Despite these challenges, commentators have argued that at least some of the *Customary IHL Study* rules on medical care reflect customary IHL applicable in both IAC and NIAC. These include the rules requiring respect and protection—and governing the loss of protection—for medical personnel, units, and transports of a party to the conflict.¹²⁶

However, the identified challenges proved insurmountable, in our view, for some putative medical-care rules put forward in the *Customary IHL Study*.¹²⁷ An example is Rule 26, which the ICRC submits to apply in both IAC and NIAC: “Punishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited.”¹²⁸ This rule derives in important part from both AP I and AP II, as

126. ICRC, *CIHLS*, Rules 25, 28, and 29. In support of the customary character of these rules, see Susan Breau, “Protected Persons and Objects,” in *Perspectives on the ICRC Study on Customary International Humanitarian Law* 175–78 (Wilmshurst and Breau eds. 2007) [hereinafter, Breau, “Protected Persons and Objects”]. See also, concurring with respect to *CIHLS* Rule 25 (medical personnel), Mehring, *Medical Ethics in IHL*, supra note 1, at pp. 231–32.

The protections in the *lex scripta* for those rules in *NIAC* are rooted in AP II, which means the ICRC would need to show evidence of sufficient buy-in from non-AP II parties. (Common Article 3 is silent regarding such personnel, units, and transports.) In this connection, recently the United States (through its Department of Defense), which is not a party to AP II, included those AP II-rooted protections for medical personnel, units, and transports in NIAC in its recently promulgated Department of Defense *Law of War Manual*. U.S. Department of Defense, *Law of War Manual* §§ 17.15.1 and 17.15.2 (2015).

127. Benoit criticizes part of the evidence and analysis assembled to support the *CIHLS* rules 109–111. James P. Benoit, “Mistreatment of the Wounded, Sick and Shipwrecked by the ICRC Study on Customary International Humanitarian Law,” 11 *YIHL* (2008) 193–215 [hereinafter, Benoit, “Mistreatment of the Wounded, Sick and Shipwrecked”].

128. ICRC, *CIHLS* Vol. I: Rules, Rule 26, p. 86. Perhaps the most important is rule 110 (“The wounded, sick

no provision of GCs I–IV nor of Common Article 3 references medical ethics for these (or other) purposes.¹²⁹ Thus, in order to establish this rule for both IAC and NIAC, the *Customary IHL Study* authors would need to show sufficient buy-in for the putative norms from states that are *not party* to the Protocols. Yet all of the relevant cited military manuals and national legislations for this rule are from states parties—or states that would become party—to AP I and/or AP II.¹³⁰

Practical gaps in the law

Despite imposing extensive obligations on the parties, IHL treaties and customary IHL do not cover all facets of impartial wartime medical care. Here we raise five

and shipwrecked must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. No distinction may be made among them founded on any grounds other than medical ones.”); Benoit criticizes that rule for implicitly conflating protections owed to combatants versus civilian wounded, sick and shipwrecked, and for seeking to extending the obligations to care for wounded, sick, and shipwrecked in toto to NIAC. Benoit, “Mistreatment of the Wounded, Sick and Shipwrecked,” *supra* note 127, at p. 212. With respect to the latter ground for criticism, subsequent to Benoit’s critique, the U.S. Department of Defense *Law of War Manual* (2015) incorporated the AP II-based protections on which Rule 110 is based. U.S. Department of Defense *Law of War Manual* §§ 17.14.1 and 17.14.2 (2015).

129. While an antecedent is found in article 18(3) GC I (prohibiting convicting any person for nursing the wounded), articles 16 AP I and 10 AP II introduce the concept of medical ethics into IHL; the concept of medical ethics is not included in any IHL treaties before 1977, yet article 28 GC I requires that retained medical personnel carry out their medical duties in accordance with “professional ethics” (among other things). *CIHLS* Rule 26 thus pivots chiefly on AP I and AP II.

130. ICRC, *CIHLS*, Vol. II: Practice (Part 1), pp. 486–97. For its part, the U.S. Department of Defense *Law of War Manual* does not include either part of this rule for IAC or for NIAC. Among the things listed under “Other National Practice,” the *Customary IHL Study* authors cite the letter from the President transmitting AP II to the U.S. Senate for confirmation, even though the United States never became a party to AP II. ICRC, *CIHLS*, Vol. II: Practice (Part 1), at p. 490. Somewhat confusingly, the *Customary IHL Study* authors break down the cited state practice into two sections: respect for medical ethics and respect for medical secrecy. This structure does not track the logic of the Rule, however, which distinguishes between two prohibitions: one on “[p]unishing a person for performing medical duties compatible with medical ethics,” and another on “compelling a person engaged in medical activities to perform acts contrary to medical ethics” [italics added]. For her part, Mehring considers that “[g]enerally, there is so little evidenced cited, that this cannot prove the acceptance of the rule in both international and non-international armed conflicts,” and that “it clearly cannot be concluded that states accepted the respect for medical ethics and medical confidentiality as customary international law, either in international nor non-international conflicts.” Mehring, *Medical Ethics in IHL*, *supra* note 1, at pp. 232 and 233. Yet another scholar, Breau, concludes, though without additional evidence of state practice and *opinio juris* or analysis, that “[i]t is difficult to argue that the first part of Rule 26 [prohibiting punishment] is not customary due to long-standing treaty antecedents; however, that is not the case with the second part [prohibiting compulsion]. The Study does not contain the scope of practice needed and therefore, this part of the Rule cannot be said to be unequivocally customary.” Breau, “Protected Persons and Objects,” *supra* note 126, at p. 179.

areas of current practice that IHL does not regulate or that IHL regulates non-comprehensively.

First, with respect to NIACs to which AP II does not apply, IHL lays down, in Common Article 3 and customary IHL applicable to NIAC, relatively few medical-care measures. (Where applicable, the Rome Statute of the ICC may supplement these provisions for NIACs meeting that instrument's threshold of application.¹³¹)

Second, so far, states have been unwilling to extend all of the types of protections to medical personnel in NIACs—even under AP II—that they have established for certain medical personnel in IACs. IHL treaties do not regulate the capture or retention of medical personnel in former, but they do—at least for certain personnel—in the latter.¹³²

Third, neither AP I nor AP II defines *medical ethics*. Contracting states thus have a wide (and potentially overbroad) margin of discretion to implement a concept on which many protections—including those against punishment for care to the enemy—pivot.

Fourth, where they exist, IHL protections against being compelled to denounce (that is, communicate information about) patients to authorities are weak. Those protections subject the international legal norm to varying domestic legislations.¹³³

And fifth, extant IHL contains no explicit safeguards for a key set of contemporary caregivers: those seeking to travel to conflict areas to provide impartial wartime care to all wounded and sick persons—fighters *hors de combat* and civilians alike.

131. Articles 8(2)(d) and (f) ICC RS.

132. See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Capture, detention, and retention.”

133. This produces an unsatisfactory result at least from a purely legal viewpoint: the *international* legal norm varies according to different *national* legislations. ICRC, *Commentary on the APs*, para. 688.

Related Fields of International Law

IHL establishes the most highly regulated set of international legal provisions concerning medical care in armed conflict. Yet two additional international law fields—IHRL and ICL—may apply alongside of, or in an otherwise complementary manner to, those IHL provisions.¹³⁴

International human rights law

While IHL traces its roots to the regulation of interstate wars, IHRL arose out of an attempt to regulate, as a matter of international law and policy, the relationship between the state—through its governmental authority—and its population. Unlike the relatively narrow war-related field of IHL, IHRL spans a seemingly ever-growing range of dealings an individual, community, or nation may have with the state.

In recent decades, the connection between IHL and IHRL has been the subject of increased jurisprudential treatment and interpretation by states. The precise links between the two branches of public international law have also merited extensive academic commentary.

The debate on this relationship is largely over three issues. First, whether IHRL applies extraterritorially such that states bring all, some, or none of their obligations with them when they fight wars under IHL outside of their territories. Second, whether OAGs have IHRL obligations (or, at least, responsibilities). And third, what is the apposite interpretive procedure or principle to use when discerning the content of a particular right under the relevant framework(s).

Few, if any, of these questions, however, significantly affect the practical scope of international law protections for wartime medical care for terrorists. That is because in general the protections for the two main sets of elements of medical care (discussed

134. International refugee law (IRL) may also pertain to impartial medical care to designated terrorists in, or to those alleged to have committed terrorism in connection with, an armed conflict. We do not examine that body of law in this report.

in the next section) are regulated much more specifically and comprehensively under IHL than IHRL. Unlike with IHRL, moreover, there is no meaningful disagreement with the view that at least some IHL applies in armed conflicts involving terrorism.

Nonetheless, IHRL may buttress IHL safeguards for impartial wartime medical assistance. IHRL may do so, for instance, by helping support the normative framework for medical care in conflicts involving terrorism where IHL is seemingly weakest: in armed conflicts where the state is not a party to the relevant Additional Protocol and where the state contests the applicability of customary IHL. For example, commentators have argued that the IHRL rights to life and health may strengthen cognate IHL provisions.¹³⁵ In addition, the IHRL principle of legality may help shield medical caregivers from abuses flowing from unlawfully ambiguous definitions of terrorism-related offenses.¹³⁶ Finally, human rights-based safeguards may provide normative points of reference concerning medical ethics, including in relation to non-denunciation and medical confidentiality.¹³⁷

135. See Alexander Breitegger, “The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies,” 95 *IRRC* No. 889 (2013) 83–127. See also Mehring, *Medical Ethics in IHL*, supra note 1, at pp. 236–274. Article 72 AP I provides that “[t]he provisions of this Section are additional to the rules concerning humanitarian protection of civilians and civilian objects in the power of a Party to the conflict contained in the Fourth Convention, particularly Parts I and III thereof, as well as to other applicable rules of international law relating to the protection of fundamental human rights during international armed conflict” and that part of the preamble of AP II recalls that “international instruments relating to human rights offer a basic protection to the human person.”

136. *De La Cruz-Flores v. Peru*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 115, para. 102 (Nov. 18, 2004) [hereinafter *IACtHR, De La Cruz-Flores v. Peru*]; see also *id.* at para. 188(1).

137. ICRC, *Commentary on the APs*, para. 670 fn 21 (defining medical confidentiality in this context as “the discretion that a doctor must observe with respect to third parties regarding the state of health of his patients and the treatment he has administered or prescribed for them”) [citation omitted]. See generally Amrei Müller, *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law: An Analysis of Health-Related Issues in Non-International Armed Conflict* 191–237 (2013). Pursuant to article 10(3) AP II, there is a corresponding obligation, which is subject to national law, to respect the confidentiality of information that may be acquired when providing medical care. See also *IACtHR, De La Cruz-Flores v. Peru*, Separate Opinion of Judge Sergio García-Ramírez, supra note 136, at para. 13 (“I [...] consider it necessary to prohibit incriminating the conduct of a doctor who abstains from providing information to the authorities about his patient’s punishable conduct, which he is aware of through information provided to him by the patient in connection with the medical procedure. In that case, there could be an absolute excuse similar to that which protects the next of kin of the defendant in cases of concealment owing to kinship.”)

International criminal law

As part of a broader post-WWII trend, internal affairs traditionally thought to be solely the prerogative of the state increasingly became matters of international concern. In addition to developing treaty provisions on NIAC through Common Article 3, for instance, this shift was reflected, initially, in the jurisprudence of international criminal tribunals in Germany and Japan and in the rise of IHRL. Later, in the 1990s, these developments were complemented by the revival of ICL mechanisms. In general, ICL imposes individual liability—not state responsibility—for international crimes, such as war crimes, crimes against humanity, and genocide.

While it is not designed to fill substantive gaps in the legal regime, ICL helps fortify IHL protections for impartial wartime medical care.¹³⁸ It does so by imposing individual criminal responsibility for certain especially serious violations of IHL related to medical activities and abuses. Those include violations laid down in the grave breaches regime introduced in GCs I–IV and subsequently strengthened in AP I.

138. For a more extensive analysis concerning ICL and medical care in relation to armed conflict, see, e.g., Mehring, *Medical Ethics in IHL*, supra note 1, pp. 131–188.

4

IMPARTIAL WARTIME MEDICAL
CARE IN ARMED CONFLICTS
INVOLVING TERRORISTS:
TWO SETS OF KEY
PROTECTIONS UNDER IHL

Kimberly-Clark

In this section, we sketch the two key interrelated sets of protections under IHL for impartial medical care in armed conflicts involving terrorists. The first set involves the entitlement to and the protection of medical care for the wounded and sick hors de combat. As a corollary to the first, the second set encompasses the most salient protections for medical caregivers, transports, units, and supplies. Within each of these main sets of measures, we highlight the most important subsidiary categories of protection.

This section is meant to be a primer: it focuses on the most salient aspects of IHL protections for impartial medical care concerning terrorists.¹ We do not raise or address other elements of protections for impartial wartime medical care—and there are *many*. They range from identification standards for medical aircraft to provisions on establishing hospital and safety zones. Nor do we examine protections falling under the broader umbrella of humanitarian relief and assistance, including medical supplies.

The upshot of our analysis is that because there is no specific status of “terrorist” in IHL, the protections for impartial medical care concerning terrorists largely turn on those persons’ status under the relevant source of IHL. And the specific medical-care protections that attach to a particular status track the more general fragmentation between states and across types of armed conflict. However, as a general matter, where they do exist, none of the identified IHL medical-care protections is limited—in any way—due to involvement in terrorist acts or a terrorist designation.

Discerning the scope of medical-care protections under IHL for a specific person fighting in or (otherwise) affected by an armed conflict involving terrorism may turn on such factors as:

- Her status, tasks, and/or functions under IHL;
- The category of armed conflict: an IAC or a NIAC;

1. For those interested in the technical scope of the broader *lex scripta*, the accompanying Compendium provides verbatim excerpts of the medical-care protections in GCs I–IV, Common Article 3, and the Additional Protocols.

- The applicable treaty (or treaties); and
- The applicable rule(s) of customary IHL.

Alongside narrative summaries, for each of the IHL protections outlined below, we use a table (Table 1, which is at the end of this section) to summarize the level of fragmentation (if any) in the *lex scripta* for the relevant norm. In that same table we also include, where relevant, a snapshot of the rule and the analysis in the *Customary IHL Study* related to the underlying norm.

Entitlement to and Protection of Medical Care for the Wounded and Sick *Hors de Combat*

Definition of the wounded and sick

First thing first: who, exactly, falls under the IHL protections for the “wounded and sick”?

There is no general definition that applies across all situations of armed conflict under IHL.² While AP I defines the “wounded and sick,” that definition is expressly limited to the purposes of that treaty.³

Therefore, as with so many other legal categories lacking a general definition, “common sense and good faith”⁴ are the best starting points. Accordingly, the main definitional contours for the *condition* of being “wounded and sick” are relatively uncontroversial: a person who is in need of medical assistance or care and who refrains from any act of hostility.⁵

2. AP I contains a definition of the wounded and sick expressly *for purposes of that Protocol*. For the purposes of AP I, “wounded” and “sick” are defined as meaning “persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, *are in need of medical assistance or care and who refrain from any act of hostility.*” Article 8(a) AP I [italics added]. The term “wounded and sick” “also cover[s] maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility.” *Id.* See also article 8(b) AP I.

3. Article 8 chapeau and (a) AP I.

4. ICRC, *Commentary on GC IV*, p. 134.

5. See, e.g., Article 8(a) AP I; see also ICRC, *Commentary on the APs*, para. 4638.

Yet whether a particular person qualifies for the specific IHL protections for the wounded and sick requires more information and analysis. Depending on the person and the circumstances she finds herself in, it may entail an assessment of her status under IHL; the category of armed conflict (IAC or NIAC); and the relevant source(s) of IHL (treaty and/or customary).

The main fault line here is whether—in addition to wounded, sick, and shipwrecked *combatants* and *prisoners of war* in IAC⁶—*civilians* in IACs and both *fighters and civilians* in NIACs qualify for some, or all, of the protections for the wounded and sick.

The answer is clearest under AP I and AP II. All civilians and fighters may qualify for those conventions' respective protections for the wounded and sick.⁷

For its part, GC IV expressly references wounded and sick civilians and extends certain important protections to them.⁸ And GC IV provides particular additional

6. Recall that GC I extensively elaborates obligations concerning wounded and sick members of the armed forces in the field. GC II extends the protective regime to wounded, sick, and shipwrecked members of the armed forces at sea. See, e.g., Jann K. Kleffner, "Protection of the Wounded, Sick, and Shipwrecked," in *The Handbook of International Humanitarian Law* 322 (3d ed., ed. Fleck, 2014). GC III regulates the status and treatment of prisoners of war. In particular, GC I applies with respect to wounded and sick—while GC II applies with respect to wounded, sick, and shipwrecked—persons who are entitled to prisoner-of-war status in accordance with article 4(A) GC III. Article 13 GC I and GC II. According to article 13 GC I, the Convention shall apply with respect to the wounded and sick belonging to one of six listed categories; see also articles 13 GC II and 44(8) AP I. Those categories include (but are not limited to) members of the armed forces of a party to the conflict; members of militia or volunteer corps forming part of those armed forces; and members of other militaries or volunteer corps belonging to a party to the conflict so long as they fulfill certain conditions. For the full list: article 13(1)–(6) GC I and GC II; see also article 4(A) GC III. Moreover, the "wounded and sick of a belligerent who fall into enemy hands shall be prisoners of war, and the provisions of international law concerning prisoners of war shall apply to them." Article 14 GC I; this article is subject to article 12 GC I; see also article 16 GC II.

7. Article 8(a) AP I and 7(1) AP II. Part III (articles 7–12) of AP II relates to the wounded, sick, and shipwrecked. Unlike AP I, AP II does not contain definitions of the terms "wounded and sick," though there appears to be general agreement among commentators that these terms have the same meaning in AP II as in AP I. Thus in AP II "wounded and sick" would seem to encompass at least those "persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility." This view is supported by the explicit text of article 7(2) AP II ("*a*ll the wounded, sick and shipwrecked, *whether or not they have taken part in the armed conflict*, [...].") [italics added]. Moreover, in its *Commentary*, the ICRC emphasizes that "[t]he definition of wounded and sick protected by this Part is based on two criteria: 1) requiring medical care; [and] 2) refraining from any act of hostilities." See, e.g., ICRC, *Commentary on the APs*, paras. 4636–4639.

8. E.g., article 16 GC IV.

protections to, for instance, wounded and sick “protected persons” interned by the enemy and civilians in occupied territory.⁹ But compared to those for their wounded and sick combatant and prisoner-of-war counterparts under GCs I-III, in general the medical-care protections for wounded and sick civilians under GC IV are somewhat weak.¹⁰

Common Article 3—in laying down generally that the “wounded and sick shall be collected and cared for”¹¹—is silent on the matter. The ICRC’s *Commentary* suggests that the “wounded and sick” under this provision includes both military and civilian persons.¹² That conclusion, however, does not necessarily follow from the text of the article itself, which does not expressly set out the provision’s personal scope. This part of the law, in short, seems to be imprecise. (For their part, both of Additional Protocols aim, in part, to ensure medical protections to all wounded and sick persons—military and civilian alike—hence the explicit language in AP I and AP II to that effect.¹³) While recognizing the imprecision in the text, for the sake of our analysis, we nonetheless assume that the “wounded and sick” in Common Article 3 refers both to the parties to the conflict and to civilians.

As with Common Article 3, the relevant rules on the wounded and sick put forward in the ICRC *Customary IHL Study* do not expressly include or exclude

9. E.g., articles 38(2), 55(1), 81(1)–(2), 91–92, 109(1), and 127(2)–(3) GC IV.

10. E.g., compare article 16(1)–(2) GC IV with article 12(1) GC I; see also ICRC, *Commentary on GC IV*, p. 135 (stating that “saving civilians is the responsibility of the civilian authorities rather than of the military.”).

11. Common Article 3(2) GCs I–IV.

12. ICRC, *Commentary on GC IV*, pp. 40–41. In support of this view, Amrei Müller, “States’ obligations to mitigate the direct and indirect health consequences of non-international armed conflicts: complementarity of IHL and the right to health,” 95 *IRRC* No. 889 (2013) 136 (arguing thus that “treaty rules on the wounded and sick were more inclusive in [NIAC] than in [IAC] already in 1949, when Common Article 3 of GC I–IV was adopted.”) [citations omitted].

13. See, e.g., ICRC, *Commentary on the APs*, para. 4624; Michael Bothe, Karl Josef Partsch, and Waldemar A. Solf, *New Rules for Victims of Armed Conflicts: Commentary on the Two 1977 Protocols Additional to the Geneva Conventions of 1949* 116 (2d. ed., 2013) (commenting, with respect to the personal scope of article 10 AP I, as read in conjunction with article 8(a) AP I, that “Article 10 parallels Art. 12 of the First and Second Conventions. Although Art. 10 applies to all wounded, sick, and shipwrecked, be they military or civilian, it does not really add anything essential to the Conventions as far as military persons are concerned. Its main importance lies in that it ensures the protection and care of wounded, sick and shipwrecked *civilians*.”) [italics original].

civilians.¹⁴ The accompanying commentary to the rule, however, has been interpreted to “intimate[] that civilians arguably may be included.”¹⁵ That intimation has been criticized for not citing adequate state practice and sufficiently clear *opinio juris* on two grounds: first, for purportedly expanding the obligations in GCs I–IV, and, second, for embracing “the admittedly innovative rule” in APs I–II.¹⁶

Search for, collection, and evacuation without adverse discrimination

Moving on to the actual protections, the starting point is the norm requiring the parties to *search for, collect, and evacuate the wounded and sick*—and to do so *without adverse discrimination*. This obligation is subject to practical limitations: military commanders may judge what is possible.¹⁷

For IACs, this norm is well grounded—especially for wounded, sick, and shipwrecked combatants—in GCs I–II.¹⁸ (Though the temporal scope of obligation varies a bit in the *lex scripta*.¹⁹) GC IV leaves a gap in protection: the military parties were obliged only to “facilitate” steps to search for wounded and sick civilians.²⁰ Civilian, not military, authorities were ultimately responsible for them.²¹ For contracting states, AP I closes this gap.²²

For NIACs, Common Article 3 requires only the “search” element.²³ For

14. ICRC, *CIHLS*, Vol. I: Rules, Rules 109–111, pp. 396, 400, 403.

15. James P. Benoit, “Mistreatment of the Wounded, Sick and Shipwrecked by the ICRC Study on Customary International Humanitarian Law,” 11 *YIHL* (2008) 207 [hereinafter, Benoit, “Mistreatment of the Wounded, Sick and Shipwrecked”]; ICRC, *CIHLS*, Vol. I: Rules, Rules 109, p. 399 (stating, with respect to the scope of application, that rule 110 “applies to the wounded, sick and shipwrecked regardless to which party they belong, but also regardless of whether or not they have taken a direct part in hostilities.”).

16. Benoit, “Mistreatment of the Wounded, Sick and Shipwrecked,” *supra* note 15, at pp. 207–208.

17. See, e.g., U.S. Department of Defense, *Law of War Manual* §§ 7.4.4, 13.7.2, and 17.4.3 (2015).

18. Articles 15(1) GC I and 18(1) GC II.

19. Compare article 15(1) GC I with article 18(1) GC II.

20. Article 16(2) GC IV.

21. See ICRC, *Commentary on GC IV*, p. 135.

22. Article 10 AP I.

23. Common Article 3(2) GCs I–IV.

contracting states, AP II expressly added the “collection” part but not the “evacuate” component.²⁴

Row 1 in Table 1 summarizes the fragmentation in the *lex scripta* of IHL—and the related analysis in the *Customary IHL Study*—concerning the norm that the parties shall search for, collect, and evacuate all wounded and sick without adverse discrimination. The argument in the *Customary IHL Study* that this is a norm applicable in NIAC finds some support in the recent U.S. Department of Defense *Law of War Manual*.²⁵ While not expressly recognizing the customary status of the norm, the *Manual* includes a cognate provision for NIAC—though the *Manual* maintains the (slight) gap, as a matter of law, in GC IV for wounded and sick civilians in IACs.²⁶

All feasible medical care as soon as practicable and on an impartial basis guided by medical grounds

Next is the primary wartime medical-care norm: so long as they refrain from any act of hostility, the wounded and sick *hors de combat* must receive all feasible medical care and attention required by their condition.²⁷ That care must be provided as soon as practicable, with the least possible delay, and guided by medical need without adverse discrimination on any other (i.e., non-medical) ground.²⁸ Willfully leaving the wounded and sick without medical attention and care is prohibited.²⁹ As is creating conditions that would expose them to contagion or infection.³⁰

24. Article 8 AP II; see, e.g., ICRC, *Commentary on the APs*, para. 4649. See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* paras. 3.1.b and 3.1.4 (2006).

25. U.S. Department of Defense, *Law of War Manual* § 17.14.3 (2015).

26. *Id.* at § 7.16.1.

27. See, e.g., ICRC, *CIHLS*, Part I: Rules, Rule 110, pp. 400–403.

28. *Id.* See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* paras. 3.1.c and 3.1.4 (2006).

29. Articles 12 GC I and 12 GC II. See also U.S. Department of Defense, *Law of War Manual* §§ 7.5 and 7.5.2.1 (2015).

30. See, e.g., U.S. Department of Defense, *Law of War Manual* §§ 7.5 and 7.5.2.1 (2015).

Imposed on the parties to the conflict, this norm is generally considered an obligation of means.³¹ Amid the chaos of war, a party may not be able to provide the requisite medical care through their assigned personnel. In these circumstances, the obligation has been interpreted to include permitting impartial humanitarian organizations to provide that care.³²

For IACs, GCs I–III, considered in combination, oblige the parties to provide medical care for wounded, sick, and shipwrecked combatants and prisoners of war.³³ GC IV requires medical attention and hospital treatment for “protected persons,” including those interned for security reasons.³⁴ But it does not expressly impose the obligation with respect to *all* wounded and sick civilians.³⁵ AP I flattens this discrepancy by encompassing all wounded and sick civilians (in addition to military wounded and sick).³⁶

For NIACs, Common Article 3 requires generally that the “wounded and sick” be cared for.³⁷ As mentioned above, Common Article 3 thus does not expressly distinguish between fighters and civilians. For its part, AP II clears up any remaining confusion. Under that Protocol, the norm expressly extends to “[a]ll the wounded, sick and shipwrecked, whether or not they have taken part in armed conflict.”³⁸

ICL buttresses this IHL obligation. Under certain circumstances, the willful denial of life-saving health care in armed conflict may be interpreted to constitute

31. ICRC, *CIHLS*, Part I: Rules, Rule 110, p. 402.

32. Alexander Breitegger, “The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies,” 95 *IRRC* No. 889 (2013) 92 [citations omitted] [hereinafter Breitegger, “The legal framework”].

33. Articles 12(2) and 15(1) GC I, 12(2) and 18(1) GC II, and 15 GC III.

34. E.g., article 81(1) GC IV.

35. Compare article 16 GC IV with articles 12(2) and 15(1) GC I, 12(2) and 18(1) GC II, and 15 GC III.

36. Article 8(a) AP I.

37. Common Article 3(2) GCs I–IV.

38. Article 7 AP II. AP II also expressly requires medical treatment for those whose liberty has been restricted in relation to the armed conflict. Article 5(1)(a) AP II.

not only a violation of IHL³⁹ but also a war crime under ICL.⁴⁰ That denial may also—again under certain circumstances—be interpreted under the Rome Statute of the International Criminal Court to constitute the crime against humanity of murder by omission.⁴¹ Finally, the crime against humanity of extermination, as defined in the Rome Statute, may be committed against members of the civilian population in the event of the deliberate deprivation of access to food and medicine.⁴²

Row 2 in Table 1 summarizes the fragmentation in the *lex scripta* of IHL—and the related analysis in the *Customary IHL Study*—concerning the norm that the parties shall provide all feasible medical care to the wounded and sick *hors de combat* as soon as practicable and on an impartial basis. The row indicates two points of fragmentation reflected in the *lex scripta*. First, GC IV does not impose this norm fully for all civilians. And second, Common Article 3 does not expressly stipulate that such care must be provided impartially. The *Customary IHL Study* argument that this norm is applicable in NIAC finds support in the recent U.S. Department of Defense *Law of War Manual*, which includes this norm for NIAC.⁴³ However, as it did with respect to the search for the wounded, the *Manual* maintains the (slight) gap in the obligation to care established in GC IV for wounded and sick

39. Including, in international armed conflict, a grave breach. Articles 50 GC I, 51 GC II, 130 GC III, 147 GC IV, and 85(2) AP I.

40. When committed, for instance, in relation to an IAC against a protected person by the adverse party. Articles 11(4) AP I; 8(2)(a)(i) and (iii) ICC RS. Pursuant to the chapeau in article 8(1) ICC RS, “[t]he Court shall have jurisdiction in respect of war crimes in particular when committed as part of a plan or policy or as part of a large-scale commission of such crimes.”

41. See article 7(1)(a) ICC RS. The relevant chapeau elements under the Rome Statute of the International Criminal Court would need to be met. Pursuant to article 7(1) ICC RS, for the list of penalized acts to constitute a crime against humanity, they must be “committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack,” and pursuant to article 7(2)(a) ICC RS, an “attack directed against any civilian population” is defined as “a course of conduct involving the multiple commission of acts referred to in [article 7(1) ICC RS] against any civilian population, pursuant to or in furtherance of a State or organizational policy to commit such attack.” See, e.g., Breitegger, “The legal framework,” *supra* note 32, at p. 107 [citations omitted].

42. Article 7(1)(b) and (2)(b) of the Elements of Crimes of the ICC RS. See also Breitegger, “The legal framework,” *supra* note 32, at p. 107 [citations omitted].

43. U.S. Department of Defense, *Law of War Manual* § 17.14.2 (2015).

civilians in IACs (compared to wounded and sick combatants).⁴⁴

Respect and protection of the wounded and sick: prohibition on knowingly attacking, firing upon, or unnecessarily interfering with them

For well over a century, IHL treaties have required the parties not only to care for the wounded and sick but also to *respect and protect* them.⁴⁵ That term of art is not expressly defined in the *lex scripta*. But, as noted above, the concept has been interpreted to mean, at a minimum, that, so long as they refrain from any hostile acts, the wounded and sick must not knowingly be attacked, fired upon, or unnecessarily interfered with.⁴⁶ (This norm does not, however, immunize the wounded and sick—even if they are receiving medical care—from necessary security measures, such as search, capture, or detention.⁴⁷)

For IACs, this norm has long-running antecedents. Its modern incarnations are found in GCs I–II, GC IV, and AP I.⁴⁸ (GC IV inverts the terminology and amplifies the requirement by providing that wounded and sick civilians “shall be the object of *particular protection and respect*.”⁴⁹) For NIAC, this norm is not expressly provided in Common Article 3. But it is clearly set down in AP II.⁵⁰

With respect to IACs, these protections are reinforced by the exceptions laid down in IHL treaties that expressly prohibit reprisals against certain wounded and sick.⁵¹ (Prohibitions on similar acts—though not captioned as “reprisals”—have been

44. Compare *id.* at § 7.5.2 with *id.* at §§ 7.16 and 7.16.1.

45. See the discussion and corresponding citations *supra* Section 3: “IHL Treaties — Antecedents to the Geneva Conventions of 1949.”

46. E.g., U.S. Department of Defense, *Law of War Manual* §§ 7.3.3 and 17.14.1.2 (2015). See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* para. 3.1.a (2006).

47. E.g., U.S. Department of Defense, *Law of War Manual* §§ 7.3.3.2–3 and 17.14.1.2 (2015).

48. Articles 12(1) GC I, 12(1) GC II, 16(1) GC IV, and 10(1) AP I.

49. Article 16(1) GC IV.

50. Article 7(1) AP II.

51. E.g., articles 46 GC I, 47 GC III, 13(3) GC III, and 33(3) GC IV.

interpreted by the ICRC to apply to NIACs,⁵² even though neither Common Article 3 nor AP II expressly stipulates as much.)

ICL also bolsters this norm. Intentionally directing attacks against buildings where the wounded and sick are collected in IAC and NIAC—so long as those buildings are not military objectives—is penalized as a war crime under the ICC’s jurisdiction.⁵³

Row 3 in Table 1 summarizes the fragmentation in the *lex scripta* of IHL concerning the norm that the parties shall respect and protect the wounded and sick *hors de combat*, including by not knowingly attacking, firing upon, or unnecessarily interfering with them. (The *Customary IHL Study* did not directly address this norm by formulating it as a rule.) The row indicates two points of related fragmentation reflected in the *lex scripta*. Both pertain to Common Article 3, which does not expressly include this norm (i) for fighters or (ii) for civilians.

Protection against ill-treatment and pillage of personal property

The wounded and sick must also be protected against ill-treatment and pillage of their personal property. This norm requires the parties to protect them against the “hyena[s] of the battlefield.”⁵⁴ The concept has been interpreted to prescribe a strong affirmative obligation: the parties must take all practicable measures—including, in some cases, *using force*—to protect the wounded and sick against pillage and ill-treatment by any person (military or civilian) seeking to harm them.⁵⁵

For IACs, this obligation was laid down in GCs I–II and IV.⁵⁶ The GC IV

52. ICRC, *CIHLS*, Part I: Rules, Rule 148, pp. 526–29; but see, e.g., Dinstein, *Non-International Armed Conflicts in International Law* 140–142 (2014) [hereinafter, Dinstein, *NIACs in International Law*].

53. Articles 8(2)(b)(ix) and (2)(e)(iv) ICC RS.

54. ICRC, *Commentary on GC I*, p. 152.

55. E.g., U.S. Department of Defense, *Law of War Manual* § 7.4.2 (2015) (citing to ICRC, *Commentary on GC I*, p. 152).

56. Articles 15(1) GC I, 18(1) GC II, and 16(2) GC IV.

provision (concerning civilians), however, imposes a more flexible obligation compared to the counterpart obligations for wounded, sick, and shipwrecked combatants. Under GC IV, the military parties “shall *facilitate the steps* taken” to protect the civilian wounded and sick against pillage and ill-treatment.⁵⁷ AP I does not expressly incorporate this norm.

For NIACs, Common Article 3 says nothing about pillage. But it does prohibit various forms of ill-treatment—though not in that exact terminology—against persons taking no active part in hostilities, including those placed *hors de combat* by sickness or wounds.⁵⁸ AP II expressly includes the two elements of this norm for both military and civilian wounded and sick.⁵⁹

Row 4 of Table 1 summarizes the fragmentation in the *lex scripta* of IHL—and the related analysis in the *Customary IHL Study*—concerning the norm that the parties shall protect the wounded and sick against ill-treatment and pillage of personal property. The row indicates five areas of fragmentation in the *lex scripta*: the less extensive obligation concerning civilians in GC IV; the lack of express protections against pillage in Common Article 3 (for civilians and for fighters) and in AP I; and the lack of express protections against ill-treatment in AP I. The *Customary IHL Study* does not directly address whether wounded and sick civilians fell under the related proposed norm of customary IHL.⁶⁰

Humane treatment

IHL stipulates that the parties to an armed conflict shall treat the wounded and sick humanely. Broadly formulated on purpose, humane treatment is an “overarching concept.”⁶¹ It is said to assume “its full significance” when “human values appear to

57. Article 16(2) GC IV.

58. Common Article 3(1) GCs I–IV.

59. Article 8 AP II. See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* para. 3.1.b (2006).

60. ICRC, *CIHLS*, Part I: Rules, Rule 111, pp. 403–406.

61. *Id.* at Rule 87, pp. 306–307

be in greatest danger”—such as when persons are prisoned or interned in armed conflict.⁶² The modern incarnations of the norm are found in GCs I–IV, Common Article 3, and both Additional Protocols.⁶³

Row 5 of Table 1 summarizes the *lack* of fragmentation in the *lex scripta* of IHL concerning the norm that the parties shall treat the wounded and sick *hors de combat* humanely. (The *Customary IHL Study* does not directly address this particular norm with respect to the wounded and sick as such, though it does put forward a more general norm of humane treatment for all persons *hors de combat*.⁶⁴)

Prohibition on mutilations, certain experiments, and certain other medical procedures

Parties to armed conflict are prohibited from mutilating and engaging in certain experiments and certain other medical procedures against the wounded and sick.⁶⁵ The specific scope of obligations may differ significantly depending on the applicable treaty. For its part, ICL fortifies these IHL prohibitions.⁶⁶

Row 6 of Table 1 summarizes the significant fragmentation in the *lex scripta* of IHL—and the related analysis in the *Customary IHL Study*—concerning the norm prohibiting mutilations, certain experiments, and certain other medical procedures not indicated by the state of health of the person and not consistent with generally accepted medical standards. Seven elements of fragmentation in the *lex scripta* emerge. First, GCs I–II prohibit biological experiments but not certain medical and scientific experiments.⁶⁷ Second, the reverse is true for GC III (for prisoners of war) and GC

62. ICRC, *Commentary on GC IV*, p. 205.

63. Articles 3(1) and 12(2) GC I, 3(1) and 12(2) GC II, 3(1) and 13(1) GC III, 3(1), 27(1), and 37(1) GC IV, 10(1) and 75(1) AP I, 4(1), 5(3), and 7(2) AP II. See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* para. 3.1.c (2006).

64. ICRC, *CIHLS*, Rules: Part I, Rule 87, pp. 306–308.

65. Articles 3(1)(a), 12(2), and 50 GC I, 3(1)(a), 12(2), and 51 GC II, 3(1)(a), 13(1), and 130 GC III, 3(1)(a), 32, and 147 GC IV, 11 and 75(2)(4) AP I, 4(2)(a) and 5(2)(e) AP II. See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* para. 1.2.4.9 (2006).

66. See, e.g., ICRC, *CIHLS*, Rules: Part I, Rule 92, pp. 322–323.

67. Articles 12(2) GC I and 12(2) GC II.

IV (for civilians): those treaties prohibit the latter but not the former.⁶⁸ Third, none of GCs I–IV contains the more general prohibition against certain other medical procedures that are not indicated by the state of health of the person concerned and that are not consistent with generally accepted medical standards.⁶⁹ Fourth and fifth, Common Article 3, while prohibiting mutilations, does not contain any of the more specific prohibitions—whether committed against fighters or against civilians. Sixth and seventh, AP II lays down the more general prohibition against any person in detention, but it does not include the more specific prohibition—against fighters or against civilians—on certain medical, scientific, and biological experiments.⁷⁰ These variances in the *lex scripta* may be interpreted to undermine the overall coherence of the treaty sources for the corresponding general rule put forward in the *Customary IHL Study*.⁷¹

Corollary Protections for Medical Caregivers, Transports, Units, and Supplies

Those providing medical care and the means to do so are not specifically protected in themselves but rather *as a corollary* to the protections for the wounded and sick.

Definition of caregivers, transports, and units

Before going into the protections for them, we must first define who and what are encompassed in these corollary protections.

The starting point is that *not all medical caregivers* in armed conflict qualify for the protections of *medical personnel*.⁷² Distilled to their core, two general criteria must

68. Articles 13(1) GC III and 32 GC IV; but see article 147 GC IV (which includes “biological experiments” as one of the acts that may constitute a grave breach where committed against a person protected by the Convention).

69. Compare articles 12(2) GC I, 12(2) GC II, 13(1) GC III, and 32 GC IV with articles 11(1) AP I and 5(2)(e) AP II.

70. Compare article 5(2)(e) AP II with articles 12(1) GC I, 12(1) GC II, 13(3) GC III, 32 GC IV, and 11(2)(b) AP I.

71. ICRC, *CIHLS*, Part I: Rules, Rule 92, pp. 320–23.

72. Kalshoven, for example, breaks down the relevant legal categories of aid workers as follows: (i) personnel attached

be met to obtain that status. First, the personnel must be authorized and recognized by (and thus function under the control of) a party to the conflict. Second, they must exclusively be so assigned to—and do in fact—perform medical functions. In general, the same logic holds for medical units⁷³ (whether mobile or fixed) and medical transports. (Something of an exception is found in GC IV. Pursuant to that treaty, as noted above, in IACs hospitals, their personnel, and their convoys—even though they are not under a party to the conflict’s direct control—may obtain a special status akin to that provided to their military counterparts.⁷⁴) Temporary medical personnel, units, and transports obtain this special status only for the duration of their assignment.⁷⁵

The reason for these requirements is that the protective regime pivots in part on trust and mutual self-interest between the parties. The parties reposed in one another

to “medical units,” including (i)(a) military medical units and their personnel and (i)(b) civilian medical units and their staff; (ii) other professional medical aid workers; and (iii) persons who are incidentally involved with the care of the wounded or sick. Frits Kalshoven, “Legal Aspects of ‘Medical Neutrality,’” in *Reflections on the Law of War* 1027–1031 (2007). See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* para. 3.2.2 (2006); Michael N. Schmitt, “Targeting in Operational Law,” in *The Handbook of the International Law of Military Operations* 263 (eds. Terry D. Gill and Dieter Fleck, 2010) (“Individuals who are not assigned to medical [...] duties are not protected by the rule even if acting in that capacity.”). Kalshoven gives the following examples of those *not* eligible for special protection: “the general practitioner and the chemist, health care institutions not recognised or authorised by the qualified authorities, as well as the staff of a non-recognised society for medical aid working in an area of conflict outside their own country.” Frits Kalshoven, “Legal Aspects of ‘Medical Neutrality,’” in *Reflections on the Law of War* 1030 (2007); see also *id.* at p. 1031 (summarizing “that the protection of the function that may be widely termed as the care of the wounded and sick victims of conflict situations varies from the minimal (every civilian) to the very extensive (the officially recognised medical formation); and that the requirements for the most extensive protection are strict. Many professional medical aid workers remain denied this protection, including the use of the red cross or red crescent as protective emblem. This applies to the not-recognised local health workers in countries where only highly rudimentary organised health provisions exist as much as to the doctors and other medical aid workers who are dispatched to conflict areas by non-recognised societies. The latter’s problems increase if they enter such an area without official permission.”).

73. See, e.g., articles 8(e) and 12(2) AP I; ICRC, *Commentary on the APs*, paras. 522–28; ICRC, *CIHLS*, Part I: Rules, Rule 28, p. 95 (“While a lot of practice does not expressly require medical units to be recognised and authorised by one of the parties, some of it refers to the provisions of Additional Protocol I, or does require such authorisation in another way. *Unauthorised medical units must therefore be regarded as being protected according to the rules on the protection of civilian objects* [...], but do not have the right to display the distinctive emblems.”) [footnotes omitted; italics added].

74. Articles 18(1), 19, 20, and 21 GC IV.

75. See Article 8(k) AP I; see also, e.g., ICRC, *Commentary on the APs*, paras. 390–96.

not only the capacity but also the legal duty to oversee and control their respective medical personnel, units, and transports. The obligation on the parties in IACs to subject certain medical personnel to military laws and regulations are examples of that control.⁷⁶

For IACs, under GC I, state armed forces may assign medical personnel from the military medical service, national Red Cross societies, organizations from neutral states, and other organizations.⁷⁷ Under GC IV, personnel of civilian hospitals may have a similar status,⁷⁸ and in occupied territory medical personnel of all categories shall be allowed to carry out their duties.⁷⁹ Without modifying the position of such civilian hospital personnel and medical personnel in occupied territory under GC IV, AP I defines and establishes protections for (other) civilian medical personnel⁸⁰ and for civil defense medical service personnel.⁸¹ AP I stipulates that to obtain either of those latter statuses, however, those personnel must be authorized and recognized by a party to the conflict (unlike the civilian hospital personnel under GC IV).⁸²

For NIACs, Common Article 3 is silent on medical personnel, units, and transports. They thus do not benefit from any special status under that provision. AP II, however, expressly contemplates those personnel, units, and transports.⁸³ AP II's drafting history⁸⁴

76. E.g., article 26(1) GC I.

77. Articles 24, 26, and 27 GC I.

78. Article 20 GC I.

79. Article 56(1) GC IV; see also ICRC, *Commentary on GC IV*, p. 314.

80. Articles 8(c) and 15 AP I.

81. Article 61(a)(vi) and (c) AP I.

82. On civilian medical personnel, see ICRC, *Commentary on the APs*, paras. 349 and 610; on medical personnel (including members of the armed forces and military units assigned to civil defense organizations) and matériel of civil defense organizations, articles 61(a)(iv) and (c), 62, and 67 AP I. See Michael N. Schmitt, "Targeting in Operational Law," in *The Handbook of the International Law of Military Operations* 263 (eds. Terry D. Gill and Dieter Fleck, 2010).

83. Article 9 AP II.

84. A number of statements given by delegates during the Diplomatic Conference that led to AP II confirm the plausibility of the interpretation that the drafters of the protocol did indeed intend for the dissident armed forces or other organized armed groups (so long as those forces or groups meets the article 1(1) AP II threshold) to be capable, alongside the concerned state, of recognizing and authorizing medical personnel for purposes of AP II. For example, a member of the U.S. delegation stated that "the word 'recognized' used in that context [of a definition of "medical personnel" in an earlier draft of AP II] meant that *the organization in question had been recognized as an aid society by*

and the ICRC *Commentary*⁸⁵ seem to establish that, under that Protocol, both the state and the OAG opposing it may assign those personnel, units, and transports. A terrorist designation does not remove that assignment authority established under IHL.

Members of the civilian population as well as independent humanitarian organizations who have *not* been assigned by a party to the conflict may still provide medical care and attention to the wounded and sick. Numerous IHL treaties—stretching back to GC 1864—expressly recognize their capacity to do so.⁸⁶ These unassigned caregivers do not, however, qualify as *medical personnel* (as they are not under the control of a party). Thus unassigned caregivers do not enjoy the full protections deriving from that special status.

Caregivers not meeting an IHL definition of medical personnel are nonetheless protected as civilians (so long as they do not forfeit that status by, for example, directly participating in hostilities).⁸⁷ Moreover, as highlighted below, a number of key IHL

the competent authorities, namely, the Government in the case of an international armed conflict or *a party to the conflict in the case of a non-international armed conflict* [...].” O.R. Vol. XII, CDDH/II/SR.80, p. 270, para. 21 [italics added]. (Note the use by the delegate of the indefinite article “a”—rather than the definite article “the”—preceding “party,” which can be read to imply that the delegate was submitting that *either* the government *or* the other party to the armed conflict—namely, the dissident armed forces or organized armed group meeting the article 1(1) AP II criteria—could recognize and authorize medical personnel.) Along the same lines, a delegate of the U.S. stated that “the word ‘authorized’ meant that the organization had been *specifically authorized by a party to the conflict* to form medical units in order to care for the wounded and the sick.” Id. [italics added]. A delegate of Australia “fully supported that view.” Id. at p. 271, para. 22. Also seeming to promote that view, more recently, in 2004, the United Kingdom *Manual of the Law of Armed Conflict* states that with respect to AP II “[i]n the case of insurgents, [the competent authority] will be the *de facto* authority.” United Kingdom Ministry of Defence, Joint Service Publication 383, *The Joint Service Manual of the Law of Armed Conflict* para. 15.48 fn 113 (2004). Note that the Rapporteur of the Drafting Committee, when discussing the work of the small group that had discussed part of an earlier draft definition of “medical personnel” for use in AP II, stated that “[i]t had been considered necessary to specify that aid societies other than Red Cross organizations *must be located within the territory of the State where the armed conflict is taking place*,” as the drafters sought “to avoid the situation of an obscure private group from outside the country establishing itself as an aid society within the territory and being recognized by the rebels.” O.R. Vol. XII, CDDH/II/SR.80, p. 270, para. 15 (Mr. Bothe, Federal Republic of Germany); see also article 18(1) AP II.

85. E.g., ICRC, *Commentary on the APs*, p. 1420, para. 4660–6; see also O.R. Vol. XIII, CDDH/235/Rev.1, pp. 303–305.

86. See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies.”

87. See, e.g., ICRC, *CIHLS*, Part I: Rules, Rule 25, p. 82 (explaining that “[o]nly medical personnel *assigned to medical duties by a party to the conflict* enjoy protected status. Other persons performing medical duties enjoy protection against attack *as civilians*, as long as they do not take a direct part in hostilities (see Rule 6 [*CIHLS*]). Such persons are not

protections are intentionally extended to anyone—irrespective of medical-personnel status or not—who provide care to the wounded and sick *hors de combat*.

Respect and protection of medical personnel, units, and transports: prohibition on knowingly attacking, firing upon, or unnecessarily preventing them from discharging their proper functions

As noted above, the obligations entailed in the duty to *respect and protect* medical personnel, units, and transports are not expressly enumerated in the *lex scripta*.⁸⁸ But those obligations have been interpreted to mean that, at a minimum, medical personnel, units, and transports—in both IACs and NIACs—must not knowingly be attacked, fired upon, or unnecessarily prevented from discharging their proper functions.⁸⁹ In general, those protections may not cease unless medical personnel commit or medical units and transports are being used to commit—outside their humanitarian duties or functions—acts harmful to the enemy.⁹⁰ Even then, that protection of medical units and transports may not cease until a warning has been

medical personnel and as a result they have no right to display the distinctive emblems.”) [*italics added*]; see also Frits Kalshoven, “Legal Aspects of ‘Medical Neutrality,’” in *Reflections on the Law of War* 1030 (2007) (“The protection ‘as a civilian’ is also suspended if and as long as such persons ‘participate directly in the hostilities’. This concept is not defined further and is subject to diverse interpretations. The possibility cannot be altogether excluded that one party to the conflict assumes that, for instance, the activities of a medical team that appears to be acting without special protection on the side of the opposing party constitutes such direct participation and as a result deliberately attacks the team. Such an interpretation may, in light of better insight, be unacceptable, but the damage will have been done before anyone can persuade the party of the incorrectness of the view.”).

88. Compare the definitions put forward in, for example, ICRC, *Commentary on GC I*, pp. 134 and 220 with U.S. Department of Defense, *Law of War Manual* §§ 7.8.2, 7.10.1, 17.15.1.2, and 17.15.2.2 (2015).

89. E.g., U.S. Department of Defense, *Law of War Manual* §§ 7.8.2, 7.10.1, and 17.15.1.2 (2015).

90. See articles 21 GC I, 34(1) GC II, 19 and 21 GC IV, 13(1) AP I, and 11(2) AP II; the terminology is slightly different in some of the provisions. See also, e.g., ICTY, *Prosecutor v. Galić*, Appeals Chamber, Judgement No. IT-98-29-A, November 30, 2006, paras. 341–342, 344, and 346; U.S. Department of Defense, *Law of War Manual* §§ 7.10.3.1, 7.11.1, 7.12.6, 7.17.1, 7.18.1, and 17.15.2 (2015); ICRC, *Commentary on the APs*, paras. 551 and 4728; ICRC, *CIHLS*, Part I: Rules, Rules 25, 28, and 29, pp. 79, 84–86, 91, 97–98, and 102. The treaty rules on loss of protection expressly regulate medical units and/or transports; nonetheless, “the rule on loss of protection contained therein can be applied by analogy to medical personnel.” ICRC, *CIHLS*, Part I: Rules, Rule 25, p. 85; this view is supported, at least with respect to IAC, in U.S. Department of Defense, *Law of War Manual* § 7.8.3 (2015) (citing to ICRC, *Commentary on GC IV*, p. 221). Concerning the position of civil defense personnel and objects, see articles 65(1) and 67(e) AP I.

given, setting, wherever appropriate, a reasonable time limit, and after that warning has gone unheeded.⁹¹ (This norm does not immunize those personnel, units, and transports, however, from legitimate security measures such as search.⁹²)

What about unassigned medical caregivers, units, and transports? Under GC IV, in IACs the above-mentioned respect-and-protect obligations also extend to the following caregivers and objects:

- “Civilian hospitals organized to give care to the wounded and sick, the infirm and maternity cases;”⁹³
- “Persons regularly and solely engaged in the operation and administration of civilian hospitals [...]”⁹⁴ as well as “[o]ther personnel who are engaged in the operation and administration of civilian hospitals [...], while they are employed on such duties;”⁹⁵ and
- “Convoys of vehicles or hospital trains on land or specially provided vessels on sea, conveying wounded and sick civilians, the infirm and maternity cases [...]”⁹⁶

Other unassigned medical caregivers, units, and transports—whether in IACs or NIACs—do not benefit under IHL from the so-called “special protections” for

91. See articles 21 GC I, 34(1) GC II, 19 and 21 GC IV, 13(1) AP I, and 11(2) AP II; again, the terminology is slightly different in some of the provisions. See also, e.g., ICTY, *Prosecutor v. Galić*, Appeals Chamber, Judgment, No. IT-98-29-A, November 30, 2006, paras. 344 and 346; U.S. Department of Defense, *Law of War Manual* §§ 7.10.3.2, 7.11.1, 7.12.6.1, 7.17.1.2, 7.18.1, and 17.15.2 (2015). ICRC, *CIHLS*, Part I: Rules, Rules 25, 28, and 29, pp. 79, 84–86, 91, 97–98, and 102.

92. See, e.g., U.S. Department of Defense, *Law of War Manual* §§ 7.8.2.2, 7.10.1.2, 17.15.1.2, and 17.15.2.2 (2015).

93. Article 20(1) GC IV. Pursuant to article 18(2) GC IV, “States which are Parties to a conflict shall provide all civilian hospitals with certificates showing that they are civilian hospitals and that the buildings which they occupy are not used for any purpose which would deprive these hospitals of protection in accordance with Article 19 [GC IV].”

94. Articles 19 and 20(1) GC IV.

95. Article 20(3) GC IV.

96. Article 21(1) GC IV. Pursuant to article 22(1) GC IV, “[a]ircraft exclusively employed for the removal of wounded and sick civilians, the infirm and maternity cases, or for the transport of medical personnel and equipment, shall not be attacked, but shall be respected while flying at heights, times and on routes specifically agreed upon between all the Parties to the conflict concerned.”

medical personnel, units, and transports assigned by a party to the conflict. Rather, such unassigned caregivers are generally protected under IHL as civilians, so long as they do not take a direct part in hostilities.⁹⁷ And such unassigned units and transports are general protected under IHL as civilian objects (so long as they are not military objectives).

With respect to IACs, the above-mentioned protections against attack are reinforced by the exceptions laid down in IHL treaties expressly prohibiting reprisals against certain medical personnel and objects.⁹⁸ (As mentioned above, prohibitions on similar acts—though not captioned as “reprisals”—have been interpreted by the ICRC to apply to NIACs,⁹⁹ even though neither Common Article 3 nor AP II expressly stipulates as much.)

Row 7 of Table 1 summarizes the fragmentation in the *lex scripta* of IHL—and the related analysis in the *Customary IHL Study*—concerning the norm that the parties shall respect and protect medical personnel, units, and transports. Five areas of fragmentation in the *lex scripta* emerge. First, in IACs not all unassigned caregivers, units, and transports under GC IV and AP I are specially protected—only those civilian hospitals, their personnel, and their convoys that are expressly protected under GC IV are.¹⁰⁰ Second, AP II does not include any such special protections for unassigned medical caregivers, units, and transports. Third and fourth, Common Article 3 contains no cognate norm for assigned personnel, units, and transports, nor for their unassigned counterparts. The related norm put forward in the *Customary*

97. Under IHL, attacks directed at unassigned caregivers—so long as they have not forfeited their protections under the law—would be prohibited based on those persons’ civilian status and on the respect due to the wounded and sick *hors de combat*. See, e.g., ICRC, *CIHLS*, Part I: Rules, Rule 25, p. 82 (explaining that “[o]nly medical personnel assigned to medical duties by a party to the conflict enjoy protected status. *Other persons performing medical duties enjoy protection against attack as civilians, as long as they do not take a direct part in hostilities* (see Rule 6 [*CIHLS*]).”) [italics added].

98. E.g., articles 46 GC I, 47 GC III, 13(3) GC III, and 33(3) GC IV.

99. ICRC, *CIHLS*, Part I: Rules, Rule 148, pp. 526–29; but see, e.g., Dinstein, *NIACs in International Law*, *supra* note 52, at pp. 140–142.

100. Pursuant to article 1(3) AP I, the Protocol “supplements” GCs I–IV; AP I does not modify, but does incorporate by reference, the scope of application under GC IV concerning the special protections for unassigned caregivers, units, and transports.

IHL Study encompasses only medical personnel, units, and transports assigned by a party to the conflict.¹⁰¹ It thus excludes from its scope those who are unassigned.

Capture, detention, and retention

With few limited exceptions, IHL does not protect medical personnel against capture or detention.¹⁰² Those exceptions are laid down in GC I. That treaty contemplates that medical personnel (except those from neutral states¹⁰³) may fall into the hands of the enemy party.¹⁰⁴ In principle, certain such personnel—in particular, military medical service members as well as authorized and recognized Red Cross societies and those from other voluntary relief societies¹⁰⁵—may not be detained. Rather, they may retained, but only insofar as the state of health and number of prisoners of war require.¹⁰⁶

In comparison, IHL treaty provisions governing NIAC do not directly protect medical personnel from being captured, detained, or retained.¹⁰⁷ As a result, the state armed forces are not obliged to afford retained status to any captured medical personnel of an organized armed group.¹⁰⁸ (Nor in NIACs are OAGs obliged to afford the medical personnel of the state armed forces, upon capture, retained status.)

101. ICRC, *CIHLS*, Part I: Rules, Rules 25, 28, and 29, pp. 81–83, 95, and 100.

102. E.g., Articles 30(1) and 32(1) GC I and 36 GC II.

103. Article 32(1) GC I.

104. Article 30(1) GC I. See ICRC, *Commentary on GC I*, p. 242 (stating that “[t]he wording [medical personnel ‘who fall into the hands of the adverse Party’] implies that the capture of medical personnel must be a matter of chance and depend upon fluctuations at the battle front; for it is hardly conceivable that a belligerent should deliberately try to capture such personnel. An organized ‘medical hunt’ would certainly be a sorry sight and completely contrary to the spirit of the Geneva Convention.”).

105. In particular, those defined in articles 24 (military medical service) and 26 (authorized and recognized Red Cross societies and other voluntary relief societies) GC I.

106. Articles 28(1) GC I and 33 GC III; see also United Kingdom Ministry of Defence, Joint Service Publication 383, *The Joint Service Manual of the Law of Armed Conflict* paras. 7.8 and 8.58 (2004).

107. See, e.g., U.S. Department of Defense, *Law of War Manual* § 17.15.1.2 (2015) (stating with respect to IHL applicable to NIAC that “[t]he respect and protection afforded medical [...] personnel do not immunize them from search, or from other necessary security measures, or from capture and detention” and that “AP II and applicable treaties to which the United States is a Party (such as the 1949 Geneva Conventions) do not afford medical [...] personnel belonging to non-State armed groups retained personnel status if captured.”) [internal reference omitted].

108. *Id.*

Row 8 of Table 1 summarizes the fragmentation in the *lex scripta* of IHL concerning the norm that medical caregivers shall, upon capture, not be detained but rather only retained, and only then insofar as the state of health and number of prisoners of war or other detainees, as relevant, require. Seven elements of fragmentation in the *lex scripta* emerge. In short, in IACs certain assigned medical personnel—namely, permanent military medical personnel and authorized medical personnel of aid societies—benefit from such retained status.¹⁰⁹ No IHL treaty establishes the status of retained personnel for any assigned medical personnel in NIACs. Nor does any IHL treaty establish that status for any *unassigned* caregiver in IACs or in NIACs. (The *Customary IHL Study* did not directly address this norm.)

Prohibition on punishment

The threat of punishment may act as a strong deterrent to giving medical care to the enemy. Developed out of the abuses against those who provided care to the enemy during WWII, GC I lays down a prohibition on convicting anyone for having nursed the wounded or sick.¹¹⁰ This prohibition extends not only to the medical personnel assigned by a party to the conflict but to anyone who provided such care.¹¹¹ (However, if a wounded terrorist is considered a civilian, rather than a combatant, these protections in GC I may not necessarily apply with respect to that person.)

Over time, states strengthened this norm. Both AP I and AP II provide that “[u]nder no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.”¹¹² Common Article 3, however, does not expressly prohibit punishment

109. Article 28(1) GC I. Pursuant to article 32(1) GC I, the personnel belonging to neutral countries (as laid down in article 27 GC I) “may not be detained”; rather, pursuant to article 32(2) GC I, those personnel shall, unless otherwise agreed, “have permission to return to their country, or if this is not possible, to the territory of the Party to the conflict in whose service they were, as soon as a route for their return is open and military considerations permit.”

110. Article 18(3) GC I.

111. ICRC, *Commentary on GC I*, p. 193.

112. Articles 16(1) AP I and 10(1) AP II [*italics added*]; see also article 17(1) AP I (stipulating that “[n]o one shall be harmed, prosecuted, convicted or punished for [certain] humanitarian acts.”). According to the ICRC, concerning

of medical activities.

Row 9 of Table 1 summarizes the fragmentation in the *lex scripta* of IHL¹¹³—and the related analysis in the *Customary IHL Study*—concerning the norm that under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of who benefits therefrom. Mirroring the intent of the drafters of GC I, AP I, and AP II, we make no distinction for this norm between assigned and unassigned caregivers. Two elements of fragmentation in the *lex scripta* still emerge. First, the cognate norm in GC I, while revolutionary, expressly prohibits only *convicting* and molesting (in the sense of ill-treating) persons who *nursed* the wounded and sick. (AP I and AP II prohibit all forms of punishment more broadly and expand the scope of protection to encompass all medical activities compatible with medical ethics.) And second, Common Article 3 contains no protections whatsoever against punishment of medical caregivers. The related norm put forward in the *Customary IHL Study* was based largely in the formulations

the provision in AP I, “[t]he obligation to refrain from punishing is addressed to *all authorities in a position to administer punishment*, from the immediate superior in the hierarchy of the person concerned who is entitled to do so, to the supreme court of a State.” ICRC, *Commentary on the APs*, para. 651 [italics added]. That obligation to refrain from punishing entailed in article 16(1) AP I purportedly “applies not only to the enemy authorities, but also to the authorities of the State of which the person concerned is a national. This is important, because there could be a great temptation for a State to punish its own nationals who have administered care to the enemy wounded.” *Id.* Pursuant to the ICRC’s analysis, falling within the ambit of these protections under article 10(1) AP II would include not only doctors but also, among others, “nurses, midwives, pharmacists and medical students who have not yet qualified.” ICRC, *Commentary on the APs*, para. 4686. See also International Committee of the Red Cross, *Draft Additional Protocols to the Geneva Conventions of August 12, 1949: Commentary*, October 1973, Geneva, p. 148 (stating that “[t]his rule is the corollary of the principle whereby the wounded and the sick shall be entitled to the care necessitated by their condition [...]. It concerns any person exercising a medical activity, whether doctor, dentist, nurse or stretcher-bearer; whether a member of the medical personnel as defined in [a draft article that was ultimately not included in AP II] or persons exercising such an activity, although not attached to a medical unit of a party to the conflict.”) [italics added]. Further, according to the ICRC *Commentary* on the relevant provision in AP II, “[t]he reference to punishing is meant to cover all forms of sanction, including both penal and administrative measures.” ICRC, *Commentary on the APs*, para. 4691. And, again according to the ICRC *Commentary*, “[t]he term ‘medical activities’ should be interpreted very broadly. The concept is broader than that of medical care and treatment. A doctor not only treats patients, he may also be called upon to issue death certificates, vaccinate people, make diagnoses, give advice[,] *etc.*” *Id.* at para. 4687 [internal citations omitted].

113. Today, the IHRL principle of legality may help shield caregivers from the abuse of unlawfully ambiguous definitions of terrorism-related offenses. See, e.g., *De La Cruz-Flores v. Peru*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 115, para. 102 (Nov. 18, 2004) [hereinafter IACtHR, *De La Cruz-Flores v. Peru*]; see also *id.* at para. 188(1).

set down in AP I and AP II. Yet the authors cited military manuals and national legislation only from states that are party to one or both of those Protocols.¹¹⁴ (The prohibition on punishing medical activities in NIACs, in particular, was noticeably absent from the recent U.S. Department of Defense *Law of War Manual*.¹¹⁵)

Prohibition on illegitimate compulsion

Amid the tumult of war, caregivers often face increased pressure to act against their patients' medical interests. That pressure may peak when the patient is designated an enemy of the state, such as a terrorist.

An implicit prohibition on illegitimate compulsion of caregivers can be read into various IHL protections. Consider the provisions prescribing humane treatment, those requiring that care be provided impartially, and those prohibiting certain medical experiments.¹¹⁶

Yet states did not agree to explicit IHL protections against compelling illegitimate acts or omissions of caregivers until the Additional Protocols. Generally stated, under both AP I and II, anyone who engages in medical activities—not just

114. ICRC, *CIHLS*, Vol. II: Practice, Part 1, pp. 486–492.

115. Article 10(1) AP II is one of the few provisions of the Protocol that the *Manual* does not expressly incorporate. While the *Manual* does not expressly prescribe criminal punishment for those who provide medical care to the enemy in NIAC, it also does not prohibit such punishment. Moreover, the *Manual* does reference the capacity of the state to sentence those who “support” enemy non-state armed groups to a variety of offenses, including “material support to terrorism or terrorist organizations.” U.S. Department of Defense, *Law of War Manual* § 17.17.1.2 (2015). Under U.S. law, that offense includes the provision of certain medically related activities (except medicine itself)—such as “expert advice or assistance”—to terrorist organizations. See *infra* Section 5: “Domestic Proceedings against Medical Caregivers — United States of America.” The reasoning for the lack of inclusion of the protection against punishment laid down in AP II is left unstated in the *Manual*. The *Manual* notes in a different section that, over all, “[a]lthough the [United States] is not a Party to AP II, reviews have concluded that the provisions of AP II are consistent with U.S. practice, and that any issues could be addressed with reservations, understandings, and declarations.” *Id.* at § 19.20.2.1 [citations omitted]. None of the referenced reservations, understandings, or declarations would, however, limit the scope of protection under article 10(1) AP II. Indeed, the only relevant reservation concerning article 10(1) AP I is found in an analysis attached to the letter transmitting AP II to the Senate for ratification, which states that “[a] reservation to this Article is necessary to preserve the ability of the U.S. Armed Forces to control the actions of their medical personnel, who might otherwise feel entitled to invoke these provisions to disregard, under the guise of ‘medical ethics’, the priorities and restrictions established by higher authority.” *Detailed Analysis of Provisions*, Attachment 1 to George P. Shultz, Letter of Submittal, December 13, 1986, *Message from the President Transmitting AP II*, p. 5 [italics added].

116. Articles 12 GC I, 12 GC II, 13 GC III, 32 GC IV, 11(2) AP I, and 5(2)(e) AP II.

medical personnel—is protected against being compelled to act contrary to medical ethics and other rules designed to protect the wounded and sick.¹¹⁷ Those persons are also protected against being compelled to *refrain from acting* in accordance with those ethics and rules.¹¹⁸ These norms help protect against unnecessary procedures. But they also prohibit tasks that are incompatible with the humanitarian mission, such as camouflaging military operations under the cover of medical functions.¹¹⁹

ICL fortifies these protections by imposing individual criminal liability for various so-called “medical war crimes.”¹²⁰ IHRL, too, may help safeguard the underlying protection, including by establishing normative points of reference concerning medical ethics.¹²¹

Row 10 of Table 1 summarizes the fragmentation in the *lex scripta* of IHL—and the related analysis in the *Customary IHL Study*—concerning the norm that medical

117. The exact contours of the protection are formulated slightly differently between the Protocols: compare article 16(2) AP I with 10(2) AP II. See also International Institute of Humanitarian Law, *The Manual on the Law of Non-International Armed Conflict with Commentary* para. 3.2.b (2006) (“Medical [...] personnel must not be required to perform tasks other than appropriate medical [...] duties. They must be given all available assistance when performing their duties.”).

118. Articles 16(2) AP I and 9 and 10(2) AP II.

119. According to the ICRC’s *Commentary on the APs*, “[t]he use of the verb ‘to compel’, taken from [article 33 GC III], refers to cases where medical [...] personnel have fallen into the hands of the adversary. In addition to being protected by [article 5 AP II], like any other persons deprived of their liberty for reasons related to the conflict, they are also granted the guarantee of not being compelled to carry out tasks which are incompatible with their mission.” ICRC, *Commentary on the APs*, para. 4676 [internal citations omitted]. The *Commentary* elaborates that

[t]his could refer to medical experiments, but also [...] to camouflaging military operations under cover of medical tasks. The second possibility may materialize not only when medical or religious personnel have fallen into the hands of the adversary: the parties to the conflict may in no case compel the personnel in question to carry out military tasks as these are, by their very nature, incompatible with any humanitarian mission; medical assignment must be exclusive.”

Id.

120. See generally Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* 133–175 (2015).

121. See, e.g., Section 3: “Related Fields of International Law — International human rights law.” IHRL also provides an independent basis for the IHL protections against torture, against cruel, inhuman, and degrading treatment, and against being subjected without one’s free consent to medical or scientific experimentation. Articles 7 and 4(2) International Covenant on Civil and Political Rights, December 16, 1966, 999 U.N.T.S. 171 (ICCPR). None of those rights may be derogated from.

caregivers shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick. In line with the drafters of AP I and AP II, we make no distinction for this norm between authorized personnel and unassigned caregivers. Two elements of fragmentation in the *lex scripta* still emerge. Both flow from the lack of express protections against such compulsion in GCs I–IV and in Common Article 3. Meanwhile, the related norm put forward in the *Customary IHL Study* derives significantly from the Additional Protocols.¹²² Yet all of the relevant cited military manuals and national legislation were from parties to AP I and/or AP II.¹²³

Limitations on denunciation

Under IHL, may a caregiver be compelled to give authorities information on persons whom they have treated? Not only health-related information, but information on their patients' activities, connections, and position—or even on the *existence* of the wounded?¹²⁴

As noted earlier, concern regarding such wartime denunciation arose after WWII.¹²⁵ During that conflict, occupying forces had “ordered inhabitants, including doctors, to denounce [to the authorities] the presence of any presumed enemy,

122. ICRC, *CIHLS*, Vol. I: Rules, Rule 26, pp. 86–87.

123. ICRC, *CIHLS*, Vol. II: Practice (Part 1), pp. 486–97. See the discussion and corresponding citations *infra* Section 3: “Customary IHL — ICRC’s *Customary IHL Study*.”

124. Breitegger, “The legal framework,” *supra* note 32, at p. 119 [citation omitted]. With respect to the issue of non-denunciation, medical ethics are said to be in tension with IHL. *Id.* Non-denunciation implicates not only medical confidentiality in particular but also medical ethics more generally. Medical confidentiality in this context refers as a general rule “to the *discretion* that a doctor must observe with respect to *third parties regarding the state of health of his patients and the treatment he has administered or prescribed for them.*” ICRC, *Commentary on the APs*, para. 670 fn 21 (referring to CE/7b, p. 22) [italics added]. Medical ethics “generally require absolute confidentiality with regard to the patient’s identity and other personal information as well as health-related information [...]” Breitegger, “The legal framework,” *supra* note 32, at p. 119 [citation omitted]. In general, that absolute confidentiality is “subject to the [...] discretion of health-care personnel when there is a *real and imminent threat to the patient or others* and this threat can only be removed by breaching confidentiality.” *Id.* at pp. 119–120 [citation omitted; italics added].

125. ICRC, *Commentary on the APs*, paras. 670–675.

under threat of grave punishment.”¹²⁶ Of course, if they were to be denounced to the authorities, the wounded were less likely to seek treatment. While drafting GCs I–IV, the delegates did not agree, however, on whether to establish a protection allowing medical personnel and the civilian population to conceal information about the wounded whom they had cared for.¹²⁷

After wide-ranging and often heated discussions during the Diplomatic Conference, non-denunciation regulations were laid down in the Additional Protocols.¹²⁸ The relevant rules in AP I and AP II are fashioned slightly differently.¹²⁹

126. *Id.* at para. 671.

127. See ICRC, *Commentary on the APs*, paras. 670–74.

128. For many delegates at the Diplomatic Conference, the protection due to those engaged in medical activities in NIACs raised threshold questions regarding state sovereignty, especially the power to compel information about those who have engaged in unlawful activities. Some delegates favored deleting the entire article or certain of its paragraphs. See, e.g., in CDDH/II/SR.28, the statements of the delegations of Canada, Mr. Marriot, p. 283, para. 14; of Australia, Mr. Clark, p. 283, para. 17; and of Indonesia, Mr. Ijas, p. 283, para. 19. Others were adamant that the non-denunciation protections had to remain, with a delegate of the Union of Soviet Socialist Republics (U.S.S.R.), for example, emphasizing that the draft provisions concerning compelling information “raised a point of crucial importance, which would indicate just how far the Conference was prepared to go in extending the humanitarian law applicable to any type of armed conflict.” CDDH/II/SR.28, Mr. Krasnopeev, U.S.S.R., p. 284, para. 25 (and further stating that “[i]t had already been agreed that a rule of that type was appropriate in the case of international conflicts; it was impossible to argue that the same provision, in the case of internal conflicts, constituted a violation of national sovereignty, or were there any grounds for saying that the paragraph would be inapplicable in the case of an internal conflict.”). *Id.* at pp. 284–85, para. 25. See also, e.g., in CDDH/II/SR.28, the statements of the delegations of the Ukrainian Soviet Socialist Republic, Mr. Denisov (stating that “he could not agree that paragraph 3 should be deleted. It had nothing to do with sovereignty; it was a question of providing protection to medical personnel in the case of an internal conflict. To delete the paragraph would seriously weaken the impact of the whole Protocol.”), p. 284, para. 22; of Iraq, Mr. Al-Fallouji (stating that “[t]he real question was how far the international community was ready to go in humanizing such conflicts. He thought it was prepared to make some advance, but it should not be pushed too far. The present Conference was useful precisely because it helped to reveal the degree of maturity of international opinion.”), p. 285, para. 29.

A working group was established to consider the provisions regarding compelling information. See, e.g., O.R. Vol. XI, CDDH/II/SR.41, pp. 447–456. During the discussion, Mr. Krasnopeev, of the U.S.S.R. delegation, stated that “[i]t was [...] clearly necessary also in the case of an internal conflict to protect medical personnel against abusive external pressure and to allow the doctor himself to decide if he should act as a doctor or as a participant in the armed conflict.” O.R. Vol. XI, CDDH/II/SR.40, p. 424, para. 31. Mr. Krasnopeev also stated that according to the proposal under review an obligation for doctors to give information concerning their suspicions “would be valid in an armed internal conflict not only in cases of common law crimes but also in the case of political crimes, since every government considered those who had sided against it as political criminals. Many historic cases could be cited of individuals regarded by the authorities of former days as dangerous political criminals who had afterwards become Heads of State. That had even occurred many times in the case of Napoleon.” *Id.*

129. See Articles 16(3) AP I and 10(4) AP II. The AP I provision is also subject to the requirement that “[r]egulations

But the upshot is that the protection against compulsory denunciation¹³⁰ in both treaties may be subject to certain national law.¹³¹ Conditioning the international legal norm on various domestic legislations weakened these protections.¹³²

Row 11 of Table 1 summarizes the fragmentation in the *lex scripta* of IHL¹³³ concerning the norm that no person engaged in medical activities may be penalized for refusing or failing to give information concerning the wounded or sick who are, or have been, under her care, if such information would, in her opinion, prove harmful to the patients concerned or to their families. Four elements of fragmentation in

for the compulsory notification of communicable diseases shall [...] be respected.” Id.

130. See ICRC, *Commentary on the APs*, para. 684 (stating that “there is no obligation upon those exercising medical activities to remain silent. They may denounce the presence of the wounded to the authorities even when they know that this will be prejudicial to the wounded person or his family, if such denunciation is in their view necessary for saving lives. The prohibition is aimed at those who could *compel such denunciations*.”) [italics added].

131. See ICRC, *Commentary on the APs*, paras. 686–88.

132. See, e.g., ICRC, *Commentary on the APs*, para. 688. Conforming that view with respect to the “subject to national law” condition in AP II, United Kingdom Ministry of Defence, Joint Service Publication 383, *The Joint Service Manual of the Law of Armed Conflict* para. 15.46.b fn. 108 (2004) (also explaining that “the final text was a compromise to avoid a perceived violation of the principle of non-interference with the internal affairs of states”).

When the “subject to national law” provisions were initially adopted during the negotiations, the Head of the Norwegian delegation strongly protested: the “provision was contrary to the very essence of international law and would be *extremely dangerous for the whole body of humanitarian law*.” O.R. Vol. XI, CDDH/II/SR.46, p. 513, para. 2 [italics added] (also stating that “[i]t was unacceptable to his Government that an international legal norm of the importance of the Protocol should be made subject to the national law of any country.”). Id. See also ICRC, *Commentary on the APs*, para. 4684; Alexander Breitegger, “The legal framework,” *supra* note 32, at pp. 118–22.

133. As noted above, human rights-based safeguards may provide important normative points of reference concerning medical ethics, including in relation to non-denunciation. In addition, the IHRL right not to be subjected to arbitrary or unlawful interferences with one’s privacy protects against undue disclosure of medical and other private data to persons not privy to the physician–patient relationship. Article 17(1) ICCPR. Yet as with some other IHRL rights, this right may under certain circumstances be derogated from in times of public emergency, such as armed conflict. Human Rights Committee, General Comment No. 16, paras. 3–5 and 10. See the discussion in Breitegger, “The legal framework,” *supra* note 32, at pp. 122–123. See generally Amrei Müller, *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law: An Analysis of Health-Related Issues in Non-International Armed Conflict* 191–237 (2013). Pursuant to article 10(3) AP II, there is a corresponding obligation, which is subject to national law, to respect the confidentiality of information that may be acquired when providing medical care. See further Separate Opinion of Judge Sergio García-Ramírez, IACtHR, *De La Cruz-Flores v. Peru*, *supra* note 113, para. 13 (“I [...] consider it necessary to prohibit incriminating the conduct of a doctor who abstains from providing information to the authorities about his patient’s punishable conduct, which he is aware of through information provided to him by the patient in connection with the medical procedure. In that case, there could be an absolutive excuse similar to that which protects the next of kin of the defendant in cases of concealment owing to kinship.”)

the *lex scripta* emerge. First, GCs I–IV contain no such protection. Second, neither does Common Article 3. Third and fourth, both AP I and AP II subject the norm to certain domestic legislation. (The *Customary IHL Study* does not put forward a rule that expressly encompassed that norm. Though, in the discussion of a related rule, the authors comment on respect for medical secrecy more broadly.¹³⁴)

Display of the distinctive emblems

The use of protected emblems has long been a key element of IHL.¹³⁵ They are intended to signify one thing “of immense importance: respect for the individual who suffers and is defenceless, who must be aided, whether friend or enemy, without distinction of nationality, race, religion, class or opinion.”¹³⁶ Today, the distinctive emblems include the red cross, red crescent, red lion and sun, and red crystal.¹³⁷

In general, with few exceptions, IHL provides that the distinctive emblems may be used only under the control of the competent authority of a party to the conflict.¹³⁸ That is because the protective regime pivots in part on the trust between the parties,

134. ICRC, *CIHLS*, Vol. I, Rules, Rule 26, p. 88.

135. See, e.g., article 7 GC 1864 (regulating the use of a distinctive sign in the form of a flag or an armlet bearing a red cross on a white ground). See generally Jean-François Quéguiner, “Commentary on the Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III),” 89 *IRRC* 865 (2007) 175–78.

136. ICRC, *Commentary on GC I*, p. 305. As emphasized in the ICRC’s *Commentary on the APs*, “the entire system of protection established in the [GCs] is based on the trust which can be placed in the proper use of the distinctive emblem, the control of such use and the repression of abuse are of paramount importance.” ICRC, *Commentary on the APs*, para. 736.

137. The ICRC notes that “[t]he Islamic Republic of Iran—the only State to have employed the red lion and sun—has since abandoned its use.” International Committee of the Red Cross, “Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III), 8 December 2005,” available at <https://www.icrc.org/applic/ihl/ihl.nsf/Treaty.xsp?documentId=8BC1504B556D2F80C125710F002F4B28&action=openDocument> [<https://perma.cc/YH5V-TU5W>]. See Jean-François Quéguiner, “Commentary on the Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III),” 89 *IRRC* 865 (2007) 177 fn. 12 (noting that “[p]er a diplomatic note, dated 4 September 1980, the Islamic Republic of Iran declined to exercise its right to use the red lion and sun and opted instead for the red crescent, while reserving the right to return to the red lion and sun should new emblems be recognized.”).

138. See, e.g., articles 38–44 and 53–54 GC I, 39 and 41–45 GC II, 18(3)–(4), 20(2), 21, and 22(2) GC IV, 8(1), 18, 23(1), 37(1)(d), 38(1), 85(3)(f) AP I, and 12 AP II.

who must ensure that the “special” status of medical personnel, units, and transports is not abused. Thus, as with the assignment of medical personnel, a key criterion of authorizing the use of the distinctive emblem is that the entity is subject to the party’s *control*.¹³⁹ (The ICRC and certain other parts of the International Movement of the Red Cross and Red Crescent are exceptions, though GC I contemplated that National Red Cross Societies may work under a party’s control.¹⁴⁰)

The authorization of the use of the distinctive emblems—for protective purposes for medical personnel, units, transports, equipment, and supplies—is extensively regulated in GCs I–II, GC IV, and AP I.¹⁴¹ Common Article 3, however, contains no provisions on the emblems. A major development for NIAC occurred in AP II. That Protocol reposes the power to authorize the emblems not only in states but *also in organized armed groups*.¹⁴² A terrorist designation does not modify that OAG’s power to do so under IHL.

ICL buttresses this system of control. The ICC Statute penalizes as a war crime in IAC making improper use of the emblems where such use results in death or serious personal injury.¹⁴³ It also lays down as a war crime in both IAC and NIAC intentionally directing attacks against medical personnel and objects displaying the distinctive emblems in conformity with IHL.¹⁴⁴

Row 12 of Table 1 summarizes the fragmentation in the *lex scripta* of IHL, and the related analysis in the *Customary IHL Study*, concerning the norm that the parties may authorize—and, if they do so, must control—the display of the distinctive

139. See, e.g., Frits Kalshoven, “Legal Aspects of ‘Medical Neutrality,’” in *Reflections on the Law of War* 1031 (2007).

140. Those exceptions pertain, for example, to personnel and property of the components of the International Movement of the Red Cross and Red Crescent. E.g., article 44(3) GC I. E.g., compare article 40 GC I with article 44 GC I.

141. E.g., articles 38–44 and 53–54 GC I, 39 and 41–45 GC II, 18(3)–(4), 20(2), 21, and 22(2) GC IV, 8(1), 18, 23(1), 37(1)(d), 38(1), and 85(3)(f) AP I.

142. See article 12 AP II; see also ICRC, *Commentary on the APs*, para. 4746.

143. Article 8(2)(b)(vii) ICC RS.

144. Articles 8(2)(b)(xxiv) and 8(2)(e)(ii) ICC RS.

emblems by medical caregivers, units, transports, equipment, and certain other things used to discharge their proper functions.¹⁴⁵ Five elements of fragmentation emerge in the *lex scripta*. One of those elements relates to the fact that under GC IV only some unassigned caregivers and objects—namely, authorized civilian hospitals, their personnel, and their convoys¹⁴⁶—may use the emblem. Three more of those fragmentation elements come from the lack of authorization in AP I, in Common Article 3, or in AP II for any unassigned caregivers, units, and transports to display the emblems. And the fifth fragmentation element flows from the lack of provisions in Common Article 3 concerning the authorization of the emblems by any personnel or objects controlled by the parties. The rule put forward in the *Customary IHL Study* addresses the use of the emblems by medical personnel, units, and transports assigned by a party to the conflict, not their unassigned counterparts.¹⁴⁷ For NIAC, the main source of *lex scripta* for this norm is found in AP II.¹⁴⁸

145. ICRC, *CIHLS*, Vol. II: Practice, Part 1, pp. 1269–1317; U.S. Department of Defense, *Law of War Manual* § 17.16 (2015).

146. Articles 18(3), 20(2)–(3), and 21 GC IV; see also, with respect to certain air transports, article 22(2) GC IV.

147. ICRC, *CIHLS*, Vol. I: Rules, Rule 59, p. 209.

148. Though not a contracting party to AP II, the U.S. Department of Defense, *Law of War Manual* incorporates article 12 AP II. U.S. Department of Defense, *Law of War Manual* § 17.16 (2015).

Table 1: Fragmentation under IHL of Key Impartial Wartime Medical Care Norms

	International armed conflict			Non-international armed conflict		
	GCs I–IV	AP I	ICRC CIHLS	CA3	AP II	ICRC CIHLS
Entitlement to and protection of medical care for the wounded & sick who are <i>hors de combat</i>						
1. The parties shall search for, collect, and evacuate the wounded & sick without adverse discrimination						
Wounded & sick combatants/fighters	⚡	⚡	+	○	⚡	+
Wounded & sick civilians/others	○	⚡	±	○	⚡	+
2. The parties shall provide all feasible medical care to the wounded & sick as soon as practicable and on an impartial basis (i.e., guided by medical grounds, with no [other] grounds for adverse discrimination)						
Wounded & sick combatants/fighters	⚡	⚡	+	○	⚡	+
Wounded & sick civilians/others	○	⚡	±	○	⚡	+
3. The parties shall respect and protect the wounded & sick; the parties shall thus not knowingly attack, fire upon, or unnecessarily interfere with them						
Wounded & sick combatants/fighters	⚡	⚡	N/A	○	⚡	N/A
Wounded & sick civilians/others	⚡	⚡	N/A	○	⚡	N/A
4. The parties shall protect the wounded and sick against ill-treatment and pillage of personal property						
Wounded & sick combatants/fighters	⚡	✗	+	○	⚡	+
Wounded & sick civilians/others	○	✗	N/A	○	⚡	N/A
5. The parties shall treat the wounded & sick humanely						
Wounded & sick combatants/fighters	⚡	⚡	N/A	⚡	⚡	N/A
Wounded & sick civilians/others	⚡	⚡	N/A	⚡	⚡	N/A
6. Mutilations; medical, scientific, or biological experiments; or any other medical procedure not indicated by the state of health of the person concerned and not consistent with generally accepted medical standards are prohibited						
Wounded & sick combatants/fighters	○	⚡	±	○	○	+
Wounded & sick civilians/others	○	⚡	N/A	○	○	N/A
Corollary protections for medical caregivers, units, supplies, & transports						
7. The parties shall respect and protect medical caregivers, units, & transports, so long as they are exclusively assigned to medical duties and do not commit, outside their humanitarian functions, acts harmful to the enemy; such caregivers, units, & transports may not knowingly be attacked, fired upon, or unnecessarily prevented from discharging their proper function; the foregoing protections may cease only if those caregivers, units, or transports commit, outside their humanitarian functions/duties, acts harmful to the enemy and only after (an unheeded) warning (which, where appropriate, had set a reasonable time limit)						
Medical personnel, units, & transports assigned by a party	⚡	⚡	+	✗	⚡	+
Unassigned caregivers, units, and transports	○	✗	N/A	✗	✗	N/A
8. In the event of capture, the parties shall retain medical caregivers only insofar as the state of health and number of prisoners of war (IAC)/detainees (NIAC) requires						
Medical personnel assigned by a party	⚡	✗	N/A	✗	✗	N/A
Unassigned caregivers	✗	✗	N/A	✗	✗	N/A
9. Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of who benefits therefrom						
Medical personnel assigned by a party & unassigned caregivers	○	⚡	±	✗	⚡	±
10. Medical caregivers shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick						
Medical personnel assigned by a party & unassigned caregivers	✗	⚡	±	✗	⚡	±
11. No person engaged in medical activities may be penalized for refusing or failing to give information concerning the wounded and sick who are, or who have been, under her care, if such information would, in her opinion, prove harmful to the patients concerned or to their families						
Medical personnel assigned by a party & unassigned caregivers	✗	○	N/A	✗	○	N/A
12. During armed conflict, the parties may authorize—and, if so, must control—the display of the distinctive emblems by medical caregivers, units, transports, & equipment etc.						
Medical personnel, units, equipment, & transports etc. under a competent authority of a party	⚡	⚡	+	✗	⚡	+
Other caregivers, units, equipment, & transports etc. (*see text re ICRC)	○	✗	N/A	✗	✗	N/A
KEY <i>Sources of lex scripta and studies of customary IHL</i> AP I According to the explicit scope and terms of Additional Protocol I (1977) AP II According to the explicit scope and terms of Additional Protocol II (1977) CA3 According to the explicit scope and terms of Common Article 3 (1949) GCs I–IV According to the explicit scope and terms of Geneva Conventions I–IV (1949) ICRC CIHLS According to the ICRC's <i>Customary International Humanitarian Law Study</i> (2005)						
<i>Scope of protection for the particular medical-care norm under the referenced source(s) of IHL</i> ⚡ Generally protected under the referenced source of IHL ○ Protection under the referenced source of IHL exists but suffers key weakness ✗ Not expressly protected as such under the referenced source of IHL						
<i>Evaluation of evidence and analysis put forward in the ICRC CIHLS</i> + The evidence submitted for the related rule seems to support the basis for it ± There is a specific question concerning the evidence for the related ICRC <i>CIHLS</i> rule N/A Not addressed: The ICRC <i>CIHLS</i> did not directly address the norm(s) under review						



5

STATE RESPONSES TO TERRORISM

In this section, we highlight central elements of states' response to terrorism. Terrorists range from individual lone-offender attackers, to networks of organizations with shared normative commitments, to rebel groups seeking to supplant governing authorities, to state “sponsors” of terrorism. Legal definitions of terrorists increasingly encompass not only those who conduct terrorist acts but also those who provide direct or indirect support to those perpetrators.

In sum, to counter these diverse perceived threats, states draw on a growing collection of legal frameworks, administrative tools, cooperation mechanisms, forcible measures, surveillance systems, and funding streams. A key element cutting across these sectors is the prohibition of diverse forms of support and resources to terrorists.

A hybrid war-and-policing model underpins these efforts. The policing dimension draws on the traditional objectives of the criminal law system, including deterrence, incapacitation, rehabilitation, and retribution, mixed with trans-border interdiction and cooperation between states.¹ The war dimension adds lethal targeting and security detention.

Conventional and Customary Definitions of Terrorism

Terrorism has been a matter of international concern since the 1930s.² Yet the near decade and a half following the attacks of September 11, 2001 in the United States has occasioned a groundswell of support for increasingly robust anti-terrorism agendas. Nonetheless, despite its relatively long history and these recent developments, the generic term *terrorism*—as a legal concept and a category of offense to be regulated in international law—continues to evade definitional consensus.³

1. See, e.g., S.C. Res. 1373 (2001), para. 2(f) (deciding that all states shall “[a]fford one another the greatest measure of assistance in connection with criminal investigations or criminal proceedings relating to the financing or support of terrorist acts, including assistance in obtaining evidence in their possession necessary for the proceedings”).

2. See Ben Saul, “The Legal Response of the League of Nations to Terrorism,” 4 *JICJ* 78 (2006).

3. See, e.g., Robert P. Barnidge, Jr., “Terrorism: Arriving at an Understanding of the Term,” in *Terrorism and*

At the international level, states remain deadlocked on certain aspects of the scope of application of a comprehensive terrorism convention that would cover transnational offenses. Major points of disagreement concern, for instance, the concept of “state terrorism,” as well as whether to exclude from the convention’s scope acts already governed by IHL.⁴

Despite these difficulties in agreeing to a generic comprehensive terrorism convention, states have developed numerous international⁵ and regional⁶

International Law 192 (ed. Glennon, 2008) (concluding that “[a]t present [...] international law has yet to recognize a definition of terrorism that exists in a legally obligatory way and that operates without reference to international treaties related to terrorism.”); Kai Ambos and Anina Timmermann, “Terrorism and customary international law,” in *Research Handbook on International Law and Terrorism* 28 fn 48 (ed. Saul, 2014).

4. U.N. General Assembly, Sixth Committee, “Summary record of the 28th meeting,” November 13, 2014, UN doc. A/C.6/69/SR.28, paras. 4–6, 8–9, and 15–17.

5. International Convention for the Suppression of Acts of Nuclear Terrorism, 2445 U.N.T.S. 89; International Convention for the Suppression of the Financing of Terrorism, 2178 U.N.T.S. 197; International Convention for the Suppression of Terrorist Bombings, 2149 U.N.T.S. 256; Convention on the Safety of United Nations and Associated Personnel, 2051 U.N.T.S. 363; Convention on the Marking of Plastic Explosives for the Purpose of Detection, I.C.A.O. Doc. 9571; Protocol for the Suppression of Unlawful Acts of Violence at Airports Serving International Civil Aviation, I.C.A.O. Doc. 9518; Convention for the Suppression of Unlawful Acts against the Safety of Civil Aviation, 974 U.N.T.S. 177; Protocol for the Suppression of Unlawful Acts against the Safety of Fixed Platforms Located on the Continental Shelf, 1678 U.N.T.S. 304; Convention for the Suppression of Unlawful Acts against the Safety of Maritime Navigation, 1678 U.N.T.S. 201; Convention on the Physical Protection of Nuclear Material, 1456 U.N.T.S. 101; International Convention against the Taking of Hostages, 1316 U.N.T.S. 205; Convention on the Prevention and Punishment of Crimes against Internationally Protected Persons, Including Diplomatic Agents, 1035 U.N.T.S. 167; Convention for the Suppression of Unlawful Seizure of Aircraft, 60 U.N.T.S. 105; Convention on Offences and Certain Other Acts Committed on Board Aircraft, 704 U.N.T.S. 219.

6. Association of South East Asian Nations, ASEAN Convention on Counter Terrorism; Council of Europe, Convention on the Prevention of Terrorism, C.E.T.S. No. 196; South Asian Association for Regional Cooperation, Additional Protocol to the SAARC Regional Convention on Suppression of Terrorism Convention, SAARC/SUMMIT.12/SC.29/27, Annex III; Organization of the African Union, Protocol to the OAU Convention on the Prevention and Combating of Terrorism, July 8, 2004; European Union, Protocol Amending the European Convention on the Suppression of Terrorism, C.E.T.S. No. 190; Council Framework Decision 2002/475 on Combating Terrorism, 2002 O.J. (L 164) 3 (EC); Organization of American States, Inter-American Convention Against Terrorism, June 3, 2002, AG/RES. 1840 (XXXII-O/02); Organization of the Islamic Conference, Convention of the Organization of the Islamic Conference on Combating International Terrorism, July 1, 1999, Annex to Resolution No. 59/26-P; Organization of African Unity, OAU Convention on the Prevention and Combating of Terrorism, June 14, 1999; Commonwealth of Independent States, Treaty on Cooperation among States members of the Commonwealth of Independent States in Combating Terrorism, June 4, 1999; League of Arab States, The Arab Convention on the Suppression of Terrorism, Apr. 22, 1998; South Asian Association for Regional Cooperation, SAARC Regional Convention on Suppression of Terrorism; European Convention on the Suppression of Terrorism, C.E.T.S. No. 090; Organization of American States, Convention to Prevent and Punish Acts of Terrorism taking the Form of Crimes

counterterrorism agreements. These include a raft of sectoral anti-terrorism treaties, covering, for example, hijacking and hostage taking, as well as nuclear terrorism, terrorist bombings, and terrorist financing.

Some international and domestic courts have addressed customary international law developments concerning terrorism. In 2011, the Appeals Chamber of the Special Tribunal for Lebanon, for instance, ruled that an international crime of terrorism has emerged as a rule of customary international law—at least in peacetime,⁷ though not yet in relation to situations of armed conflict.⁸

Security Council Anti-Terrorism Frameworks

In some key respects, the Security Council is at the apex of the international anti-

Against Persons and Related Extortion that are of International Significance, Feb. 2, 1971, O.A.S.T.S. No. 37.

7. Interlocutory Decision on the Applicable Law: Terrorism, Conspiracy, Homicide, Perpetration, Cumulative Charging, Case No. STL-11-01/I, Feb. 16, 2011, pp. 49–50, para. 85 (concluding “that a customary rule of international law regarding the international crime of terrorism, *at least in time of peace*, has indeed emerged.”) [italics original; footnote omitted]; *R v. Mohammed Gul* [2012] EWCA Crim 280 [35] (holding that “[t]here is, we think, no doubt that international law has developed so that the crime of terrorism is recognised in situations where there is no armed conflict.”). But see Kai Ambos and Anina Timmermann, “Terrorism and customary international law,” in *Research Handbook on International Law and Terrorism* 38 (ed. Saul, 2014) (concluding that “one may qualify terrorism, at best, as a particularly *serious transnational, treaty-based crime* that is on the brink of becoming a true international crime. [...] While the elements of terrorism have a solid basis in customary international law, their lack of precision is proof of the lack of consensus of the international community as to the details of the definition of an international crime of terrorism.”) [italics original].

8. The Appeals Chamber of the Special Tribunal for Lebanon has concluded that:

[A] customary rule is incipient (*in statu nascendi*) which also covers terrorism in time of armed conflict (or rather, the contention can be made that the current customary rule on terrorism is being gradually amended). It is plausible to envisage that state practice [...] may gradually solidify the view taken by so many States through Article 2(1)(b) of the Convention for the Suppression of Financing of Terrorism. If this occurs and State practice in addition extends such view to other manifestations of terrorism, one day the conclusion will be warranted that the customary rule currently in force has broadened so as to also embrace terrorism in time of armed conflict.

Interlocutory Decision on the Applicable Law: Terrorism, Conspiracy, Homicide, Perpetration, Cumulative Charging, Case No. STL-11-01/I, Feb. 16, 2011, p. 72, para. 109 [italics original; footnote omitted]. For the Tribunal’s definition of the international crime of terrorism in peacetime, *id.* at pp. 49–50, para. 85. The reasoning underlying this decision, however, has been criticized. See, e.g., Kai Ambos and Anina Timmermann, “Terrorism and customary international law,” in *Research Handbook on International Law and Terrorism* 36–38 (ed. Saul, 2014).

terrorism system.⁹ Delegated the capacity to decide binding security measures,¹⁰ the Council has authored an array of anti-terrorism resolutions that all U.N. member states must carry out.¹¹ The far-reaching obligations entailed in those decisions generally trump obligations under other international agreements.¹² A swelling counterterrorism bureaucracy helps implement these measures.¹³

The Global Counter-Terrorism Strategy, which the U.N. General Assembly adopted in 2006 and which it reaffirmed most recently in 2014, complements these Security Council resolutions.¹⁴ In the Strategy, all U.N. member states have agreed to a common strategic approach to fighting terrorism. That approach includes steps aimed at strengthening state capacity to counter terrorist threats and at better coordinating counterterrorism activities in the U.N. system.

General counterterrorism measures

Under the Resolution 1373 (2001) regime, the Security Council obliges member states to take diverse measures to combat terrorism.¹⁵ These obligations range from denying terrorists safe havens to inhibiting the flow of weapons to terrorists, from suppressing terrorism financing to refraining from supporting those involved in

9. See generally Kim Lane Scheppele, “The International Standardization of National Security Law and Policy,” 4 *JNSLP* 437 (2010) 446.

10. Article 24 Charter of the United Nations, June 26, 1945, 59 Stat. 1031 (UN Charter).

11. Article 25 UN Charter. In this section, we do not highlight all potentially relevant Security Council anti-terrorism resolutions but only those that may be most relevant to impartial medical care concerning terrorists.

12. Article 103 UN Charter. In the initial resolutions of the 1267 and 1373 regimes, the Security Council did not expressly require that states act in conformity with IHL in discharging the obligations entailed in the decisions. In later resolutions in both regimes—e.g., S.C. Res. 2161 (2014) and S.C. Res. 2129 (2013)—the Security Council reaffirms in preambles that states must act in accordance with their other international law obligations, including their IHL obligations, in taking steps to combat threats to international peace and security caused by terrorist acts and to combat terrorism.

13. See, e.g., Dustin A. Lewis (ed.), “International Counterterrorism Efforts: An Initial Mapping,” *United Nations Counterterrorism Efforts*, Harvard Law School Program on International Law and Armed Conflict, February 2015, available at <http://pilac.law.harvard.edu/united-nations-efforts-home> [<http://perma.cc/DAC3-L7K9>].

14. See, most recently, U.N.G.A., “The United Nations Global Counter-Terrorism Strategy Review,” Resolution, June 24, 2014, UN doc. A/RES/68/276, para. 2.

15. See, e.g., S.C. Res. 1373 (2001), paras. 1–2.

terrorist acts.¹⁶ The Security Council established the Counter-Terrorism Committee and, later, the Counter-Terrorism Executive Directorate to help implement this cluster of resolutions.¹⁷

Resolution 1373 imposes an obligation to ensure that any person who participates in the financing, planning, preparation, or perpetration of terrorist acts is brought to justice.¹⁸ This obligation expressly encompasses *any person who participates in “supporting” terrorist acts*.¹⁹

States must ensure, moreover, that terrorist acts are established as serious criminal offenses in domestic laws and regulations and that the punishment of those acts duly reflects their seriousness.²⁰ Member states are thus required to bring their domestic legislation into conformity with these Council decisions. By imposing those obligations, the Security Council has been characterized as “legislating” a global net of legal interdiction.²¹

Sanctions against (associates of) al-Qaeda

A distinct, though sometimes overlapping,²² cluster of Security Council counterterrorism measures currently directed against al-Qaeda and its associates was born with Resolution 1267.²³ Previously, these measures were (also) directed

16. Id. at paras. 1(a) and 2(a) and (c).

17. The Counter-Terrorism Committee was established to monitor implementation and to receive state reports. S.C. Res. 1373 at para. 6. The Counter-Terrorism Executive Directorate was established pursuant to S.C. Res. 1535 (2004), para. 2.

18. S.C. Res. 1373 (2001), para. 2(e).

19. Reaffirmed in S.C. Res. 2178 (2014), para. 6.

20. S.C. Res. 1373 (2001), para. 2(e); see also S.C. Res. 2178 (2014), para. 6.

21. The Council has been characterized, in particular with respect to Resolution 1373, as thus taking the “first step” into “unexplored legal territory.” Erling Johannes Husabø and Ingvid Bruce, *Fighting Terrorism Through Multilevel Criminal Legislation: Security Council Resolution 1373, the EU Framework Decision on Combatting Terrorism and their Implementation in Nordic, Dutch and German Criminal Law* 39 (2009) (concluding that “Resolution 1373 satisfies even the strictest definition of international legislation. The Security Council thereby took a first step into what Szasz in 1995 called ‘unexplored legal territory’: to take ‘general legislative decisions as distinguished from those that relate to a particular dispute or situation’.” Id. [citation and reference omitted; hereinafter, Husabø and Bruce, *Fighting Terrorism*]. See generally Paul C. Szasz, “The Security Council Starts Legislating,” 96 *AJIL* 901 (2002).

22. E.g., S.C. Res. 2133 (2014); S.C. Res. 2170 (2014); S.C. Res. 2178 (2014).

23. S.C. Res. 1267 (1999).

against individuals and entities associated with the Taliban.²⁴ Nearly two-dozen resolutions have followed in its path.²⁵ These decisions oblige member states to impose an asset freeze, an arms embargo, and a travel ban on designated individuals and entities associated with al-Qaeda.²⁶ The al-Qaeda Sanctions Committee, which is supported by the Analytical Support and Sanctions Monitoring Team, designates individuals and entities for inclusion on the list.²⁷ An Ombudsperson receives requests from designees seeking to be removed from the list and makes (non-binding) recommendations for retaining the listing or for de-listing.²⁸

The Council's definition of what constitutes being "associated with" al-Qaeda is strikingly broad. As could be expected, the concept encompasses traditionally recognized offenses, such as selling arms to and recruiting for al-Qaeda.²⁹ Yet, in

24. Security Council Resolutions 1988 (2011) and 1989 (2011) bifurcated the monitoring and sanctions regimes, with the former applying to the Taliban (and associated individuals, groups, undertakings, and entities) and the latter applying to al-Qaeda (and associated individuals, groups, undertakings, and entities). We focus on (associates of) al-Qaeda and not on (associates of) the Taliban here for two reasons. First, the Security Council considers (associates of) al-Qaeda as a threat to international peace and security, while (associates of) the Taliban are considered, as of Resolution 1988, a threat to the peace and security of Afghanistan. S.C. Res. 1989 (2011), preamble; S.C. Res. 1988 (2011), para. 1. Second, while the Taliban is designated a terrorist group by some states (such as Canada), al-Qaeda and its associates are designated as terrorists in far more jurisdictions.

25. S.C. Res. 1333 (2000); S.C. Res. 1363 (2001); S.C. Res. 1388 (2002); S.C. Res. 1390 (2002); S.C. Res. 1452 (2002); S.C. Res. 1455 (2003); S.C. Res. 1456 (2003); S.C. Res. 1526 (2004); S.C. Res. 1617 (2005); S.C. Res. 1699 (2006); S.C. Res. 1730 (2006); S.C. Res. 1732 (2006); S.C. Res. 1735 (2006); S.C. Res. 1822 (2008); S.C. Res. 1904 (2009); S.C. Res. 1989 (2011); S.C. Res. 2083 (2012); S.C. Res. 2161 (2014); S.C. Res. 2170 (2014); S.C. Res. 2178 (2014); S.C. Res. 2199 (2015).

26. S.C. Res. 2161 (2014), para. 1; S.C. Res. 2178 (2014), para. 8. The asset freeze on (associates of) al-Qaeda expressly applies to the payment of ransoms to designees, irrespective of how or by whom the ransom is paid. S.C. Res. 2161 (2014), para. 7.

27. S.C. Res. 1267 (1999), paras. 4(a)(b), 6, and 8. The most recent resolution in this line of decisions is S.C. Res. 2161 (2014). Concerning the scope of the 1267/1989 arms embargo, asset freeze and travel ban, see Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, *Assets Freeze: Explanation of Terms*, February 24, 2015; Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, *Arms Embargo: Explanation of Terms*, February 24, 2015; Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, *Travel Ban: Explanation of Terms*, February 24, 2015.

28. S.C. Res. 1904 (2009), paras. 20–21; S.C. Res. 1989 (2011), paras. 21–23; S.C. Res. 2161 (2014), para. 41.

29. S.C. Res. 1617 (2005), para. 2; reaffirmed in S.C. Res. 1822 (2008), para. 2; S.C. Res. 1904 (2009), para. 2; S.C. Res. 1989 (2011), para. 4; S.C. Res. 2083 (2012), para. 2; S.C. Res. 2161 (2014), para. 2. See also S.C. Res. 2178 (2014), paras. 7 and 20.

a residual category, the concept also expressly sweeps in “*otherwise supporting acts or activities*” of al-Qaeda.³⁰ The definition is not limited to providing support to al-Qaeda as such; it also extends to providing support to “*any cell, affiliate, splinter group or derivative*” of al-Qaeda.³¹

Currently, the Security Council al-Qaeda sanctions list includes 229 individuals and 71 entities.³² Many of those designees are involved in armed conflicts. The territories listed as the addresses or operations bases for entities designated under this regime stretch across over 30 states.³³ These Security Council-designated associates of al-Qaeda are diverse. They range, for example, from the Abu Sayyaf Group in the Philippines; to ISIS in Syria and Iraq; to the Eastern Turkistan Islamic Movement in Afghanistan, China, and Pakistan; to the *Mouvement pour l’Unification et le Jihad en Afrique de l’Ouest* in Algeria, Mali, and Niger.

Collateral counterterrorism resolutions

In addition to the measures under the al-Qaeda-sanctions and 1373 regimes, the Security Council combats terrorism collaterally in other clusters of resolutions. For instance, al-Shabaab is designated not only under the al-Qaeda sanctions regime but also as part of the Somalia arms embargo.³⁴ The Council has also, for example,

30. S.C. Res. 1617 (2005), paras. 2 [*italics added*] and 3; reaffirmed in S.C. Res. 1822 (2008), paras. 2(d) and 3; S.C. Res. 1904 (2009), para. 2(d) and 3; S.C. Res. 1989 (2011), para. 4(c) and 5; S.C. Res. 2083 (2012), para. 2(c) and 3; S.C. Res. 2161 (2014), para. 2(c) and 4. See also S.C. Res. 2178 (2014), paras. 7 and 20; S.C. Res. 2214 (2015), para. 5.

31. S.C. Res. 1617 (2005), para. 2 [*italics added*]; reaffirmed in S.C. Res. 1822 (2008), para. 2; S.C. Res. 1904 (2009), para. 2; S.C. Res. 1989 (2011), para. 4; S.C. Res. 2083 (2012), para. 2; S.C. Res. 2161 (2014), para. 2. See also S.C. Res. 2178 (2014), para. 20.

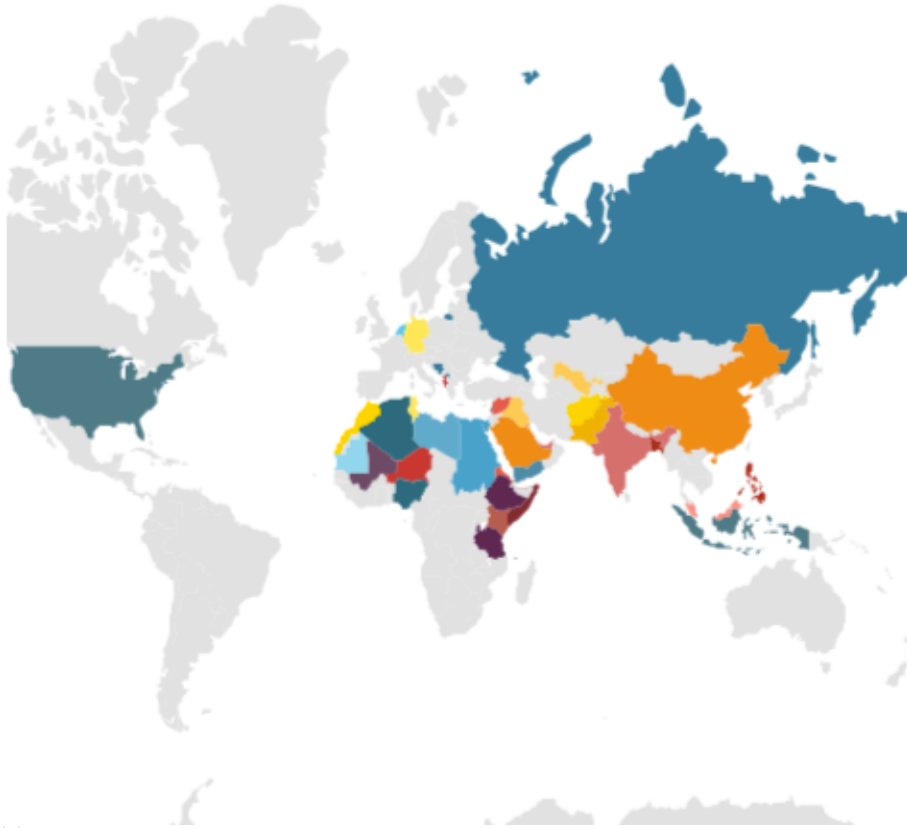
32. Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, “The List established and maintained by the Committee pursuant to resolutions 1267 (1999) and 1989 (2011) with respect to individuals, groups, undertakings and other entities associated with Al-Qaida,” available at http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml [<http://perma.cc/S8KN-7WLJ>], last updated on August 6, 2015.

33. Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, “The List established and maintained by the Committee pursuant to resolutions 1267 (1999) and 1989 (2011) with respect to individuals, groups, undertakings and other entities associated with Al-Qaida,” available at http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml [<http://perma.cc/S8KN-7WLJ>], last updated on August 6, 2015.

34. The 1844 List established and maintained by the Committee pursuant to resolutions 751/1907 (2009) with

Map 1

Listed Locations of Security Council-designated Terrorist



Map 1: Territories listed by the Security Council al-Qaeda Sanctions Committee as the *address* or *operational area* of a *designated entity or organization* (*not* of designated individuals). Source: Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, “The List established and maintained by the Committee pursuant to resolutions 1267 (1999) and 1989 (2011) with respect to individuals, groups, undertakings and other entities associated with Al-Qaida,” available online at: http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml [<http://perma.cc/S8KN-7WLJ>], last updated on August 6, 2015.

requested the U.N. Multidimensional Integrated Stabilization Mission in Mali (MINUSMA) to pass information to the al-Qaeda Sanctions Committee and the Analytical Support and Sanctions Monitoring Team.³⁵

respect to individuals, entities, groups, or undertakings, available at http://www.un.org/sc/committees/751/sanctions_list.shtml [<http://perma.cc/5W8V-CLA5>].

35. S.C. Res. 2164 (2014), para. 18.

Exemptions and limiting conditions

The two main clusters of Security Council counterterrorism resolutions outlined above—the 1373 and 1267/1989 regimes—contain some exemptions and saving clauses. These limitations are of either a broad or a specific character. An example of the former is where the Council recalls states’ general obligation to comply with all “relevant” bodies of international law in countering terrorism. And an example of the latter is where the Council stipulates expressly that states must discharge a *particular* counterterrorism obligation in conformity with IHL. Only with respect to two specific counterterrorism obligations—prohibiting incitement to terrorist acts and suppressing certain forms of support to foreign terrorist fighters—has the Council expressly required that member states act consistently with IHL.³⁶

Over all, these broad and specific limitations do not effectively exempt protections for impartial wartime medical care for terrorists from the reach of the sanctions. To recall, such protection would be offered at least under some IHL sources under some conditions. Understanding why these Security Council measures do not provide such effective exemptions requires digging into the text of the resolutions as well as the listed bases for designating associates of al-Qaeda.

At the most general level, the Security Council recognizes that effective counterterrorism measures and respect for human rights, fundamental freedoms, and the rule of law are “complementary and mutually reinforcing.”³⁷ It considers the latter protections an “essential part” of successful counterterrorism efforts.³⁸ The Council even recognizes that failure to comply with these and other international obligations is a factor that contributes to increased radicalization and fosters a sense of impunity.³⁹

At times, moreover, the Security Council has reaffirmed the need to combat—in accordance with IHL and IHRL—threats to international peace and security caused

36. As well as IHRL and IRL. S.C. Res. 2178 (2014), para. 5. See also S.C. Res. 1624 (2005), para. 4.

37. S.C. Res. 2170 (2014), preamble; S.C. Res. 2178 (2014), preamble.

38. S.C. Res. 2214 (2015), para. 6; S.C. Res. 2170 (2014), preamble; S.C. Res. 2178 (2014), preamble.

39. S.C. Res. 2178 (2014), preamble.

by terrorist acts.⁴⁰ The simultaneous references to both bodies of international law illustrate the hybrid war-and-policing model underpinning the Council's approach to counterterrorism. Less frequently, the Council has expressly reaffirmed that member states must ensure that any measures taken to combat terrorism, including the obligations in the relevant resolution, comply with their IHL obligations.⁴¹ Yet the Council makes almost all of these references to IHL in preambular recitals. Of those IHL references that are in operative paragraphs, *none* directly conditions the respective resolution's provision on impermissible "support" for terrorism.⁴²

The Security Council has clarified that the al-Qaeda asset freeze does not apply to funds that the relevant state has determined to be necessary for basic expenses—such as "medicines and medical treatment"—of the designee.⁴³ Yet, somewhat paradoxically, in principle a person who *provides medical care or medical supplies to someone associated with al-Qaeda or any of its derivatives* remains susceptible to designation herself to the extent such care constitutes "otherwise supporting" al-Qaeda.⁴⁴

To be clear, no individual or entity is listed under the Security Council's al-Qaeda sanctions based solely on engaging in medical activities. But alongside more traditional grounds for a terrorist designation—such as funding those associated

40. As well as in accordance with the U.N. Charter, IHRL, and IRL. S.C. Res. 1822 (2008), preamble; S.C. Res. 1904 (2009), preamble; S.C. Res. 1989 (2011), preamble; S.C. Res. 2083 (2012), preamble; S.C. Res. 2161 (2014), preamble; S.C. Res. 2170 (2014), preamble; S.C. Res. 2199 (2015), preamble. See also S.C. Res. 1456 (2003), Annex: Declaration on the issue of combating terrorism.

41. As well as other international law obligations. S.C. Res. 2170 (2014), preamble; S.C. Res. 2178 (2014), preamble; S.C. Res. 2214 (2015), para. 6.

42. As noted above, only with respect to two of these specific counterterrorism obligations—prohibiting incitement to terrorist acts and suppressing certain forms of support to foreign terrorist fighters—has the Council expressly required that member states act consistently with IHL (as well as with IHRL and IRL). S.C. Res. 2178 (2014), para. 5; S.C. Res. 1624 (2005), para. 4.

43. S.C. Res. 1452 (2002), para. 1(a). Also, the Security Council required member states to exempt certain humanitarian organizations from sanctions imposed against, among others, al-Shabaab; that exemption was imposed not as part of the al-Qaeda sanctions regime but rather as part of the sanctions regime concerning Eritrea and Somalia. S.C. Res. 1916 (2010), para. 5; S.C. Res. 1972 (2011), para. 4.

44. S.C. Res. 1617 (2005), paras. 2 [italics added] and 3; reaffirmed in S.C. Res. 1822 (2008), paras. 2(d) and 3; S.C. Res. 1904 (2009), para. 2(d) and 3; S.C. Res. 1989 (2011), para. 4(c) and 5; S.C. Res. 2083 (2012), para. 2(c) and 3; S.C. Res. 2161 (2014), para. 2(c) and 4. See also S.C. Res. 2178 (2014), paras. 7 and 20; S.C. Res. 2214 (2015), para. 5.

with al-Qaeda—the Sanctions Committee has referenced medical activities as a part of a basis for listing two individuals and two entities:

- In addition to co-founding, serving as second-in-command of, and recruiting and financing for Lakshar-e-Tayyiba/Jamaat-ud-Dawa (LeT/JuD) (among other things), Zafar Iqbal was *the president of the LeT/JuD “medical wing”*;⁴⁵
- In addition to being a leader of the Rajah Solaiman Movement and planting a bomb in Manila Bay that killed over 100 people and wounded hundreds more on February 27, 2004 (among other things), Redendo Cain Dellosa *provided medical supplies to members of the Abu Sayyaf Group*;⁴⁶
- In addition to providing financial and logistical support and arranging travel for (associates of) al-Qaeda (among other things), the al-Akhtar Trust International was *“secretly treating wounded members of Al-Qaida [...] at the medical centers it was operating in Afghanistan and Pakistan”*;⁴⁷ and
- In addition to providing financial and other assistance to, and receiving funding from, individuals associated with al-Qaeda

45. Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, “Narrative Summaries for Reasons for Listing: QDi.308 ZAFAR IQBAL,” available at <http://www.un.org/sc/committees/1267/NSQDi308E.shtml> [<http://perma.cc/938L-84UK>] [italics added].

46. Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, “Narrative Summaries for Reasons for Listing: QDi.246 REDENDO CAIN DELLOSA,” available at <http://www.un.org/sc/committees/1267/NSQDi246E.shtml> [<http://perma.cc/YXP8-YCJ2>] [italics added].

47. Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, “Narrative Summaries for Reasons for Listing: QDe.121 AL-AKHTAR TRUST INTERNATIONAL,” available at <http://www.un.org/sc/committees/1267/NSQDe121E.shtml> [<http://perma.cc/ZB8U-MSGP>] [italics added]. See also U.S. Treasury Dep’t, “U.S. Designates Al Akhtar Trust: Pakistani Based Charity is Suspected of Raising Money for Terrorists in Iraq,” Press Release, October 14, 2003, available at <http://www.treasury.gov/press-center/press-releases/Pages/js899.aspx> [<http://perma.cc/F4NC-3N2F>] (noting as background information to the listing of the al-Akhtar Trust that “Operation Enduring Freedom, the military phase of the war against terrorism, began on October 7, 2001. The U.S. government has information that, as of mid-November [sic] 2001, the AL AKHTAR TRUST was secretly treating wounded Al Qaida members at the medical centers it was operating in Afghanistan and Pakistan.”).

(among other things), the Global Relief Foundation (GRF) had an employee who interacted with the Taliban—in particular, a GRF “*medical-relief coordinator*” traveled to Afghanistan and “*had dealings with Taliban officials* until the collapse of the Taliban regime.”⁴⁸

These references suggest that the Sanctions Committee and, by extension, its supervisory body—the Security Council itself—view *medical care and medical supplies as forms of impermissible support to al-Qaeda and its associates*.

Domestic Proceedings against Medical Caregivers

At the domestic level, states have developed wide-ranging criminal and civil penalties against providing various forms of support to terrorist organizations.⁴⁹ Domestic legislations often prohibit financial transactions with terrorists as well as providing (or conspiring or attempting to provide) material support or resources to terrorists.⁵⁰ Like the Security Council and sometimes at its behest, states also designate individuals and entities as terrorists or as being associated with terrorism. (Under the U.N. Charter, the decisions in the aforementioned resolutions act as a floor of obligations that states may build upon but not go below.) The scope and consequences of these listings vary between jurisdictions. A growing number of states also prescribe extraterritorial application of their municipal anti-terrorism laws.⁵¹ A rationale invoked to justify

48. Security Council Committee pursuant to resolutions 1267 (1999) and 1989 (2011) concerning Al-Qaida and associated individuals and entities, “Narrative Summaries for Reasons for Listing: QDe.091 GLOBAL RELIEF FOUNDATION (GRF),” available at <http://www.un.org/sc/committees/1267/NSQDe091E.shtml> [<http://perma.cc/QC76-RJHJ>] [italics added].

49. While not a focus of this report, some states also use forcible measures in responding to terrorist threats. For instance, where a state is deemed to have not met its responsibility to take sufficient steps to address threats of terrorism emanating from its territory, at least some states take the view that they may take forcible measures—even without specific Security Council authorization—to avert those perceived threats. Colombia, Israel, Turkey, and the United States are among those states that have invoked anti-terrorism justifications to engage in extraterritorial enforcement operations or uses of force abroad. See, e.g., Andrea Bianchi and Yasmin Naqvi, *International Humanitarian Law and Terrorism* 73–82 (2011).

50. For an overview of the anti-terrorism measures of major humanitarian donors, see Kate Mackintosh and Patrick Duplat, *Study of the Impact of Donor Counter-Terrorism Measures on Principled Humanitarian Action*, U.N. Office for the Coordination of Humanitarian Affairs and the Norwegian Refugee Council, July 2013, pp. 19–44.

51. See, e.g., Husabø and Bruce, *Fighting Terrorism*, supra note 21, at p. 447 (noting that Sweden, Finland, and

this claim of extraterritorial jurisdiction is the universal jurisdiction principle: acts of terrorism—wherever and against whomever they may be directed—threaten a global interest.⁵² States also address terrorism through administrative regulations, for instance by barring asylum for supporters of terrorism.⁵³ Finally, some states have adopted humanitarian exceptions to counterterrorism laws.⁵⁴ Others have not.

States have instituted legal proceedings for supporting terrorists through medical activities in the course of armed conflicts. In the rest of this sub-section, we describe such proceedings in Peru, Colombia, and the United States.⁵⁵ This sample illustrates

Norway apply a form of universal jurisdiction). 18 U.S.C. § 2339B antedates these Security Council resolutions and applies not only to the extraterritorial conduct of U.S. citizens but also to the extraterritorial conduct of non-nationals. 18 U.S.C. § 2339B(d) and § 2339B(d)(1)(A), (B), (C), and (D). See Charles Doyle, “Terrorist Material Support: An Overview of 18 U.S.C. 2339A and 2339B,” Congressional Research Service, July 19, 2010, pp. 13–14.

52. See, e.g., *Flatow v. Islamic Republic of Iran*, 999 F. Supp. 1, 23 (D.D.C. 1998) (observing that “terrorism has achieved the status of almost universal condemnation, as have slavery, genocide, and piracy, and the terrorist is the modern era’s *hosti humani generis*—an enemy of all mankind”).

53. U.S. law prohibits granting asylum to people who have engaged in terrorist activity. 8 U.S.C. § 1182. There is a limited exception concerning (only) certain forms of medically related material support to terrorism. U.S. Department of Homeland Security, Implementation of New Exemption Under INA Section 212(d)(3)(B)(i) for the Provision of Material Support in the Form of Medical Care, Policy Memorandum, PM-602-0052, November 20, 2011. But see Leonard S. Rubenstein, “Punishing Health Care Providers for Treating Terrorists,” *Hastings Center Report* 45, no. 4 (2015) 14.

54. See, e.g., Criminal Code [Canada], R.S.C. 1985, c. C-46, § 83.01(1) (providing that the definition of “terrorist activity” expressly “does not include an act or omission that is committed during an armed conflict and that, at the time and in the place of its commission, is in accordance with customary international law or conventional international law applicable to the conflict, or the activities undertaken by military forces of a state in the exercise of their official duties, to the extent that those activities are governed by other rules of international law.”); Terrorism Suppression Act 2002 (NZ) s 10(3) (providing, as an exception to the prohibition on making property, or financial or related services, available to designated terrorist entity that “[a]n example of making property available with a reasonable excuse, for the purposes of subsection (1), is where the property (for example, items of food, clothing, or medicine) is made available in an act that does no more than satisfy essential human needs of (or of a dependant of) an individual designated under this Act.”); [Australia] Criminal Code Act 1995 (Cth) s 102.8(4)(c) (providing that the section on the crime of associating with terrorist organizations “does not apply if: [...] the association is only for the purpose of providing aid of a humanitarian nature”), s 119.2(3)(a) (providing that the section on the crime of entering, or remaining in, declared areas “does not apply if the person enters, or remains in, the area solely for one or more of the following purposes: providing aid of a humanitarian nature”), s 119.4(7) (providing that the section on the crime of preparations for incursions into foreign countries for purpose of engaging in hostile activities “does not apply if the person engages in conduct solely by way of, or for the purposes of, the provision of aid of a humanitarian nature.”), and s 119.5(4) (providing that the section on the crime of allowing the use of buildings, vessels and aircraft to commit offences “does not apply if the person engages in conduct solely by way of, or for the purposes of, the provision of aid of a humanitarian nature.”).

55. Our use of the term “armed conflict” in this context is not meant to weigh in, with respect to the individual cases

some of the diverse legal and policy interests states pursue under counterterrorism frameworks in domestic systems. Of the states profiled, only Colombia recognized that IHL established protections (however limited) for medical care for terrorists with respect to the armed conflict at issue. In the surveyed Peruvian and U.S. cases, the available records suggest that no IHL-based arguments were raised during the domestic proceedings. (However, IHL was referenced in the Inter-American Court of Human Rights in the case involving Peru.⁵⁶)

Colombia

For about half a century, the government of Colombia has been fighting the Revolutionary Armed Forces of Colombia (FARC), a non-state armed group designated as a terrorist organization by Colombia and a number of other states.⁵⁷ At

to be outlined, on whether a particular situation amounted to an armed conflict under IHL.

Separately, as noted above, in the ongoing armed conflict in Syria, the government has reportedly invoked anti-terrorism laws to curtail medical support to opposition factions and their purported supporters. U.N. Human Rights Council, *Report of the independent international committee of inquiry on the Syrian Arab Republic*, U.N. doc. A/HRC/25/65, Feb. 12, 2014, para. 111 and Annex VII, “Assaults on Medical Care,” para. 21. Reports indicate that the anti-terrorism laws passed in July 2012 “effectively made it a crime to provide medical care to anyone suspected of supporting the rebels.” Aryn Baker, “Syria’s Health Crisis Spirals As Doctors Flee,” *Time Blog*, February 4, 2014, available at <https://time.com/3968/syrias-health-crisis-spirals-as-doctors-flee/> [<https://perma.cc/D3JW-98ZD>]. We have not, however, uncovered any domestic legal proceedings instituted in Syria against medical caregivers in relation to care for terrorists.

Finally, we reiterate that the institution of domestic proceedings appears to be under active consideration in Australia and the United Kingdom. See, e.g., Marga Zambrana and Emma Graham-Harrison, “American and Canadian among group of medics in Isis stronghold,” *The Guardian*, March 23, 2015, available at www.theguardian.com/world/2015/mar/23/american-canadian-maleeh-hamdoun-among-medics-group-isis-syria [<http://perma.cc/LX3S-DPKN>] (quoting the Home Office as saying, in respect of 11 medical school students—of American, British, and Canadian nationalities—who crossed into ISIS-controlled parts of Syria and who were believed to be working in hospitals there, that “even if they were in areas under Isis control, the medics would not automatically face prosecution under anti-terror laws if they tried to return to the UK, as long as they could prove they had not been fighting.”); Tim Williams and Sheradyn Holderhead, “Former Adelaide doctor Tareq Kamleh joins terror group ISIS, releases propaganda video,” *Sunday Herald Sun*, April 26, 2015, available at <http://www.adelaidenow.com.au/news/south-australia/former-adelaide-doctor-tareq-kamleh-joins-terror-group-isis-releases-propaganda-video/story-fni6uo1m-1227321062787> [<http://perma.cc/K8M6-4U9W>] (reporting that an Australian physician who travelled to Raqqa to provide medical care and who appeared in an “Islamic State video urging other medical professionals to travel to Syria and join the holy war against the West” could face up to 25 years’ imprisonment).

56. E.g., *De La Cruz-Flores v. Peru*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 115, para. 57(c) (Nov. 18, 2004) [hereinafter IACtHR, *De La Cruz-Flores v. Peru*].

57. See generally Felicity Szesnat and Annie R. Bird, “Colombia,” in *International Law and the Classification of*

various times, the FARC has exerted de facto control over territory in Colombia.⁵⁸

Medical assistance to the FARC implicates the definitional boundaries of the crime of rebellion under Colombian law. That crime prescribes punishment for “those who, through the use of arms, intend to overthrow the national government or remove or modify the existing constitutional or legal regime.”⁵⁹ The crime of rebellion “constitutes a permanent act, meaning that a person responsible for rebellion will be criminally liable for the whole duration of his or her membership of the armed group.”⁶⁰ As for the subjective element, “the person must have been *aware of the criminal purpose* of the group to overthrow the legally constituted government, and must have had the *intention* to contribute to it.”⁶¹

Prior to the state becoming a party to AP II, Colombian jurisprudence had specified that *medical care could fall under the criminal prohibition on rebellion* for being part of or collaborating with an armed group. The rationale underlying that position was that

acts of rebellion not only refer to armed confrontations with members of the Security Forces, to the point that this type of crime also *finds realisation in the mere belonging of the individual agent to the rebel group and, for this reason, a person may be assigned any activity, such as (...) medical care*, or any other activity that does not relate directly to the use of weapons but that *is a suitable instrument for the maintenance, strengthening or functioning of the rebel group*.⁶²

Conflicts 214–228 (ed. Wilmshurst, 2012).

58. *Id.*

59. Colombian Criminal Code, art. 467. In other words, the crime of rebellion “encompasses all kinds of acts that are directed at destabilising the state’s institutions.” Ekaterina Ortiz Linares and Marisela Silva Chau, “Reflections on the Colombian case law on the protection of medical personnel against punishment,” 95 *IRRC* 891 (2013) 259 [hereinafter, “Linares and Chau, *Colombian case law*”].

60. *Id.* at p. 261 (citing to Supreme Court of Justice of Colombia, Criminal Cassation Court, Case No. 19915, June 10, 2005, p. 29).

61. *Id.* at p. 261 (citing to Higher Tribunal of the Northern Judicial District of Santander, Criminal Decision Chamber, Ordinary Condemnatory Sentence, second instance, Case No. 54-498-31-04-002-2007-00111-01, July 9, 2009) [italics added].

62. Linares and Chau, *Colombian case law*, supra note 59, at p. 260 [italics added] (citing Supreme Court of Justice

However, once Colombia became a party to AP II, in 1995, this *prohibition on medical care became legally invalid*. That is, the domestic law prohibition on medical care, previously an objective element of the crime of rebellion, was displaced with the ratification of AP II.⁶³ (Recall that AP II imposes an obligation not to punish any person for carrying out medical activities compatible with medical ethics, regardless of who may benefit from those activities.⁶⁴)

In 2007, the Plenary Chamber of Colombia's Constitutional Court held that the obligation in AP II to respect medical duties "has attained customary status, mainly due to its impact on State practice and on conflicts in the last decades."⁶⁵ That holding aligns with the view that, under Colombian law, in the context of the NIAC between the government and the FARC, "the crime of rebellion should not include *the mere provision of medical services to members of the armed group that may require it [...]*."⁶⁶ Yet where a physician provides medical services to members of the FARC "with a *continuous and permanent intention to overthrow the existing government*, then he could be held criminally liable for an act of rebellion."⁶⁷

Colombian jurisprudence has addressed that distinction in interpreting the scope of permissible medical care for the FARC. In a recent case, a medical professional provided medical and surgical services to members of the FARC. That professional also managed the FARC patients sent to a hospital in Bogotá, referring them to specialized clinics based on their medical condition.⁶⁸ The Colombian Supreme Court of Justice upheld the conviction. The Court reasoned that those *referral services*

of Colombia, Criminal Cassation Chamber, Case No. 7504, August 12, 1993, as cited in Supreme Court of Justice of Colombia, Criminal Cassation Chamber, Case No. 33558, July 7, 2010, p. 25.).

63. Id.

64. Article 10(1) AP II.

65. ICRC, *CIHLS*, Practice Relating to Rule 26, Online edition, available at https://www.icrc.org/customary-ihl/eng/docs/v2_rul_rule26_sectionb [<https://perma.cc/PXS8-HDWH>] (citing to Constitutional Court, Constitutional Case No. C-291/07, Judgment, April 25, 2007).

66. Linares and Chau, *Colombian case law*, supra note 59, at p. 262.

67. Id.

68. Id. at pp. 262–63 (quoting Supreme Court of Justice of Colombia, Criminal Cassation Chamber, Case No. 27227, May 21, 2009, p. 3).

fell outside of the scope of medical activities protected by IHL (as incorporated into Colombian law) and into the crime of rebellion.⁶⁹

This decision has been criticized for meeting neither the objective nor the subjective elements of the crime of rebellion.⁷⁰ The chief criticism concerning the former is that “the activity itself has been classified as being part of the health-care professional’s medical activities, and hence protected by IHL.”⁷¹ The criticisms concerning the subjective element are two-fold. First, “the mere remission to legally constituted clinics and hospitals does not prove in itself the criminal purpose of intentionally aiming to overthrow the legally constituted government.”⁷² And second, even where she knows of her patient’s membership in a criminal group, the health-care provider does not have the obligation to denounce it under Colombia law.⁷³ Rather, under Colombian law, the obligation to denounce the commission of crimes by individuals is limited to crimes of “great social impact,” such as genocide and torture.⁷⁴

Peru

In the 1980s and 1990s, a NIAC pitted the government of Peru against multiple opposition groups.⁷⁵ One of those groups was a Maoist-inspired rebel faction, the Shining Path, which the government of Peru—as well as others, such as the United States—considered a terrorist organization. Alongside engaging in hostilities against

69. In the eyes of the Court, “the medical activities performed by the accused, even though they had *no relation with the armed confrontation, strengthened the guerrilla group* since healed members of the group would *subsequently return to fight* against the government armed forces.” Id. at p. 263 (citing to Supreme Court of Justice of Colombia, Criminal Cassation Chamber, Case No. 27227, May 21, 2009, p. 12) [italics added].

70. Id. at p. 263.

71. Id.

72. Id.

73. Id.

74. Id. (citing to Colombian Criminal Code, art. 441).

75. Peru Truth and Reconciliation Commission, *Final Report*, Vol. VIII, “General Conclusions,” (English ed., May 2014), p. 331 available at https://www.ictj.org/sites/default/files/ICTJ_Book_Peru_CVR_2014.pdf [<https://perma.cc/Y3JY-W2FA>].

the Shining Path, Peru instituted legal proceedings against individuals for providing various resources and services to, or collaborating with, the Shining Path.⁷⁶

Amid the armed conflict, in July 1989, Peru became a party to AP II.⁷⁷ Recall that AP II prohibits punishing anyone who carries out medical activities compatible with medical ethics, regardless of who benefits therefrom.

Peru prosecuted physicians on terrorism-related offenses for supporting the Shining Path at least in part through medically related activities. Dr. María De La Cruz-Flores was one such physician. On March 27, 1990, a security guard detained Dr. De La Cruz-Flores at her clinic. A man allegedly tried to attach “*pegatinas*” (flyers or stickers) “inciting the population to an armed strike on March 28, 1990”—purportedly convened by the Shining Path—“to the walls of one of the washrooms on the third floor” of the clinic. Dr. De La Cruz-Flores allegedly covered up for that man by saying that he was her patient and that his package was hers.⁷⁸ In connection with those allegations, Dr. De La Cruz-Flores was kept in detention until July 26, 1990, when her unconditional liberty was granted. A May 18, 1992 judgment reissued orders for her arrest.⁷⁹ Those orders were apparently not acted upon, however, for over half a decade.

By then, Dr. De La Cruz-Flores had already been convicted, on other grounds, for *the crime of terrorism in the form of acts of collaboration*. That conviction arose out of an order issued in 1995 to open the pre-trial investigation against Dr. De La Cruz-Flores and others. In that order, a criminal court in Lima stated, among other things,

76. IACtHR, *De La Cruz-Flores v. Peru*, supra note 56, at para. 73(34) (noting proceedings against at least four other physicians on terrorism-related offenses). See also *id.* at para. 74(gg) (stating that the IACmHR indicated that “[i]n January 1999, the National Corporative Chamber for Cases of Terrorism acquitted two physicians charged with the crime of terrorism, because it concluded that the mere testimony of one or more ‘*arrepentidos*’ [repentant terrorism or treason convict] was insufficient grounds for a conviction. It acknowledged that the behavior of these physicians was in keeping with the ethics and legality of their professional activities; [...].”).

77. ICRC, States parties to Additional Protocol II, available at https://www.icrc.org/applic/ihl/ihl.nsf/States.xsp?xp_viewStates=XPages_NORMStatesParties&xp_treatySelected=475 [<https://perma.cc/H7EM-WRAQ>].

78. IACtHR, *De La Cruz-Flores v. Peru*, supra note 56, at para. 73(8).

79. *Id.* at para. 73(33).

that the defendants

were members of the Peruvian Community Party ([Shining Path]), and had provided medical attention, treatment and operations, supply of medicines and medical instruments for the care of criminal terrorist[s];] acts [that] constitute the crime established and penalized in Article 4 of Decree Law No. 25,475 [crime of terrorism in the category of acts of collaboration].⁸⁰

After making its way through the system,⁸¹ the case against Dr. De La Cruz-Flores came before the Special Criminal Chamber of the Lima Superior Court of Justice. The Chamber was a “faceless” tribunal, in the sense that the identities of the judges were not made known to the defendant.

In its November 21, 1996 judgment in the proceedings against Dr. De La Cruz-Flores, that tribunal considered that:

“[The case file] contained documentation from 1992 [...], which implicated the defendant, and in which she appears with the alias ‘Elíana’; one of these documents refers not only to meetings with the defendant, but there is also an analysis of her doctrinal and ideological evolution within the organization; *there are descriptions of talks [...] she has given, as a physician; that she has taken part in an operation as the assistant surgeon, and of problems within the health sector*, all of which has been corroborated [...] by the defendant, Elisa Mabel Mantilla Moreno, who, in the presence of the Prosecutor states that, on one occasion, she met with María Teresa De la [sic] Cruz on the orders of her ‘handler,’ to coordinate several matters; [...] the same defendant

80. Id. at para. 73(20) [citation omitted].

81. Based on available materials, while Peru had at this point become party to AP II, that Protocol does not seem to be incorporated into the proceedings. Two prosecutors, however, issued reports in Dr. De La Cruz-Flores’s favor. One report stated that her criminal liability had not been proved, and the other suggested to the criminal chamber that there were no grounds for a trial because Dr. De La Cruz-Flores’s “participation [...] had consisted in providing medical care to militants.” Id. at para. 73(20) [citation omitted]. The Special Terrorism Chamber of the Lima Supreme Court did not admit either of those prosecutors’ reports, however, and decided instead to submit the case to the Supreme Criminal Prosecutor. Id. at para. 73(24).

[...] accuses her of being one of the supportive elements responsible for providing treatment and performing operations; [...] accuses her of participating in an operation on 'Mario' whose hand had been burned, which corroborates the foregoing; namely, that she took part as assistant surgeon in a skin-grafting operation; and that it is evident that the defendant has denied this during the proceeding so as to elude her criminal liability, which has been adequately proved.”⁸²

Partly on that basis, the Tribunal convicted Dr. De La Cruz-Flores on the charge of the *crime of collaboration with terrorists*⁸³ and sentenced her to 20 years' imprisonment.⁸⁴ Another court confirmed that judgment on June 8, 1998.⁸⁵

Less than a year later, the charges stemming from the 1990 incident regarding the “*pegatinas*” reemerged. Based on that incident, on March 4, 1999, a court convicted Dr. De La Cruz-Flores of the *unlawful association crime of terrorism* and sentenced her to 10 years' imprisonment.⁸⁶ However, a judgment of June 15, 2000 decreed an annulment of Dr. De La Cruz-Flores's conviction for the *unlawful association crime of terrorism*. The annulment was due to the concurrence of criminal proceedings with the 1996 conviction for the *unlawful collaboration crime of terrorism*.⁸⁷

The government continuously detained Dr. De La Cruz-Flores from March 27, 1996 to July 9, 2004, when she was conditionally released. By then, the armed conflict involving the Shining Path had ended. Yet terrorism-related proceedings

82. Id. [italics added; citation omitted]. On July 1, 2004, as noted by the IACtHR, “at the request of the alleged victim's [Dr. De La Cruz-Flores's] defense lawyer and for the first time during the proceeding, a confrontation procedure was conducted between the alleged victim and Jacqueline Aroni Apcho, she said that Mrs. De La Cruz Flores [sic] was not 'Elíana', that she did not know Mrs. De La Cruz Flores, that she did not recall the physical characteristics of 'Elíana' and that she did not know the latter's real name. Moreover, two other testimonial statements made by individuals [...] stated that 'they did not know' María Teresa De La Cruz Flores.” Id. at para. 73(46) [citation omitted].

83. The relevant law defines such prohibited acts of collaboration as including “[t]he ceding or use of any type of accommodation or other means which could be used to [...] serve as a deposit for [...] provisions, medicines, and other belongings related to terrorist groups or their victims.” Id. at para. 85.

84. Id. at para. 73(27).

85. Id. at para. 73(29).

86. Id. at para. 73(32).

87. Id. at para. 73(10)–(11).

against Dr. De La Cruz-Flores continued after her conditional release.⁸⁸

Dr. De La Cruz-Flores pursued her case in the Inter-American Commission of Human Rights, which referred it to the Inter-American Court of Human Rights (IACtHR). Less than five months after her conditional release, that Court found that Peru's proceedings against and its treatment of Dr. De La Cruz-Flores had violated numerous rights under the *American Convention on Human Rights* (ACHR).⁸⁹ In particular, Peru had violated the right to freedom from *ex post facto* laws; the right to personal liberty; the right to a fair trial; and the right to humane treatment.⁹⁰

Much of the Court's judgment turns on its holding that Peru had violated the *principle of legality*. That principle requires a person to be informed with sufficiently advanced and sufficiently specific notice of what acts and omissions are penalized before that person can be punished.

To understand the Court's holding, it is important to recall the domestic anti-terrorism judgments against Dr. De La Cruz-Flores. She was convicted in 1996 for the crime of *unlawful collaboration with terrorists* and in 1999 for the crime of *unlawful association with terrorists* (annulled in 2000). She was *not* convicted for *membership in a terrorist organization* nor for *failing to report possible terrorist acts*. Peru, however, argued at the IACtHR, that "[t]he grounds for the judgment [against Dr. De La Cruz-Flores] have been duly explained and 'it can be seen clearly that the defendant has been convicted for [*belonging to the Shining Path*]'."⁹¹

According to the IACtHR, Peru had, in its November 21, 1996 judgment

88. Id. at para. 73(49)–(50).

89. American Convention on Human Rights, November 22, 1969, 1144 U.N.T.S. 123 (ACHR).

90. IACtHR, *De La Cruz-Flores v. Peru*, supra note 56, at paras. 103, 109, 114, 136, and 188. The Court found that Peru had violated the right to humane treatment to the detriment not only of Dr. De La Cruz-Flores but also her next of kin: her children, her mother, and her siblings. Id. at para. 136.

91. Id. at para. 76(d) [italics added]. That is, in its proceedings in front of the Court, Peru suggested that what was at stake was Dr. De La Cruz-Flores's purported *membership* in the Shining Path (which was a stand-alone crime), as well as her failure to report possible terrorist acts, even though she had been convicted of different crimes. Id. at paras. 87–88.

convicting Dr. De La Cruz-Flores of the crime of *unlawful collaboration with terrorists*,

violated the principle of legality: by taking into account as elements that gave rise to criminal liability, membership in a terrorist organization and failure to comply with the reporting obligation, but only applying an article that did not define these behaviors; by not specifying which of the behaviors established in article 4 of Decree Law No. 25,475 [prohibiting the crime of terrorism of acts of collaboration] had been committed by the alleged victim in order to be found guilty of the crime; *for penalizing a medical activity, which is not only an essential lawful act, but which it is also the physician's obligation to provide; and for imposing on physicians the obligation to report the possible criminal behavior of their patients, based on information obtained in the exercise of their profession.*⁹²

Part of the Court's holding that Peru violated Dr. De La Cruz-Flores's right to freedom from ex post facto laws is thus grounded in the penalization of medical activities.⁹³ The Court—whose jurisdiction comprises cases concerning the interpretation and application of the ACHR⁹⁴—did not apply the relevant provisions of IHL as a matter of law. In dicta, however, the Court did recall (“for information only”) the provision in GC I stipulating that no one may be molested or convicted for having treated the wounded or sick in armed conflict. It also recalled in dicta the provisions in AP I and AP II prohibiting the punishment of any person for carrying

92. Id. at para. 102.

93. Id. at para. 188(1) (citing to, among others, paras. 90–93 [concerning penalization of medical activities] in finding a violation of the right to freedom from *ex post facto* laws). In his separate opinion in the case, Judge Sergio García-Ramírez notes that

In brief, I consider that it is inadmissible – a consideration that coincides with the opinion of the Inter-American Court, as stated in the judgment in this case – to criminally penalize the conduct of a doctor who provides care designed to protect the health and life of other individuals, notwithstanding their characteristics, activities and beliefs, and the origin of their injuries or illnesses.

Judge Sergio García-Ramírez, Separate Opinion, *De La Cruz-Flores v. Peru*, supra note 65, at para. 13.

94. Article 62(3) ACHR.

out medical activities compatible with medical ethics in armed conflict.⁹⁵

With respect to medical care for terrorists in armed conflict, the IACtHR's judgment in *De La Cruz-Flores v. Peru* raises concerns over penalizing (otherwise) legitimate medical activities and compelling physicians to denounce their patients. The judgment also strikes strong cautionary notes about the need, at a minimum, for clarity in defining offenses related to wartime medical care for terrorists.

United States of America

The armed conflicts that gave rise to the anti-terrorism proceedings against medical professionals in Peru and Colombia occurred or are occurring primarily on the territory of the respective states. Those conflicts were or are of a non-international character (with the government engaged in hostilities against a non-state organized armed group).

The current U.S. administration considers the state to be engaged in an armed conflict with (or, at least, to otherwise be conducting military operations against) al-Qaeda, the Taliban, and “associated forces” in various territories around the world. As of March 2015, those publicly acknowledged locations included Afghanistan, Iraq, Libya, Somalia, and Yemen.⁹⁶ Thus, the Obama administration, like the Bush

95. IACtHR, *De La Cruz-Flores v. Peru*, supra note 56, at para. 95.

96. Stephen W. Preston, “The Legal Framework for the United States’ Use of Military Force Since 9/11,” Speech, Annual Meeting of the American Society of International Law, Washington, D.C., April 10, 2015 (stating that “the groups and individuals against which the U.S. military was taking direct action (that is, capture or lethal operations) under the authority of the 2001 AUMF, including associated forces. Those groups and individuals are: al-Qa’ida, the Taliban and certain other terrorist or insurgent groups in Afghanistan; al-Qa’ida in the Arabian Peninsula (AQAP) in Yemen; and individuals who are part of al-Qa’ida in Somalia and Libya. In addition, over the past year, we have conducted military operations under the 2001 AUMF against the Nusra Front and, specifically, those members of al-Qa’ida referred to as the Khorasan Group in Syria. We have also resumed such operations against the group we fought in Iraq when it was known as al-Qa’ida in Iraq, which is now known as ISIL.”); Harold Hongju Koh, “The Obama Administration and International Law,” Speech, Annual Meeting of the American Society of International Law, Washington, D.C., March 25, 2010 (stating that “as a matter of international law, the United States is in an armed conflict with al-Qaeda, as well as the Taliban and associated forces, in response to the horrific 9/11 attacks, and may use force consistent with its inherent right to self-defense under international law. As a matter of domestic law, Congress authorized the use of all necessary and appropriate force through the 2001 Authorization for Use of Military Force (AUMF).”).

administration before it, considers itself on a war footing (of sorts) with al-Qaeda and al-Qaeda's associated forces.

A majority of the U.S. Supreme Court reasoned, in its 2006 *Hamdan* decision, that the armed conflict between the state and al-Qaeda qualifies as a conflict not of an international character and is thus governed by Common Article 3.⁹⁷ The United States is not a party to AP I nor to AP II (it has signed both protocols but has ratified neither). Nor has it expressly indicated whether it considers all or some of the impartial medical-care provisions of those treaties to reflect customary rules of IHL binding in the ostensible armed conflict against al-Qaeda.⁹⁸ Since the United States suffered the attacks of September 11, 2001, few, if any, attacks have occurred on U.S. territory that may be considered under international law to form part of such an armed conflict. Thus most of the detention and lethal-force operations undertaken by the United States against al-Qaeda and its associated forces have taken place outside of U.S. territory.

A key element of the attempt by the United States to obviate terrorist threats is the use of lethal force against and the detention of al-Qaeda and its associated forces.⁹⁹ Another important element is instituting criminal proceedings against U.S. citizens and others for taking steps preparatory to or engaging in acts of support to terrorists. At times, those proceedings have been based on attempts to provide impermissible support to al-Qaeda or ISIS in the form of medically related activities (among others).¹⁰⁰ We highlight two such criminal proceedings below.

97. *Hamdan v. Rumsfeld*, 548 U.S. 557, 630–31, 126 S. Ct. 2749, 2795–96, 165 L. Ed. 2d 723 (2006).

98. For the first time, in June 2015, the U.S. Department of Defense (DoD) published, as an institutional publication, a manual on the law of war that reflects DoD-wide views, rather than those of a specific service or person. U.S. Department of Defense, *Law of War Manual* v (2015). With respect to NIACs, the 2015 *Manual* does not incorporate all of the AP II medical-care protections. For instance, it does not include the prohibition on punishment laid down in article 10(1) AP II. U.S. Department of Defense, *Law of War Manual* § 17.14–15 (2015).

99. Stephen W. Preston, “The Legal Framework for the United States’ Use of Military Force Since 9/11,” Speech, Annual Meeting of the American Society of International Law, Washington, D.C., April 10, 2015.

100. With respect to ISIS, see *U.S. v. Conley*, “Plea Agreement and Statement of Facts relevant to Sentencing,” Criminal Action No. 14-cr-00163-RM, D. Colo., September 10, 2014; *U.S. v. Conley*, Criminal Complaint and Affidavit, Case No. 14-mj-01045-KLM, D. Colo., April 9, 2014.

We also note a civil action that occurred between private parties and that raised some similar legal theories.

U.S. v. Sabir

The federal criminal proceedings against Dr. Rafiq Sabir—a New York-licensed physician specializing in emergency medicine—arose alongside the prosecution of other defendants, including his friend, Tarik Shah. On December 6, 2006, a grand jury returned a fourth superseding indictment against Dr. Sabir, charging him with violations of 18 U.S.C. § 2339B: namely, conspiring to provide, and providing and attempting to provide, “material support or resources” to al-Qaeda, a designated Foreign Terrorist Organization, in the form of “medical support to wounded jihadists.” (Section 2339B applies whether the conduct was committed within the United States or extraterritorially,¹⁰¹ and it applies irrespective of whether the violation is committed by a U.S. national or a non-national.¹⁰²)

In 2001, the Federal Bureau of Investigation (FBI) began an investigation of Shah.¹⁰³ The FBI was concerned about the possible transfer of money to insurgents in Afghanistan.¹⁰⁴ A confidential FBI informant known as “Saeed” cultivated a friendship with Shah. Shah was “recorded speaking openly about his commitment to *jihad* (holy war) in order to establish *Sharia* (Islamic law) and about his wish to provide ‘deadly and dangerous’ martial arts training to *mujahideen* (jihad warriors).”¹⁰⁵ During these conversations with an FBI informant, Shah identified Dr. Sabir as his “partner.”¹⁰⁶ On March 3, 2004, the informant and Shah traveled to Plattsburgh, New York. There, the informant introduced Shah to an undercover FBI agent, Ali Soufan, posing as a recruiter for al-Qaeda.¹⁰⁷

101. § 2339B(d).

102. § 2339B(d)(1)(A), (B), (C), (D).

103. *United States v. Farhane*, 634 F.3d 127, 132 (2d Cir. 2011).

104. *Id.* at p. 132.

105. *Id.* [citations omitted].

106. *Id.* [citations omitted].

107. *Id.* [citations omitted].

In a series of meetings, Shah “detailed his martial arts expertise and offered to travel abroad to train al Qaeda combatants. Shah also told Soufan about Sabir, ‘an emergency room doctor’ who had been his ‘trusted friend[]’ for more than 25 years.”¹⁰⁸ Shah “[e]xplain[ed] that he knew Sabir’s ‘heart,’ [and] proposed that the two men join al Qaeda as ‘a pair, me and a doctor.’”¹⁰⁹ Later, “[a]t a subsequent meeting with [the informant], Shah reported that he had spoken in person with Sabir about this plan.”¹¹⁰ In April 2004, “Shah and Agent Soufan next met in Orlando, Florida, [...] at which time Shah agreed to prepare a syllabus for a martial arts training course as well as a training video. Shah also questioned Soufan at this meeting about al Qaeda suicide bombings and asked whether he could receive, as well as provide, terrorist training.”¹¹¹

An appeals court summarized the set of facts underlying Dr. Sabir’s (subsequent) conviction:

For most of the time between May 2004 and May 2005, Sabir was out of the United States, working at a Saudi military hospital in Riyadh. On May 20, 2005, during a visit to New York, Sabir met with Saeed and Agent [Ali] Soufan at Shah’s Bronx apartment. Sabir told Soufan that he would soon be returning to Riyadh. He expressed interest in meeting with *mujahideen* operating in Saudi Arabia and agreed to provide medical assistance to any who were wounded. [...] He suggested that he was ideally situated to provide such assistance because he would have a car in Riyadh and “carte blanche” to move freely about the city. [...]

To ensure that Shah and Sabir were, in fact, knowingly proffering support for terrorism, Soufan stated that the purpose of “our war, ... our *jihad*” is to “[e]xpel the infidels from the Arabian peninsula,” [...] and

108. Id. at pp. 132–33 [citation omitted].

109. Id. at p. 133 [citation omitted].

110. Id.

111. Id.

he repeatedly identified “Sheikh Osama” (in context a clear reference to Osama bin Laden) as the leader of that effort [...]. Shah quickly agreed to the need for war to “[e]xpel the Jews and the Christians from the Arabian Peninsula,” [...], while Sabir observed that those fighting such a war were “striving in the way of Allah” and “most deserving” of his help [...].

To permit *mujahideen* needing medical assistance to contact him in Riyadh, Sabir provided Soufan with his personal and work telephone numbers. [...] When Shah and Soufan noted that writing down this contact information might create a security risk, Sabir encoded the numbers using a code provided by Soufan. [...].

Sabir and Shah then participated in *bayat*, a ritual in which each swore an oath of allegiance to al Qaeda, promising to serve as a “soldier of Islam” and to protect “brothers on the path of *Jihad*” and “the path of al Qaeda.” [...] The men further swore obedience to “the guardians of the pledge,” whom Soufan expressly identified as “Sheikh Osama,” i.e., Osama bin Laden, and his second in command, “Doctor Ayman Zawahiri.”¹¹²

Shah and Dr. Sabir were arrested on May 28, 2005. They were indicted in the Southern District of New York on charges that, between October 2003 and May 2005, they conspired to provide material support or resources to al-Qaeda, a Foreign Terrorist Organization, and they provided or attempted to provide such support.

The fourth superseding indictment describes the three types of material support Shah and Dr. Sabir provided, attempted to provide, or conspired to provide as:

- (i) one or more individuals (including themselves) to work under al Qaeda’s direction and control and to organize, manage, supervise, and otherwise direct the operation of al Qaeda, (ii) instruction and

112. Id. At the relevant time, al-Qaeda considered the government of Saudi Arabia an enemy and vice versa. It is not clear whether Dr. Sabir meant to provide care impartially, in IHL terms, as that issue did not arise as such on the available record. But according to available accounts, Dr. Sabir, as an emergency-room physician, had treated all patients on an impartial basis.

teaching designed to impart a special skill to further the illegal objectives of al Qaeda, and (iii) advice and assistance derived from scientific, technical and other specialized knowledge to further the illegal objectives of al Qaeda.¹¹³

The indictment also alleges, as part of the two counts, that Dr. Sabir agreed to provide “*medical support to wounded jihadists*” while Shah would provide “martial arts training and instruction for jihadists”—with both defendants “knowing that al Qaeda had engaged and engages in terrorist activity” and “terrorism.”¹¹⁴

Dr. Sabir moved to dismiss the indictment on the ground that it was unconstitutional to prosecute a doctor under § 2339B for providing medical services. Because the issue appeared to be a matter of “first impression” (that is, no other U.S. court had addressed it), Judge Loretta A. Preska issued, on January 30, 2007, a written decision.¹¹⁵

Judge Preska traced the history of § 2339B, which has the same meaning of “material support or resources” provided in § 2339A. Originally, in 1994, Congress enacted § 2339A, exempting from its reach “humanitarian assistance to persons not directly involved in such [material-support] violations.”¹¹⁶ In 1996, however, Congress replaced that exemption with the phrase “except medicine and religious materials.”¹¹⁷

Quoting the congressional record, Judge Preska noted that “Congress intended the term ‘medicine’ to ‘be understood to be limited to the medicine itself, and does not include the vast array of medical supplies.’”¹¹⁸ Judge Preska also noted that subsequent amendments by Congress, in December 2004:

113. Id. at p. 134 [citation omitted].

114. Id. [citation omitted; italics added].

115. United States v. Shah, 474 F. Supp. 2d 492, 493 (S.D.N.Y. 2007).

116. Id. at p. 495 [citations omitted].

117. Id. [citations omitted].

118. United States v. Shah, 474 F. Supp. 2d 492, 495 (S.D.N.Y. 2007) (citing to H.R. Rep. 104–518, at 114 (1996), as reprinted in 1996 U.S.C.C.A.N. 944, 947).

- Added “expert advice or assistance” as a type of prohibited “material support or resource” (defining it as “advice or assistance derived from *scientific, technical, or other specific knowledge*”);
- Defined “personnel” to mean the provision of “[one] or more individuals (who may be or include himself) *to work under [a foreign] terrorist organization’s direction or control* or to organize, manage, supervise, or otherwise direct the operation of the organization”;
- Excluded from the scope of such “personnel,” for purposes of the statute, “[i]ndividuals *who act entirely independently* of the foreign terrorist organization to advance its goals or objectives [...]”; and
- Clarified the degree of knowledge required to violate the statute (namely, “a person must have knowledge that the organization is a designated terrorist organization [...] that the organization has engaged or engages in terrorist activity [...], or that the organization has engaged or engages in terrorism”).¹¹⁹

Dr. Sabir argued that the indictment was unconstitutional and should be dismissed because § 2339B deprived him of his right to practice medicine—specifically that § 2339B “does not sufficiently identify the prohibited conduct so that [Dr. Sabir] in his profession and practice as a medical doctor, could know, what if any of his conduct as it relates to the practice of medicine would violate the statute.”¹²⁰ That vagueness, according to Dr. Sabir, arose because § 2339B excludes “medicine” from its reach and the plain language definition of a doctor is someone who is qualified or licensed to practice medicine.¹²¹

Rejecting that argument, Judge Preska held that “Congress did not exclude from prosecution persons who provide ‘medical support’ to such organizations

119. *United States v. Shah*, 474 F. Supp. 2d 492, 495 (S.D.N.Y. 2007) [citations omitted; italics added in each bullet point].

120. *Id.* at p. 496 [citation omitted].

121. *Id.* [citation omitted].

with” the necessary knowledge.¹²² Moreover, Judge Preska held that:

[A]ny reasonable doctor would be on notice from the plain language of the statute that conspiring to provide, or providing or attempting to provide, ‘medical support to wounded jihadists’ under the direction and control of al Qaeda, knowing that al Qaeda engages in terrorism or terrorist activity, would constitute the provision of ‘expert advice or assistance’ — ‘advice or assistance derived from scientific, technical, or other specified knowledge’ [...] — and ‘personnel’ — ‘[one] or more individuals (who may be or include himself) to work under [a foreign] terrorist organizations’ direction or control’.¹²³

Finding that § 2339B does not deprive Dr. Sabir of the right to practice medicine, Judge Preska held that “[i]t is not beyond the power of Congress to prohibit the provision of medical services by a doctor working under the control or direction of a terrorist organization.”¹²⁴ Moreover, “[t]o the extent Sabir contends that Congress should not distinguish between a ‘doctor’ and ‘medicine,’ that is not an argument for this forum [that is, a court].”¹²⁵

In dismissing Dr. Sabir’s challenge to the constitutionality of the indictment, Judge Preska emphasized that:

122. Id. at p. 497.

123. Id. [citations omitted]. This excerpt leaves some ambiguity as to whether Judge Preska considered working under the direction and control of al-Qaeda to constitute a necessary element of the offense of providing proscribed “expert advice or assistance” in addition to the offense of providing proscribed “personnel.” On its terms, the statute includes that direction-and-control prong as a necessary element only for the offense of providing proscribed “personnel.” Compare 18 U.S.C. § 2339B(g)(4) (“the term ‘material support or resources’ has the same meaning given that term in section [18 U.S.C. §] 2339A (including the definitions of [...] ‘expert advice or assistance’ in that section)”) and 18 U.S.C. § 2339A(b)(3) (“the term ‘expert advice or assistance’ means advice or assistance derived from scientific, technical or other specialized knowledge.”) with 18 U.S.C. § 2339B(h) (“No person may be prosecuted under this section in connection with the term ‘personnel’ unless that person has knowingly provided, attempted to provide, or conspired to provide a foreign terrorist organization with 1 or more individuals (who may be or include himself) *to work under that terrorist organization’s direction or control* or to organize, manage, supervise, or otherwise direct the operation of that organization. Individuals who act entirely independently of the foreign terrorist organization to advance its goals or objectives shall not be considered to be working under the foreign terrorist organization’s direction and control.”) [italics added].

124. Id. at p. 498 [citations omitted].

125. Id. [citation omitted].

Sabir is not charged *merely for being a doctor or for performing medical activities*. Here, Sabir is alleged essentially to *have volunteered as a medic for the al Qaeda military, offering to make himself available specifically to attend to the wounds of injured fighters*. Much as a military force needs weapons, ammunition, trucks, food, and shelter, it *needs medical personnel to tend to its wounded*. Thus, applied to the conduct alleged against Sabir in the Indictment, § 2339B is not unconstitutionally vague.¹²⁶

Judge Preska issued her decision around seven months after the seminal U.S. Supreme Court decision in *Hamdan*. There, as noted above, a 6–3 majority held that, at a minimum, Common Article 3 governed the armed conflict with al-Qaeda.¹²⁷ At no point in the decision, however, did Judge Preska address any IHL issue. She did not, for instance, assess whether al-Qaeda may recognize and authorize its own medical personnel such that those personnel would fall under the protection of IHL. Nor did she address the potential applicability of IHL prohibitions against punishing any person for carrying out medical activities compatible with medical ethics.¹²⁸ It seems that neither Dr. Sabir, nor the prosecution, nor the judge raised any issues concerning IHL.

Judge Preska also addressed two hypotheticals posed by Dr. Sabir’s counsel during oral argument. First, Dr. Sabir’s counsel “contended that a doctor who happens to treat a wounded person while working at a hospital when the person is brought in for treatment, and it later turns out that the person was a jihadist, would be subject to prosecution, under the Government’s view of § 2339B.”¹²⁹ Second, Dr. Sabir’s counsel “asserted that a non-governmental organization (‘NGO’) which provided medical services, such as ‘Doctors Without Borders/Médecins Sans

126. Id. [italics added].

127. *Hamdan v. Rumsfeld*, 548 U.S. 557, 630–31, 126 S. Ct. 2749, 2795–96, 165 L. Ed. 2d 723 (2006).

128. See *infra* Section 4: “Corollary Protections for Medical Caregivers, Transports, Units, and Supplies — Prohibition on punishment.”

129. *United States v. Shah*, 474 F. Supp. 2d 492, 499 (S.D.N.Y. 2007) [citations omitted].

Frontières,’ would be subject to prosecution, under the Government’s view of § 2339B.”¹³⁰

Judge Preska rejected both contentions:

These hypotheticals are without merit because in both examples a reasonable doctor would understand that he could not be subject to prosecution under § 2339B. Neither the doctor in the first hypothetical who treats a terrorist by random chance, nor the doctor for the NGO in the second hypothetical who treats a terrorist in connection with an NGO’s work, is acting under the ‘direction or control’ of a designated foreign terrorist organization knowing that said organization engages in terrorism or terrorist activity. To the contrary, the doctors in these hypotheticals would constitute ‘[i]ndividuals ... act[ing] entirely independently of [a] foreign terrorist organization’ and would not be ‘considered to be working under [a] foreign terrorist organization’s direction and control.’ [...] Accordingly, the Government represented that the doctors in these hypotheticals would not be prosecuted under § 2339B. ([...] (Statement of Karl Metzner, Assistant United States Attorney: ‘[T]he concern about Doctors Without Borders and all that is ill-founded because of the definition of personnel. *The government is required to prove that Dr. Sabir worked or agreed to work under the terrorist organization’s direction or control before he can be convicted under this statute. That eliminates the nongovernmental organizations and others who provide assistance on their own.*’)).¹³¹

130. Id. [citations omitted].

131. Id. [citations omitted; italics added]. Two aspects of the referenced statement of the Assistant United States Attorney (A.U.S.A.) merit further attention. First, Dr. Sabir’s charges pertained to two forms of prohibited material support—*personnel* and *expert advice and assistance*. But the referenced statement of the A.U.S.A. pertains only to the provision of *personnel* proscribed in 18 U.S.C. § 2339B; the statement does not explicitly (also) pertain to the provision of *expert advice and assistance* proscribed in that statute. Under the statute, to prove a violation of the latter (the provision of unlawful *expert advice and assistance*), the government is not required to establish that the defendant acted under the direction and control of the designated FTO. Compare 18 U.S.C. § 2339B(g)(4) (“the term ‘material support or resources’ has the same meaning given that term in section [18 U.S.C. §] 2339A (including the definitions of [...] ‘expert advice or assistance’ in that section)”) and 18 U.S.C. § 2339A(b)(3) (“the term ‘expert advice or assistance’ means advice or assistance derived from scientific, technical or other specialized knowledge.”) with 18 U.S.C. § 2339B(h) (“No person may be prosecuted under this section in connection with the term ‘personnel’ unless that person

In light of this and the preceding reasoning, Judge Preska held that Dr. Sabir failed to demonstrate that § 2339B reached any constitutionally protected conduct. Thus she concluded that § 2339B is not facially vague either.¹³²

Following a jury trial held from April 24, 2007 to May 21, 2007, Dr. Sabir was found guilty of conspiring to provide and attempting to provide “material support or resources” to al-Qaeda, in the form of “medical support to wounded jihadists,” in violation of 18 U.S.C. § 2339B.¹³³ On October 15, 2007, Judge Preska denied Dr. Sabir’s motion for a judgment of acquittal and for a new trial.¹³⁴

On November 28, 2007, the district court sentenced Dr. Sabir principally to a 300-month (12-year) term of incarceration.¹³⁵ Dr. Sabir appealed on six grounds, including that § 2339B is unconstitutionally vague and overbroad and that the trial evidence is insufficient to support his conviction.¹³⁶

On February 4, 2011, the appeals court held in part that § 2339B “presents no overbreadth concerns and is not unconstitutionally vague as applied to Sabir’s conduct.” In reaching this holding, the appeals court relied partly on the June 21, 2010 U.S. Supreme Court decision in *Holder v. Humanitarian Law Project*. There, the Supreme Court held that § 2339B was not unconstitutionally vague as applied

has knowingly provided, attempted to provide, or conspired to provide a foreign terrorist organization with 1 or more individuals (who may be or include himself) *to work under that terrorist organization’s direction or control* or to organize, manage, supervise, or otherwise direct the operation of that organization. Individuals who act entirely independently of the foreign terrorist organization to advance its goals or objectives shall not be considered to be working under the foreign terrorist organization’s direction and control.”) [italics added].

Second, this referenced statement concerning the need for the government to establish, to prove a violation of the *personnel* prong of 18 U.S.C. § 2339B, that the defendant worked under the direction and control of the designated FTO was provided by an A.U.S.A. during a proceeding in this specific case. So far as we are aware, the Department of Justice has not promulgated a formal prosecutorial policy or other form of authoritative guidance establishing the referenced interpretation of the *personnel* prong of 18 U.S.C. § 2339B in a binding manner.

132. *Id.* at pp. 499–500 [citations omitted].

133. *United States v. Sabir*, 628 F. Supp. 2d 414, 416 (S.D.N.Y. 2007).

134. *Id.* at p. 425.

135. *United States v. Farhane*, 634 F.3d 127, 134 (2d Cir. 2011).

136. *Id.* at p. 132 (2d Cir. 2011). His other grounds of appeal were that the prosecution’s peremptory jury challenges exhibited racial bias; that evidentiary rulings deprived him of the right of confrontation and/or a fair trial; that the district court abused its discretion in addressing alleged juror misconduct; and that the prosecution’s rebuttal summation deprived him of a fair trial. *Id.*

to certain activities the plaintiffs wished to pursue; that the statute did not, as applied to the plaintiffs, violate freedom of speech; and that the statute did not violate the plaintiffs' freedom of association.¹³⁷ In reviewing the statutory framework, the appeals court also noted, in a footnote, that "Al Qaeda's designation as a terrorist organization [...] is undisputed. [...] The United States' response to al Qaeda has not, however, been limited to such designation. Two successive administrations have indicated that the nation is at 'war' with al Qaeda."¹³⁸

The appeals court rejected Dr. Sabir's contention that § 2339B is overbroad in limiting "a doctor's right to practice medicine." (The overbreadth doctrine is rooted in the freedom-of-speech protections laid down in the First Amendment of the Bill of Rights to the Constitution. Generally, a law is unconstitutionally overbroad if it "punishes a substantial amount of protected free speech, judged in relation to [its] plainly legitimate sweep."¹³⁹) In doing so, the appeals court ruled that, in the U.S. constitutional system, the right to medical practice is subordinate to police powers and the power of the legislative branch to make laws necessary and proper for the nation's defense.¹⁴⁰ The appeals court held that "[b]ecause Sabir [...] cannot claim a 'right' to provide medical treatment for terrorists that is not 'subordinate to ... the power of Congress to make laws necessary and proper' to the nation's defense [...], he cannot mount a claim that § 2339B is unconstitutionally overbroad."¹⁴¹

The court also rejected Dr. Sabir's claim that § 2339B was unconstitutionally vague—that is, that the statutory terms at issue ("training," "personnel," and "expert advise and assistance") were too vague to provide sufficient notice and that the application of those terms to his case was unconstitutional. In rejecting Dr. Sabir's vagueness challenge to the term "personnel" as applied to his case, for instance,

137. *Holder v. Humanitarian Law Project*, 561 U.S. 1, 40, 130 S. Ct. 2705, 2731, 177 L. Ed. 2d 355 (2010).

138. *United States v. Farhane*, 634 F.3d 127, 173 fn 7 (2d Cir. 2011) [citations omitted].

139. *Virginia v. Hicks*, 539 U.S. 113, 118–19, 123 S.Ct. 2191, 156 L.Ed.2d 148 (2003) [internal quotation marks omitted].

140. *United States v. Farhane*, 634 F.3d 127, 137 (2d Cir. 2011) [citations omitted].

141. *Id.* [citations omitted].

the court reasoned that Dr. Sabir’s “offer to serve as an on-call doctor for the organization, standing ready to treat wounded *mujahideen* in Saudi Arabia, falls squarely within the core” of § 2339B’s prohibition on “personnel.”¹⁴² The court stated that:

In an effort to avoid this conclusion, Sabir argues that his offer of life-saving medical treatment was simply consistent with his ethical obligations as a physician and not reflective of any provision of support for a terrorist organization. The record does not support this characterization. Sabir was *not prosecuted for performing routine duties as a hospital emergency room physician, treating admitted persons who coincidentally happened to be al Qaeda members*. Sabir was prosecuted for *offering to work for al Qaeda as its on-call doctor, available to treat wounded mujahideen who could not be brought to a hospital precisely because they would likely have been arrested for terrorist activities*. [...] In offering this support for al Qaeda, Sabir did not simply honor his Hippocratic oath. He *swore a further oath of allegiance to al Qaeda*, making clear that his treatment of wounded *mujahideen* would be provided not as an independent physician but as “one of the soldiers of Islam,” duty bound to obey al Qaeda’s leaders, including Osama bin Laden, and to protect his fellow “brothers on the path of *Jihad*” and “on the path of al Qaeda.” [...] No reasonable person with a common understanding of al Qaeda’s murderous objectives could doubt that such material support fell squarely within the prohibitions of § 2339B.¹⁴³

Upholding the reasoning of the lower court, the appeals court also rejected Dr. Sabir’s claim that the “medicine” exemption in § 2339B was unconstitutionally vague as applied to his case.

The three members of the appeals court unanimously rejected Dr. Sabir’s overbreadth and vagueness claims. As summarized by Judge Dearie in a footnote,

142. Id. at pp. 140–41 [citations omitted].

143. Id. at p. 141 [citations omitted; italics—other than *mujahideen*—added].

the court held unanimously “that § 2339B, by its terms, *criminalizes the practice of medicine (or the doctor himself) that Sabir agreed to provide to al Qaeda*.”¹⁴⁴

The panel lacked unanimity, however, regarding whether the evidence was legally sufficient to sustain Dr. Sabir’s “attempt” conviction. Judge Dearie dissented with the majority’s conclusion that the evidence was sufficient. (Judge Dearie otherwise concurred with the majority.¹⁴⁵)

In the decision, none of the appeals court judges raised any considerations regarding IHL protections for medical care in armed conflict. Nor, apparently, did the prosecution or the defense in the pleadings.

Seen in one light, Dr. Sabir’s conviction represents a successful national-security strategy: a highly skilled expert was prevented from supporting a terrorist group to which he had pledged an oath of allegiance. But in another light, Dr. Sabir’s conviction represents a troubling disconnect: a physician was precluded from providing medical care to wounded fighters in an armed conflict, yet the laws of armed conflict never factored into the legal analysis.

The legal rationale underlying Dr. Sabir’s conviction is that it is impermissible to provide medical support (except medicine itself) to wounded jihadists knowing that they have engaged in terrorist activity. That rationale remains valid under U.S. law. Indeed, it was used in the following case.

U.S. v. Warsame

On June 21, 2005, the prosecution filed a superseding indictment against Mohamed Abdullah Warsame, a Canadian citizen, on federal counterterrorism charges. According to the indictment, between 2000 and 2001 Warsame traveled to Afghanistan and Pakistan and attended al-Qaeda training camps. The government alleged that al-Qaeda paid Warsame’s travel expenses so that he could return to

144. Id. at p. 173 fn 8 [italics added].

145. Id. at p. 175. Judge Raggi filed an opinion concurring in part regarding the scope of hearsay evidence as applied to certain statements of Dr. Sabir. Id. at 171.

Canada; that Warsame sent money to an al-Qaeda associate as repayment; and that Warsame maintained communications with individuals associated with al-Qaeda after his return to Canada.¹⁴⁶

The indictment charged Warsame with conspiring to provide, and with providing, material support and resources to a designated Foreign Terrorist Organization (al-Qaeda) in violation of U.S. law. In a bill of particulars (a document specifying the charges in more detail) filed on March 16, 2007, the prosecution alleged that Warsame conspired to provide and provided material support and resources to al-Qaeda in the form of “currency,” “personnel” (himself), and “training.”¹⁴⁷

Warsame challenged the constitutionality of the prosecution on three main grounds. First, that the underlying statute unlawfully restricted freedom of association and was unconstitutionally vague and overbroad. Second, that the statute violated the Due Process Clause of the Fifth Amendment of the Bill of Rights to the Constitution because it imposes criminal liability in the absence of personal guilt. And third, that the statutory procedure for designating an organization was unsound and precluded a defendant from challenging the validity of the designation in a subsequent criminal prosecution.

In discussing how it was not convinced that the term “training” was so vague that Warsame—a Canadian citizen—could not have understood his conduct to be prohibited under the applicable U.S. statute, the court stated:

Here, the prosecution alleges that Warsame provided English lessons in an Al Qaeda clinic in Kandahar, Afghanistan, *in part to assist nurses in reading English-language medicine labels*. According to the prosecution, nurses in the clinic attended to Al Qaeda members who were participating in nearby terrorist training camps. The alleged English-language training in this case has *direct application to a FTO’s terrorist activities, as it would likely speed the healing and eventual return*

146. United States v. Warsame, 537 F.Supp.2d 1005, 1009 (2008).

147. Id. at p. 1010.

of terrorist militants to Al Qaeda training camps. Further, the training was provided in an Al Qaeda clinic in Kandahar, in close proximity to terrorist training camps. As such, the Court finds that this alleged conduct is *closely tied to terrorist activity*, such that Warsame would likely understand his conduct to be criminalized as ‘training’ under [the statute].¹⁴⁸

The court concluded that “training” was not unconstitutionally vague as applied to this alleged conduct.¹⁴⁹ In the accompanying footnote, the court further found that “the provision of English language lessons to nurses to assist in the medical treatment of injured Al Qaeda militants *does not fall within the statutory exception for ‘medicine.’*”¹⁵⁰

Ultimately, Warsame pleaded guilty to one count of conspiring to provide material support to a designated FTO.¹⁵¹ As part of his plea agreement, Warsame admitted to certain facts, including that he “provided his services to al Qaeda [...] by teaching English at a medical clinic for al Qaeda associates.”¹⁵² On the basis of that and numerous other admissions, on July 9, 2009, a judge sentenced Warsame to 92 months’ imprisonment.¹⁵³

Boim v. Holy Land Foundation

In addition to criminal charges prosecuted in U.S. courts, private plaintiffs have filed civil proceedings that raise issues related to the legal scope, under domestic law, of impartial medical care concerning terrorists in armed conflict. One such case is *Boim v. Holy Land Foundation*. It is of interest here not for the main holding but

148. Id. at p. 1019 fn 12 [citation omitted; italics added].

149. Id. at p. 1019 [citation omitted]. With respect to the more general allegation that Warsame taught English at an al-Qaeda clinic, the court found that the term “training” was, as applied to that alleged conduct, unconstitutionally vague, since “mere *allegations* that Warsame taught English at an Al Qaeda clinic, without more specific allegations tying that conduct to terrorist activity,” were not sufficient under the statute. Id. [italics added].

150. Id. at p. 1019 fn 12 [citing to *Shah*, 474 F.Supp.2d at 497; italics added].

151. United States v. Warsame, 651 F. Supp. 2d 978, 979 (D. Minn. 2009).

152. Id. at p. 980.

153. Id. at p. 979.

for the (non-binding) discussion on the scope of lawful medical care for terrorists under a civil statute.

As summarized by Judge Posner, the facts and main legal issue raised in the case were as follows:

In 1996 David Boim, a Jewish teenager who was both an Israeli citizen and an American citizen, living in Israel, was shot to death by two men at a bus stop near Jerusalem. His parents filed this suit four years later, alleging that his killers had been Hamas gunmen and naming as defendants Muhammad Salah plus three organizations: the Holy Land Foundation for Relief and Development, the American Muslim Society, and the Quranic Literacy Institute. [...] The complaint accused the defendants of having *provided financial support to Hamas* before David Boim's death and by doing so of having violated 18 U.S.C. § 2333(a), which provides that 'any national of the United States *injured in his or her person, property, or business by reason of an act of international terrorism*, or his or her estate, survivors, or heirs, may sue therefor in any appropriate district court of the United States and shall recover threefold the damages he or she sustains and the cost of the suit, including attorney's fees.'¹⁵⁴

In its 2008 judgment in the case, a majority of a federal appeals court confirmed a theory that, under U.S. law, raising money for Hamas could make the defendants civilly liable for certain acts of terrorism associated with Hamas.¹⁵⁵

In passing, the majority stated that its theory of liability would *not* sweep in medical or "other innocent" assistance by NGOs such as "the Red Cross or Doctors Without Borders that provide such assistance without regard to the circumstances giving rise to the need for it."¹⁵⁶ The majority's reasoning and the reasoning of a judge concurring and dissenting with the majority are worth reciting.

154. Boim v. Holy Land Found. for Relief & Dev., 549 F.3d 685, 687–88 (7th Cir. 2008).

155. Id. at pp. 690–91.

156. Id. at p. 699.

The majority gave the hypothetical of “an Israeli retaliatory strike at Hamas caus[ing] so many casualties that the local medical services cannot treat all of them,” and Doctors Without Borders offering assistance while knowing “*in advance that it would be providing medical assistance to terrorists.*”¹⁵⁷ The majority reasoned that in this hypothetical an organization like Doctors Without Borders would not be in violation of the civil statute at issue. Part of the reason was that Doctors Without Borders “*would be helping not a terrorist group but individual patients, and, consistent with the Hippocratic Oath, with no questions asked about the patients’ moral virtue.*”¹⁵⁸

Separately, the majority reasoned that “the rendering of medical assistance by the Red Cross or Doctors Without Borders to individual terrorists [would not] ‘appear to be intended [...] to intimidate or coerce a civilian population’ or ‘affect the conduct of a government by [...] assassination [...]’” (which are elements of a terrorist act under the statute).¹⁵⁹ And without that appearance, “there is no international terrorist act within the meaning of” the statute.¹⁶⁰

Judge Wood criticized the majority’s reasoning for establishing an unprincipled exemption: “[F]or no apparent reason other than our own sense that organizations like the Red Cross and Doctors Without Borders are good and do good, the majority simply declares them exempt from the broad liability standard that it has announced.”¹⁶¹ Judge Wood stated that “[p]roviding medical care on the battlefield

157. Id. [italics added].

158. Id. [italics added] (rather, the majority analogized, “It would be like a doctor who treats a person with a gunshot wound whom he knows to be a criminal. If doctors refused to treat criminals, there would be less crime. But the doctor is not himself a criminal unless, besides treating the criminal, he conceals him from the police (like Dr. Samuel Mudd, sentenced to prison for trying to help John Wilkes Booth, Lincoln’s assassin, elude capture) or violates a law requiring doctors to report wounded criminals. The same thing would be true if a hospital unaffiliated with Hamas but located in Gaza City solicited donations.”).

159. Id.

160. Id.

161. Judge Wood, dissenting in part and concurring in part, *Boim v. Holy Land Found. for Relief & Dev.*, 549 F.3d 685, 710–11 (7th Cir. 2008).

to individuals that one knows are Hamas terrorists [...] *undoubtedly would have the effect of aiding Hamas's terrorism—patching up an injured terrorist enables him to strike again.*"¹⁶² While noting that she does "not doubt that such aid could be given for noble and compassionate reasons," Judge Wood also stated that neither does she "doubt that from the standpoint of the Israelis whom Hamas targets, *the knowing provision of medical care to individual terrorists could be and would be understood as aid to terrorism.*"¹⁶³

In any event, it is important to recall that, in the *Boim* case, the judges were interpreting a civil statute, not the federal criminal material-support statute under which Dr. Sabir and Warsame were prosecuted. To date, the reasoning in the latter cases concerning the scope of what constitutes criminal support to a designated FTO, in violation of 18 U.S.C. § 2339B, in the form of medical care remains valid. (Meanwhile, for its part, the "medicine" exemption to that material-support statute has been interpreted quite narrowly. In short, it "shields only those who provide *substances* qualifying as medicine to terrorist organizations."¹⁶⁴)

Today, therefore, 18 U.S.C. § 2339B criminalizes the conduct not only of a person who—regardless of whether she is an American or not, and irrespective of whether her conduct takes place in the United States or not¹⁶⁵—provides medical care (except medical *substances*) to terrorists by acting under the direction and control of a designated FTO.¹⁶⁶ In principle, the statute also proscribes the conduct of a physician who—in a situation of armed conflict and acting independently of the warring parties—impartially provides expert medical assistance to an *hors de combat* member of an FTO by, for example, dressing his wounds in a field clinic,¹⁶⁷

162. Id. at 711. [internal reference omitted; italics added].

163. Id. [italics added].

164. United States v. Farhane, 634 F.3d 127, 143 (2d Cir. 2011).

165. 18 U.S.C. § 2339B(d).

166. 18 U.S.C. § 2339B(h).

167. Thus going beyond providing him with mere medical substances. On the scope of proscribed conduct in the form of expert advice or assistance, see 18 U.S.C. § 2339B(g)(4) ("the term 'material support or resources' has the same

so long as the physician knows the wounded fighter is a member of a designated FTO.¹⁶⁸

meaning given that term in section [18 U.S.C. §] 2339A (including the definitions of [...] ‘expert advice or assistance’ in that section”); 18 U.S.C. § 2339A(b)(3) (“the term ‘expert advice or assistance’ means advice or assistance derived from scientific, technical or other specialized knowledge.”).

168. According to the U.S. Supreme Court, “Congress plainly spoke to the necessary mental state for a violation of § 2339B, and it chose knowledge about the organization’s connection to terrorism, not specific intent to further the organization’s terrorist activities.” *Holder v. Humanitarian Law Project*, 561 U.S. 1, 16–17, 130 S. Ct. 2705, 2717, 177 L. Ed. 2d 355 (2010).

A photograph of three surgeons in an operating room, wearing blue scrubs, masks, and caps, focused on a surgical procedure. The scene is dimly lit, with a bright light source illuminating the surgical site. The number '6' is overlaid in the upper left quadrant.

6

CONCLUSION

A “decisive verdict, in general and imperative terms [...]” on the importance of protecting impartial medical care to enemy nationals.¹ Such is how the ICRC characterized the prohibition, in the First Geneva Convention of 1949, on mistreating or convicting anyone who nursed an enemy combatant—irrespective of that fighter’s nationality or conduct—in an IAC.

Well over six decades later, a similarly decisive verdict in favor of impartial medical care for all of the wounded and sick—including terrorists—in all armed conflicts has not been issued. That more expansive ruling would perforce need to include sufficient protections against punishing anyone who provides ethically sound wartime medical care to enemy fighters and civilians—including to terrorists. Such a verdict may not be forthcoming any time soon. So long as counterterrorism policies reject the fundamental premises on which the IHL protections for the wounded and sick are based, a clash of norms will persist. And, more broadly, irrespective of terrorism-related concerns, IHL protections for medical care could be strengthened.

Anti-terrorism framings continue to powerfully influence domestic legal regimes, international debates, and global culture. A worldwide consensus among states seems to have emerged on the importance of addressing the threat of terrorism. And, of course, states have a duty to protect their populations—in line with international legal obligations and standards—from those threats.

Yet despite a general understanding of the need to fight terrorism, there is less agreement on how exactly to do it. States do not always see eye-to-eye, for instance, on who constitutes a terrorist or what constitutes an act of terrorism.²

Of course, counterterrorism is not a monolithic advent of recent history. It has been resisted and revised by various actors within government and civil society. And despite the Security Council’s attempts at standardization, states have

1. ICRC, *Commentary on GC I*, p. 192 [italics added].

2. See, e.g., “Britain asks UAE to clarify its new terrorism watch list,” *Middle East Monitor*, November 19, 2014, available at <https://www.middleeastmonitor.com/news/europe/15346-britain-asks-uae-to-clarify-its-new-terrorism-watch-list> [<https://perma.cc/GKQ2-DRD2>].

undertaken anti-terrorism measures with varying degrees of commitment and at different speeds.

Meanwhile, many states support—including through large financial contributions and often as a pillar of their foreign-policy platforms—principled humanitarian organizations. Indeed, states and civil society actors regularly praise many humanitarian NGOs that provide wartime medical care, such as the ICRC and Médecins Sans Frontières.

The overall fragmentation in legal protections for medical care in armed conflict is partly a reflection of the diversity of state approaches to balancing military necessity with considerations of humanity. At its core, IHL is an ambivalent normative system: it is often pulled in one direction by the former and in another direction by the latter. Protections for impartial wartime medical care represent one of this system's basic humanitarian compromises.

Stepping back, it is not clear that, to date, in designing and implementing anti-terrorism frameworks, states have intentionally aimed to diminish the IHL protections for impartial wartime medical assistance. But it is also not clear that states have fully considered the potential effects that anti-terrorism frameworks may have on those IHL protections.

The rationales underpinning IHL protections for impartial wartime medical care seem difficult to square with many counterterrorism policies. If terrorists really are today's "enemies of all mankind," do states have good grounds for considering medical care to them yet another form of illegitimate support? And should states actually trust terrorist organized armed groups to control—and not to abuse—the claim of inviolability of medical personnel and objects amid the turmoil of war?

When the central challenges are cast in these terms, it may seem particularly naïve, or even dangerously misguided, to stress the importance of ensuring sufficient normative protections for everyone—even those who, like ISIS, reject the ethics on which IHL is founded.

In today's armed conflicts, should impartial medical care be considered a form of illegitimate support to certain enemies—perhaps especially if those enemies are terrorists? And if, for the sake of argument, such medical care is illegitimate, are there alternative bases on which states should repose trust in those enemies to control medical personnel and objects?

Here, perhaps, some of the hard-earned lessons of history that instructed the drafters of the Geneva Conventions may also offer contemporary decision-makers guidance. In the wake of WWII, trust among states was at a nadir. Even as the United Nations was emerging, memories of battlefield atrocities and violations were all too fresh. Meanwhile, some of the architects of the war were in the dock, their abuses laid bare for the world to scrutinize.

Yet out of the ashes of WWII, states nonetheless came together to establish—as a norm of international law—that no one could be harassed or convicted for nursing the enemy wounded. This rule applied only with respect to IACs. But the humanitarian logic underlying it seems valid for all armed conflicts: that once out of the fight, all wounded and sick fighters (and all wounded and sick civilians) should be cared for, and no one should be penalized for giving that care. In short, medical care should be above the conflict.

Does that logic hold when it is applied to the diverse set of contemporary theatres of armed conflict involving terrorism? For those situations, states considering whether to reconceptualize medical care as a form of illegitimate support to terrorists would need to address three challenges.

The first relates to the relative position of the wounded and sick *hors de combat* of state parties versus those of terrorist organizations: is there a compelling reason why the former but not the latter should be entitled to receive impartial medical care? For its part, IHL pivots on recognizing the inherent humanity of all persons *hors de combat* in need of medical attention—irrespective of which side they fight on.

The second challenge is in the same vein but focuses on the civilian wounded and sick: with respect to the entitlement to receive medical treatment, is there a compelling reason to distinguish between such persons if they are in a territory controlled by a state versus those in a territory controlled by a terrorist group? This challenge is difficult to overcome for the same rationale as the first challenge: just as it does not distinguish between fighters *hors de combat*, the fundamental IHL principle of humanity does not distinguish between civilians based on whose control they are under.

The third challenge implicates situations where terrorist organized armed groups reject (or, at least, systematically fail to comply with) IHL: is there a compelling reason why the state opposing those groups should set aside its own obligation to uphold IHL medical-care protections? This challenge must overcome the general principle that the obligation to respect and ensure respect for IHL by and large does not depend on whether the adversary also respects and ensures respect for IHL.³

Scanning the normative landscape, the result today is unsatisfactory. Prosecutions of physicians for supporting terrorists through medical care in armed conflicts likely constitute violations of at least some states' IHL treaty obligations. But in other conflicts where states intentionally curtail impartial medical care there is no clear IHL violation. Both those *actual IHL violations* and the *lack of clear IHL violations*, we think, are cause for concern. The former represent failures to implement the legal regime. And the latter spotlight the non-comprehensiveness—or, at least, the indeterminateness and the variability—of the normative framework.

The Security Council's move to legislate global counterterrorism measures has occurred without due consideration—at least due public consideration—of the

3. See generally, e.g., ICRC, *CIHLS*, Part I: Rules, Rule 140, pp. 498–99.

potential impact on the foundational ethic of IHL entailed in impartial medical care. Nor, in implementing those Council obligations and in devising their own additional anti-terrorism measures, have states sufficiently and publicly evaluated the potential consequences for that foundational ethic. Without duly considering what may be lost, these responses to terrorism risk unwittingly eroding a normative pillar of IHL.

COMPENDIUM



IHL PERTAINING TO WARTIME MEDICAL CARE

CONVENTIONAL IHL CONCERNING MEDICAL CARE AND ATTENTION

1949 Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field

[...]

CHAPTER I GENERAL PROVISIONS

[...]

ARTICLE 3

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria. To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- (a) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
- (b) Taking of hostages;
- (c) Outrages upon personal dignity, in particular, humiliating and degrading treatment;
- (d) The passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded, sick and shipwrecked shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

[...]

ARTICLE 4

Neutral Powers shall apply by analogy the provisions of the present Convention to the wounded and sick, and to members of the medical personnel and to chaplains of the armed forces of the Parties to the conflict, received or interned in their territory, as well as to dead persons found.

[...]

ARTICLE 6

In addition to the agreements expressly provided for in Articles 10, 15, 23, 28, 31, 36, 37 and 52, the High Contracting Parties may conclude other special agreements for all matters concerning which they may deem it suitable to make separate provision. No special agreement shall adversely affect the situation of the wounded and sick, of members of the medical personnel or of chaplains, as defined by the present Convention, nor restrict the rights which it confers upon them.

Wounded and sick, as well as medical personnel and chaplains, shall continue to have the benefit of such agreements as long as the Convention is applicable to them, except where express provisions to the contrary are contained in the aforesaid or in subsequent agreements, or where more favourable measures have been taken with regard to them by one or other of the Parties to the conflict.

ARTICLE 7

Wounded, sick and shipwrecked persons, as well as members of the medical personnel and chaplains, may in no circumstances renounce in part or in entirety the rights secured to them by the present Convention, and by the special agreements referred to in the foregoing Article, if such there be.

ARTICLE 8

The present Convention shall be applied with the cooperation and under the scrutiny of the Protecting Powers whose duty it is to safeguard the interests of the Parties to the conflict. For this purpose, the Protecting Powers may appoint, apart from their diplomatic or consular staff, delegates from amongst their own nationals or the nationals of other neutral Powers. The said delegates shall be subject to the approval of the Power with which they are to carry out their duties.

The Parties to the conflict shall facilitate to the greatest extent possible the task of the representatives or delegates of the Protecting Powers.

The representatives or delegates of the Protecting Powers shall not in any case exceed their mission under the present Convention. They shall, in particular, take account of the imperative necessities of security of the State wherein they carry out their duties. Their activities shall only be restricted as an exceptional and temporary measure when this is rendered necessary by imperative military necessities.

ARTICLE 9

The provisions of the present Convention constitute no obstacle to the humanitarian activities which the International Committee of the Red Cross or any other impartial humanitarian organization may, subject to the consent of the Parties to the conflict concerned, undertake for the protection of wounded, sick and shipwrecked persons, medical personnel and chaplains, and for their relief.

ARTICLE 10

The High Contracting Parties may at any time agree to entrust to an organization which offers all guarantees of impartiality and efficacy the duties incumbent on the Protecting Powers by virtue of the present Convention.

When wounded, sick and shipwrecked, or medical personnel and chaplains do not benefit or cease to benefit, no matter for what reason, by the activities of a Protecting Power or of an organization provided for in the first paragraph above, the Detaining Power shall request a neutral State, or such an organization, to undertake the functions performed under the present Convention by a Protecting Power designated by the Parties to a conflict.

If protection cannot be arranged accordingly, the Detaining Power shall request or shall accept, subject to the provisions of this Article, the offer of the services of a humanitarian organization, such as the International Committee of the Red Cross, to assume the humanitarian functions performed by Protecting Powers under the present Convention.

Any neutral Power, or any organization invited by the Power concerned or offering itself for these purposes, shall be required to act with a sense of responsibility towards the Party to the conflict on which persons protected by the present Convention depend, and shall be required to furnish sufficient assurances that it is in a position to undertake the appropriate functions and to discharge them impartially.

No derogation from the preceding provisions shall be made by special agreements between Powers one of which is restricted, even temporarily, in its freedom to negotiate with the other Power or its allies by reason of military events, more particularly where the whole, or a substantial part, of the territory of the said Power is occupied.

Whenever, in the present Convention, mention is made of a Protecting Power, such mention also applies to substitute organizations in the sense of the present Article.

ARTICLE 11

In cases where they deem it advisable in the interest of protected persons, particularly in cases of disagreement between the Parties to the conflict as to the application or interpretation of the provisions of the present Convention, the Protecting Powers shall lend their good offices with a view to settling the disagreement.

For this purpose, each of the Protecting Powers may, either at the invitation of one Party or on its own initiative, propose to the Parties to the conflict a meeting of their representatives, in particular of the authorities responsible for the wounded, sick and shipwrecked, medical personnel and chaplains, possibly on neutral territory suitably chosen. The Parties to the conflict shall be bound to give effect to the proposals made to them for this purpose. The Protecting Powers may, if necessary, propose for approval by the Parties to the conflict, a person belonging to a neutral Power or delegated by the International Committee of the Red Cross, who shall be invited to take part in such a meeting.

CHAPTER II WOUNDED AND SICK

ARTICLE 12

Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances.

They shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected

to torture or to biological experiments; they shall not wilfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.

Only urgent medical reasons will authorize priority in the order of treatment to be administered.

Women shall be treated with all consideration due to their sex. The Party to the conflict which is compelled to abandon wounded or sick to the enemy shall, as far as military considerations permit, leave with them a part of its medical personnel and material to assist in their care.

ARTICLE 13

The present Convention shall apply to the wounded, sick and shipwrecked at sea belonging to the following categories:

1. Members of the armed forces of a Party to the conflict, as well as members of militias or volunteer corps forming part of such armed forces.
2. Members of other militias and members of other volunteer corps including those of organized resistance movements, belonging to a Party to the conflict and operating in or outside their own territory, even if this territory is occupied, provided that such militias or volunteer corps, including such organized resistance movements, fulfill the following conditions:
 - (a) That of being commanded by a person responsible for his subordinates;
 - (b) That of having a fixed distinctive sign recognizable at a distance;
 - (c) That of carrying arms openly;
 - (d) That of conducting their operations in accordance with the laws and customs of war.
3. Members of regular armed forces who profess allegiance to a Government or an authority not recognized by the Detaining Power.
4. Persons who accompany the armed forces without actually being members thereof, such as civilian members of military aircraft crews, war correspondents, supply contractors, members of labour units or of services responsible for the welfare of the armed forces, provided that they have received authorization from the armed forces which they accompany.
5. Members of crews, including masters, pilots and apprentices of the merchant marine and the crews of civil aircraft of the Parties to the conflict, who do not benefit by more favourable treatment under any other provisions of international law.
6. Inhabitants of a non-occupied territory who, on the approach of the enemy, spontaneously take up arms to resist the invading forces, without having had time to form themselves into regular armed units, provided they carry arms openly and respect the laws and customs of war.

ARTICLE 14

Subject to the provisions of Article 12, the wounded and sick of a belligerent who fall into enemy hands shall be prisoners of war, and the provisions of international law concerning prisoners of war shall apply to them.

ARTICLE 15

At all times, and particularly after an engagement, Parties to the conflict shall, without delay, take all possible measures to search for and collect the wounded and sick, to protect them against pillage and ill-treatment, to ensure their adequate care, and to search for the dead and prevent their being despoiled.

Whenever circumstances permit, an armistice or a suspension of fire shall be arranged, or local arrangements made, to permit the removal, exchange and transport of the wounded left on the battlefield.

Likewise, local arrangements may be concluded between Parties to the conflict for the removal or exchange of wounded and sick from a besieged or encircled area, and for the passage of medical and religious personnel and equipment on their way to that area.

ARTICLE 16

Parties to the conflict shall record as soon as possible, in respect of each wounded, sick or dead person of the adverse Party falling into their hands, any particulars which may assist in his identification.

These records should if possible include:

- (a) designation of the Power on which he depends;
- (b) army, regimental, personal or serial number;
- (c) surname;
- (d) first name or names;
- (e) date of birth;
- (f) any other particulars shown on his identity card or disc;
- (g) date and place of capture or death;
- (h) particulars concerning wounds or illness, or cause of death.

As soon as possible the above mentioned information shall be forwarded to the Information Bureau described in Article 122 of the Geneva Convention relative to the Treatment of Prisoners of War of 12 August 1949, which shall transmit this information to the Power on which these persons depend through the intermediary of the Protecting Power and of the Central Prisoners of War Agency.

Parties to the conflict shall prepare and forward to each other through the same bureau, certificates of death or duly authenticated lists of the dead. They shall likewise collect and forward through the same bureau one half of a double identity disc, last wills or other documents of importance to the next of kin, money and in general all articles of an intrinsic or sentimental value, which are found on the dead. These articles, together with unidentified articles, shall be sent in sealed packets, accompanied by statements giving all particulars necessary for the identification of the deceased owners, as well as by a complete list of the contents of the parcel.

[...]

ARTICLE 18

The military authorities may appeal to the charity of the inhabitants voluntarily to collect and care for, under their direction, the wounded and sick, granting persons who have responded to this appeal the necessary protection and facilities. Should the adverse Party take or retake control of the area, he shall likewise grant these persons the same protection and the same facilities.

The military authorities shall permit the inhabitants and relief societies, even in invaded or occupied areas, spontaneously to collect and care for wounded or sick of whatever nationality. The civilian population shall respect these wounded and sick, and in particular abstain from offering them violence.

No one may ever be molested or convicted for having nursed the wounded or sick.

The provisions of the present Article do not relieve the occupying Power of its obligation to give both physical and moral care to the wounded and sick.

CHAPTER III MEDICAL UNITS AND ESTABLISHMENTS

ARTICLE 19

Fixed establishments and mobile medical units of the Medical Service may in no circumstances be attacked, but shall at all times be respected and protected by the Parties to the conflict. Should they fall into the hands of the adverse Party, their personnel shall be free to pursue their duties, as long as the capturing Power has not itself ensured the necessary care of the wounded and sick found in such establishments and units.

The responsible authorities shall ensure that the said medical establishments and units are, as far as possible, situated in such a manner that attacks against military objectives cannot imperil their safety.

ARTICLE 20

Hospital ships entitled to the protection of the Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, shall not be attacked from the land.

ARTICLE 21

The protection to which fixed establishments and mobile medical units of the Medical Service are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy. Protection may, however, cease only after a due warning has been given, naming, in all appropriate cases, a reasonable time limit, and after such warning has remained unheeded.

ARTICLE 22

The following conditions shall not be considered as depriving a medical unit or establishment of the protection guaranteed by Article 19:

- (1) That the personnel of the unit or establishment are armed, and that they use the arms in their own defence, or in that of the wounded and sick in their charge.
- (2) That in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort.
- (3) That small arms and ammunition taken from the wounded and sick and not yet handed to the proper service, are found in the unit or establishment.
- (4) That personnel and material of the veterinary service are found in the unit or establishment, without forming an integral part thereof.
- (5) That the humanitarian activities of medical units and establishments or of their personnel extend to the care of civilian wounded or sick.

ARTICLE 23

In time of peace, the High Contracting Parties and, after the outbreak of hostilities, the Parties thereto, may establish in their own territory and, if the need arises, in occupied areas, hospital zones and localities so organized as to protect the wounded and sick from the effects of war, as well as the personnel entrusted with the organization and administration of these zones and localities and with the care of the persons therein assembled.

Upon the outbreak and during the course of hostilities, the Parties concerned may conclude agreements on mutual recognition of the hospital zones and localities they have created. They may for this purpose implement the provisions of the Draft Agreement annexed to the present Convention, with such amendments as they may consider necessary.

The Protecting Powers and the International Committee of the Red Cross are invited to lend their good offices in order to facilitate the institution and recognition of these hospital zones and localities.

CHAPTER IV PERSONNEL

ARTICLE 24

Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, staff exclusively engaged in the administration of medical units and establishments, as well as chaplains attached to the armed forces, shall be respected and protected in all circumstances.

ARTICLE 25

Members of the armed forces specially trained for employment, should the need arise, as hospital orderlies, nurses or auxiliary stretcher-bearers, in the search for or the collection, transport or treatment of the wounded and sick shall likewise be respected and protected if they are carrying out these duties at the time when they come into contact with the enemy or fall into his hands.

ARTICLE 26

The staff of National Red Cross Societies and that of other Voluntary Aid Societies, duly recognized and authorized by their Governments, who may be employed on the same duties as the personnel named in Article 24, are placed on the same footing as the personnel named in the said Article, provided that the staff of such societies are subject to military laws and regulations.

Each High Contracting Party shall notify to the other, either in time of peace or at the commencement of or during hostilities, but in any case before actually employing them, the names of the societies which it has authorized, under its responsibility, to render assistance to the regular medical service of its armed forces.

ARTICLE 27

A recognized Society of a neutral country can only lend the assistance of its medical personnel and units to a Party to the conflict with the previous consent of its own Government and the authorization of the Party to the conflict concerned. That personnel and those units shall be placed under the control of that Party to the conflict.

The neutral Government shall notify this consent to the adversary of the State which accepts such assistance. The Party to the conflict who accepts such assistance is bound to notify the adverse Party thereof before making any use of it.

In no circumstances shall this assistance be considered as interference in the conflict.

The members of the personnel named in the first paragraph shall be duly furnished with the identity cards provided for in Article 40 before leaving the neutral country to which they belong.

ARTICLE 28

Personnel designated in Articles 24 and 26 who fall into the hands of the adverse Party, shall be retained only in so far as the state of health, the spiritual needs and the number of prisoners of war require.

Personnel thus retained shall not be deemed prisoners of war. Nevertheless they shall at least benefit by all the provisions of the Geneva Convention relative to the Treatment of Prisoners of War of 12 August 1949. Within the framework of the military laws and regulations of the Detaining Power, and under the authority of its competent service, they shall continue to carry out, in accordance with their professional ethics, their medical and spiritual duties on behalf of prisoners of war, preferably those of the armed forces to which they themselves belong. They shall further enjoy the following facilities for carrying out their medical or spiritual duties:

(a) They shall be authorized to visit periodically the prisoners of war in labour units or hospitals outside the camp. The Detaining Power shall put at their disposal the means of transport required.

(b) In each camp the senior medical officer of the highest rank shall be responsible to the military authorities of the camp for the professional activity of the retained medical personnel. For this purpose, from the outbreak of hostilities, the Parties to the conflict shall agree regarding the corresponding seniority of the ranks of their medical personnel, including those of the societies designated in Article 26. In all questions arising out of their duties, this medical officer, and the chaplains, shall have direct access to the military and medical authorities of the camp who shall grant them the facilities they may require for correspondence

relating to these questions.

(c) Although retained personnel in a camp shall be subject to its internal discipline, they shall not, however, be required to perform any work outside their medical or religious duties.

During hostilities the Parties to the conflict shall make arrangements for relieving where possible retained personnel, and shall settle the procedure of such relief.

None of the preceding provisions shall relieve the Detaining Power of the obligations imposed upon it with regard to the medical and spiritual welfare of the prisoners of war.

ARTICLE 29

Members of the personnel designated in Article 25 who have fallen into the hands of the enemy, shall be prisoners of war, but shall be employed on their medical duties in so far as the need arises.

ARTICLE 30

Personnel whose retention is not indispensable by virtue of the provisions of Article 28 shall be returned to the Party to the conflict to whom they belong, as soon as a road is open for their return and military requirements permit.

Pending their return, they shall not be deemed prisoners of war. Nevertheless they shall at least benefit by all the provisions of the Geneva Convention relative to the Treatment of Prisoners of War of 12 August 1949. They shall continue to fulfil their duties under the orders of the adverse Party and shall preferably be engaged in the care of the wounded and sick of the Party to the conflict to which they themselves belong.

On their departure, they shall take with them the effects, personal belongings, valuables and instruments belonging to them.

ARTICLE 31

The selection of personnel for return under Article 30 shall be made irrespective of any consideration of race, religion or political opinion, but preferably according to the chronological order of their capture and their state of health.

As from the outbreak of hostilities, Parties to the conflict may determine by special agreement the percentage of personnel to be retained, in proportion to the number of prisoners and the distribution of the said personnel in the camps.

ARTICLE 32

Persons designated in Article 27 who have fallen into the hands of the adverse Party may not be detained.

Unless otherwise agreed, they shall have permission to return to their country, or if this is not possible, to the territory of the Party to the conflict in whose service they were, as soon as a route for their return is open and military considerations permit.

Pending their release, they shall continue their work under the direction of the adverse Party; they shall preferably be engaged in the care of the wounded and sick of the Party to the conflict in whose service they were. On their departure, they shall take with them their effects personal articles and valuables and the instruments, arms and if possible the means of transport belonging to them.

The Parties to the conflict shall secure to this personnel, while in their power, the same food, lodging, allowances and pay as are granted to the corresponding personnel of their armed forces. The food shall in any case be sufficient as regards quantity, quality and variety to keep the said personnel in a normal state of health.

CHAPTER V. BUILDINGS AND MATERIAL

ARTICLE 33

The material of mobile medical units of the armed forces which fall into the hands of the enemy, shall be reserved for the care of wounded and sick.

The buildings, material and stores of fixed medical establishments of the armed forces shall remain subject to the laws of war, but may not be diverted from their purpose as long as they are required for the care of wounded and sick. Nevertheless, the commanders of forces in the field may make use of them, in case of urgent military necessity, provided that they make previous arrangements for the welfare of the wounded and sick who are nursed in them.

The material and stores defined in the present Article shall not be intentionally destroyed.

ARTICLE 34

The real and personal property of aid societies which are admitted to the privileges of the Convention shall be regarded as private property.

The right of requisition recognized for belligerents by the laws and customs of war shall not be exercised except in case of urgent necessity, and only after the welfare of the wounded and sick has been ensured.

CHAPTER VI MEDICAL TRANSPORTS

ARTICLE 35

Transports of wounded and sick or of medical equipment shall be respected and protected in the same way as mobile medical units.

Should such transports or vehicles fall into the hands of the adverse Party, they shall be subject to the laws of war, on condition that the Party to the conflict who captures them shall in all cases ensure the care of the wounded and sick they contain.

The civilian personnel and all means of transport obtained by requisition shall be subject to the general rules of international law.

ARTICLE 36

Medical aircraft, that is to say, aircraft exclusively employed for the removal of wounded and sick and for the transport of medical personnel and equipment, shall not be attacked, but shall be respected by the belligerents, while flying at heights, times and on routes specifically agreed upon between the belligerents concerned.

They shall bear, clearly marked, the distinctive emblem prescribed in Article 38, together with their national colours on their lower, upper and lateral surfaces. They shall be provided with any other markings or means of identification that may be agreed upon between the belligerents upon the outbreak or during the course of hostilities.

Unless agreed otherwise, flights over enemy or enemy-occupied territory are prohibited.

Medical aircraft shall obey every summons to land. In the event of a landing thus imposed, the aircraft with its occupants may continue its flight after examination, if any.

In the event of an involuntary landing in enemy or enemy-occupied territory, the wounded and sick, as well as the crew of the aircraft shall be prisoners of war. The medical personnel shall be treated according to Article 24 and the Articles following.

ARTICLE 37

Subject to the provisions of the second paragraph, medical aircraft of Parties to the conflict may fly over the territory of neutral Powers, land on it in case of necessity, or use it as a port of call. They shall give the neutral Powers previous notice of their passage over the said territory and obey all summons to alight, on land or water. They will be immune from attack only when flying on routes, at heights and at times specifically agreed upon between the Parties to the conflict and the neutral Power concerned.

The neutral Powers may, however, place conditions or restrictions on the passage or landing of medical aircraft on their territory. Such possible conditions or restrictions shall be applied equally to all Parties to the conflict.

Unless agreed otherwise between the neutral Power and the Parties to the conflict, the wounded and sick who are disembarked, with the consent of the local authorities, on neutral territory by medical aircraft, shall be detained by the neutral Power, where so required by international law, in such a manner that they cannot again take part in operations of war. The cost of their accommodation and internment shall be borne by the Power on which they depend.

CHAPTER VII THE DISTINCTIVE EMBLEM

ARTICLE 38

As a compliment to Switzerland, the heraldic emblem of the red cross on a white ground, formed by reversing the Federal colours, is retained as the emblem and distinctive sign of the Medical Service of armed forces.

Nevertheless, in the case of countries which already use as emblem, in place of the red cross, the red crescent or the red lion and sun on a white ground, those emblems are also recognized by the terms of the present Convention.

ARTICLE 39

Under the direction of the competent military authority, the emblem shall be displayed on the flags, armlets and on all equipment employed in the Medical Service.

ARTICLE 40

The personnel designated in Article 24 and in Articles 26 and 27 shall wear, affixed to the left arm, a water-resistant armlet bearing the distinctive emblem, issued and stamped by the military authority.

Such personnel, in addition to wearing the identity disc mentioned in Article 16, shall also carry a special identity card bearing the distinctive emblem. This card shall be water-resistant and of such size that it can be carried in the pocket. It shall be worded in the national language, shall mention at least the surname and first names, the date of birth, the rank and the service number of the bearer, and shall state in what capacity he is entitled to the protection of the present Convention. The card shall bear the photograph of the owner and also either his signature or his finger-prints or both. It shall be embossed with the stamp of the military authority.

The identity card shall be uniform throughout the same armed forces and, as far as possible, of a similar type in the armed forces of the High Contracting Parties. The Parties to the conflict may be guided by the model which is annexed, by way of example, to the present Convention. They shall inform each other, at the outbreak of hostilities, of the model they are using. Identity cards

should be made out, if possible, at least in duplicate, one copy being kept by the home country.

In no circumstances may the said personnel be deprived of their insignia or identity cards nor of the right to wear the armlet. In case of loss, they shall be entitled to receive duplicates of the cards and to have the insignia replaced.

ARTICLE 41

The personnel designated in Article 25 shall wear, but only while carrying out medical duties, a white armlet bearing in its centre the distinctive sign in miniature; the armlet shall be issued and stamped by the military authority.

Military identity documents to be carried by this type of personnel shall specify what special training they have received, the temporary character of the duties they are engaged upon, and their authority for wearing the armlet.

ARTICLE 42

The distinctive flag of the Convention shall be hoisted only over such medical units and establishments as are entitled to be respected under the Convention, and only with the consent of the military authorities. In mobile units, as in fixed establishments, it may be accompanied by the national flag of the Party to the conflict to which the unit or establishment belongs.

Nevertheless, medical units which have fallen into the hands of the enemy shall not fly any flag other than that of the Convention. Parties to the conflict shall take the necessary steps, in so far as military considerations permit, to make the distinctive emblems indicating medical units and establishments clearly visible to the enemy land, air or naval forces, in order to obviate the possibility of any hostile action.

ARTICLE 43

The medical units belonging to neutral countries, which may have been authorized to lend their services to a belligerent under the conditions laid down in Article 27, shall fly, along with the flag of the Convention, the national flag of that belligerent, wherever the latter makes use of the faculty conferred on him by Article 42.

Subject to orders to the contrary by the responsible military authorities, they may on all occasions fly their national flag, even if they fall into the hands of the adverse Party.

ARTICLE 44

With the exception of the cases mentioned in the following paragraphs of the present Article, the emblem of the red cross on a white ground and the words "Red Cross" or "Geneva Cross" may not be employed, either in time of peace or in time of war, except to indicate or to protect the medical units and establishments, the personnel and material protected by the present Convention and other Conventions dealing with similar matters. The same shall apply to the emblems mentioned in Article 38, second paragraph, in respect of the countries which use them. The National Red Cross Societies and other societies designated in Article 26 shall have the right to use the distinctive emblem conferring the protection of the Convention only within the framework of the present paragraph.

Furthermore, National Red Cross (Red Crescent, Red Lion and Sun) Societies may, in time of peace, in accordance with their rational legislation, make use of the name and emblem of the Red Cross for their other activities which are in conformity with the principles laid down by the International Red Cross Conferences. When those activities are carried out in time of war, the conditions for the use of the emblem shall be such that it cannot be considered as conferring the protection of the Convention; the emblem shall be comparatively small in size and may not be placed on armlets or on the roofs of buildings.

The international Red Cross organizations and their duly authorized personnel shall be permitted to make use, at all times, of the emblem of the Red Cross on a white ground.

As an exceptional measure, in conformity with national legislation and with the express permission of one of the National Red Cross (Red Crescent, Red Lion and Sun) Societies, the emblem of the Convention may be employed in time of peace to identify vehicles used as ambulances and to mark the position of aid stations exclusively assigned to the purpose of giving free treatment to the wounded or sick.

CHAPTER VIII EXECUTION OF THE CONVENTION

[...]

ARTICLE 46

Reprisals against the wounded, sick, personnel, buildings or equipment protected by the Convention are prohibited.

[...]

CHAPTER IX REPRESSION OF ABUSES AND INFRACTIONS

ARTICLE 49

The High Contracting Parties undertake to enact any legislation necessary to provide effective penal sanctions for persons

committing, or ordering to be committed, any of the grave breaches of the present Convention defined in the following Article.

Each High Contracting Party shall be under the obligation to search for persons alleged to have committed, or to have ordered to be committed, such grave breaches, and shall bring such persons, regardless of their nationality, before its own courts. It may also, if it prefers, and in accordance with the provisions of its own legislation, hand such persons over for trial to another High Contracting Party concerned, provided such High Contracting Party has made out a *prima facie* case.

Each High Contracting Party shall take measures necessary for the suppression of all acts contrary to the provisions of the present Convention other than the grave breaches defined in the following Article.

In all circumstances, the accused persons shall benefit by safeguards of proper trial and defence, which shall not be less favourable than those provided by Article 105 and those following, of the Geneva Convention relative to the Treatment of Prisoners of War of 12 August 1949.

ARTICLE 50

Grave breaches to which the preceding Article relates shall be those involving any of the following acts, if committed against persons or property protected by the Convention: wilful killing, torture or inhuman treatment, including biological experiments, wilfully causing great suffering or serious injury to body or health, and extensive destruction and appropriation of property, not justified by military necessity and carried out unlawfully and wantonly.

[...]

ARTICLE 53

The use by individuals, societies, firms or companies either public or private, other than those entitled thereto under the present Convention, of the emblem or the designation “Red Cross” or “Geneva Cross” or any sign or designation constituting an imitation thereof, whatever the object of such use, and irrespective of the date of its adoption, shall be prohibited at all times.

By reason of the tribute paid to Switzerland by the adoption of the reversed Federal colours, and of the confusion which may arise between the arms of Switzerland and the distinctive emblem of the Convention, the use by private individuals, societies or firms, of the arms of the Swiss Confederation, or of marks constituting an imitation thereof, whether as trademarks or commercial marks, or as parts of such marks, or for a purpose contrary to commercial honesty, or in circumstances capable of wounding Swiss national sentiment, shall be prohibited at all times.

Nevertheless, such High Contracting Parties as were not party to the Geneva Convention of 27 July 1929, may grant to prior users of the emblems, designations, signs or marks designated in the first paragraph, a time limit not to exceed three years from the coming into force of the present Convention to discontinue such use provided that the said use shall not be such as would appear, in time of war, to confer the protection of the Convention.

The prohibition laid down in the first paragraph of the present Article shall also apply, without effect on any rights acquired through prior use, to the emblems and marks mentioned in the second paragraph of Article 38.

ARTICLE 54

The High Contracting Parties shall, if their legislation is not already adequate, take measures necessary for the prevention and repression, at all times, of the abuses referred to under Article 53.

FINAL PROVISIONS

[...]

ARTICLE 56

The present Convention, which bears the date of this day, is open to signature until 12 February 1950, in the name of the Powers represented at the Conference which opened at Geneva on 21 April 1949; furthermore, by Powers not represented at that Conference but which are Parties to the Geneva Conventions of 1864, 1906 or 1929 for the Relief of the Wounded and Sick in Armies in the Field.

[...]

ARTICLE 59

The present Convention replaces the Conventions of 22 August 1864, 6 July 1906, and 27 July 1929, in relations between the High Contracting Parties.

[...]

ANNEX I DRAFT AGREEMENT RELATING TO HOSPITAL ZONES AND LOCALITIES

ARTICLE 1

Hospital zones shall be strictly observed for the persons named in Article 23 of the Geneva Convention for the Amelioration of

the Condition of the Wounded and Sick in the Armed Forces in the Field of 12 August 1949, and for the personnel entrusted with the organization and administration of these zones and localities, and with the care of the persons therein assembled. Nevertheless, persons whose permanent residence is within such zones shall have the right to stay there.

ARTICLE 2

No persons residing, in whatever capacity, in a hospital zone shall perform any work, either within or without the zone, directly connected with military operations or the production of war material.

ARTICLE 3

The Power establishing a hospital zone shall take all necessary measures to prohibit access to all persons who have no right of residence or entry therein.

ARTICLE 4

Hospital zones shall fulfil the following conditions:

- (a) They shall comprise only a small part of the territory governed by the Power which has established them.
- (b) They shall be thinly populated in relation to the possibilities of accommodation.
- (c) They shall be far removed and free from all military objectives, or large industrial or administrative establishments.
- (d) They shall not be situated in areas which, according to every probability, may become important for the conduct of the war.

ARTICLE 5

Hospital zones shall be subject to the following obligations:

- (a) The lines of communication and means of transport which they possess shall not be used for the transport of military personnel or material, even in transit.
- (b) They shall in no case be defended by military means.

ARTICLE 6

Hospital zones shall be marked by means of red crosses (red crescents, red lions and suns) on a white background placed on the outer precincts and on the buildings. They may be similarly marked at night by means of appropriate illumination.

ARTICLE 7

The Powers shall communicate to all High Contracting Parties in peacetime or on the outbreak of hostilities, a list of the hospital zones in the territories governed by them. They shall also give notice of any new zones set up during hostilities.

As soon as the adverse Party has received the above-mentioned notification, the zone shall be regularly constituted.

If, however, the adverse Party considers that the conditions of the present agreement have not been fulfilled, it may refuse to recognize the zone by giving immediate notice thereof to the Party responsible for the said Zone, or may make its recognition of such zone dependent upon the institution of the control provided for in Article 8.

ARTICLE 8

Any Power having recognized one of several hospital zones instituted by the adverse Party shall be entitled to demand control by one or more Special Commissioners, for the purpose of ascertaining if the zones fulfil the conditions and obligations stipulated in the present agreement.

For this purpose, the members of the Special Commissions shall at all times have free access to the various zones and may even reside there permanently. They shall be given all facilities for their duties of inspection.

ARTICLE 9

Should the Special Commissions note any facts which they consider contrary to the stipulations of the present agreement, they shall at once draw the attention of the Power governing the said zone to these facts, and shall fix a time limit of five days within which the matter should be rectified. They shall duly notify the Power who has recognized the zone.

If, when the time limit has expired, the Power governing the zone has not complied with the warning, the adverse Party may declare that it is no longer bound by the present agreement in respect of the said zone.

ARTICLE 10

Any Power setting up one or more hospital zones and localities, and the adverse Parties to whom their existence has been notified, shall nominate or have nominated by neutral Powers, the persons who shall be members of the Special Commissions mentioned in Articles 8 and 9.

ARTICLE 11

In no circumstances may hospital zones be the object of attack. They shall be protected and respected at all times by the Parties to the conflict.

ARTICLE 12

In the case of occupation of a territory, the hospital zones therein shall continue to be respected and utilized as such. Their purpose may, however, be modified by the Occupying Power, on condition that all measures are taken to ensure the safety of the persons accommodated.

ARTICLE 13

The present agreement shall also apply to localities which the Powers may utilize for the same purposes as hospital zones.

ANNEX II IDENTITY CARD FOR MEMBERS OF MEDICAL AND RELIGIOUS PERSONNEL ATTACHED TO THE ARMED FORCES

[...]

1949 Geneva Convention (II) for Amelioration of Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea

[...]

CHAPTER I GENERAL PROVISIONS

[...]

ARTICLE 3

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria. To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- (a) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
- (b) Taking of hostages;
- (c) Outrages upon personal dignity, in particular, humiliating and degrading treatment;
- (d) The passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded, sick and shipwrecked shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

[...]

ARTICLE 4

In case of hostilities between land and naval forces of Parties to the conflict, the provisions of the present Convention shall apply only to forces on board ship.

Forces put ashore shall immediately become subject to the provisions of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949.

ARTICLE 5

Neutral Powers shall apply by analogy the provisions of the present Convention to the wounded, sick and shipwrecked, and to members of the medical personnel and to chaplains of the armed forces of the Parties to the conflict received or interned in their

territory, as well as to dead persons found.

ARTICLE 6

In addition to the agreements expressly provided for in Articles 10, 18, 31, 38, 39, 40, 43 and 53, the High Contracting Parties may conclude other special agreements for all matters concerning which they may deem it suitable to make separate provision. No special agreement shall adversely affect the situation of wounded, sick and shipwrecked persons, of members of the medical personnel or of chaplains, as defined by the present Convention, nor restrict the rights which it confers upon them.

Wounded, sick, and shipwrecked persons, as well as medical personnel and chaplains, shall continue to have the benefit of such agreements as long as the Convention is applicable to them, except where express provisions to the contrary are contained in the aforesaid or in subsequent agreements, or where more favourable measures have been taken with regard to them by one or other of the Parties to the conflict.

ARTICLE 7

Wounded, sick and shipwrecked persons, as well as members of the medical personnel and chaplains, may in no circumstances renounce in part or in entirety the rights secured to them by the present Convention, and by the special agreements referred to in the foregoing Article, if such there be.

ARTICLE 8

The present Convention shall be applied with the cooperation and under the scrutiny of the Protecting Powers whose duty it is to safeguard the interests of the Parties to the conflict. For this purpose, the Protecting Powers may appoint, apart from their diplomatic or consular staff, delegates from amongst their own nationals or the nationals of other neutral Powers. The said delegates shall be subject to the approval of the Power with which they are to carry out their duties.

The Parties to the conflict shall facilitate to the greatest extent possible the task of the representatives or delegates of the Protecting Powers.

The representatives or delegates of the Protecting Powers shall not in any case exceed their mission under the present Convention. They shall, in particular, take account of the imperative necessities of security of the State wherein they carry out their duties. Their activities shall only be restricted as an exceptional and temporary measure when this is rendered necessary by imperative military necessities.

ARTICLE 9

The provisions of the present Convention constitute no obstacle to the humanitarian activities which the International Committee of the Red Cross or any other impartial humanitarian organization may, subject to the consent of the Parties to the conflict concerned, undertake for the protection of wounded, sick and shipwrecked persons, medical personnel and chaplains, and for their relief.

ARTICLE 10

The High Contracting Parties may at any time agree to entrust to an organization which offers all guarantees of impartiality and efficacy the duties incumbent on the Protecting Powers by virtue of the present Convention.

When wounded, sick and shipwrecked, or medical personnel and chaplains do not benefit or cease to benefit, no matter for what reason, by the activities of a Protecting Power or of an organization provided for in the first paragraph above, the Detaining Power shall request a neutral State, or such an organization, to undertake the functions performed under the present Convention by a Protecting Power designated by the Parties to a conflict.

If protection cannot be arranged accordingly, the Detaining Power shall request or shall accept, subject to the provisions of this Article, the offer of the services of a humanitarian organization, such as the International Committee of the Red Cross, to assume the humanitarian functions performed by Protecting Powers under the present Convention.

Any neutral Power, or any organization invited by the Power concerned or offering itself for these purposes, shall be required to act with a sense of responsibility towards the Party to the conflict on which persons protected by the present Convention depend, and shall be required to furnish sufficient assurances that it is in a position to undertake the appropriate functions and to discharge them impartially.

No derogation from the preceding provisions shall be made by special agreements between Powers one of which is restricted, even temporarily, in its freedom to negotiate with the other Power or its allies by reason of military events, more particularly where the whole, or a substantial part, of the territory of the said Power is occupied.

Whenever, in the present Convention, mention is made of a Protecting Power, such mention also applies to substitute organizations in the sense of the present Article.

ARTICLE 11

In cases where they deem it advisable in the interest of protected persons, particularly in cases of disagreement between the Parties to the conflict as to the application or interpretation of the provisions of the present Convention, the Protecting Powers

shall lend their good offices with a view to settling the disagreement.

For this purpose, each of the Protecting Powers may, either at the invitation of one Party or on its own initiative, propose to the Parties to the conflict a meeting of their representatives, in particular of the authorities responsible for the wounded, sick and shipwrecked, medical personnel and chaplains, possibly on neutral territory suitably chosen. The Parties to the conflict shall be bound to give effect to the proposals made to them for this purpose. The Protecting Powers may, if necessary, propose for approval by the Parties to the conflict, a person belonging to a neutral Power or delegated by the International Committee of the Red Cross, who shall be invited to take part in such a meeting.

CHAPTER II WOUNDED, SICK AND SHIPWRECKED

ARTICLE 12

Members of the armed forces and other persons mentioned in the following Article, who are at sea and who are wounded, sick or shipwrecked, shall be respected and protected in all circumstances, it being understood that the term “shipwreck” means shipwreck from any cause and includes forced landings at sea by or from aircraft.

Such persons shall be treated humanely and cared for by the Parties to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected to torture or to biological experiments; they shall not willfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.

Only urgent medical reasons will authorize priority in the order of treatment to be administered. Women shall be treated with all consideration due to their sex.

ARTICLE 13

The present Convention shall apply to the wounded, sick and shipwrecked at sea belonging to the following categories:

1. Members of the armed forces of a Party to the conflict, as well as members of militias or volunteer corps forming part of such armed forces.
2. Members of other militias and members of other volunteer corps including those of organized resistance movements, belonging to a Party to the conflict and operating in or outside their own territory, even if this territory is occupied, provided that such militias or volunteer corps, including such organized resistance movements, fulfill the following conditions:
 - (a) That of being commanded by a person responsible for his subordinates;
 - (b) That of having a fixed distinctive sign recognizable at a distance;
 - (c) That of carrying arms openly;
 - (d) That of conducting their operations in accordance with the laws and customs of war.
3. Members of regular armed forces who profess allegiance to a Government or an authority not recognized by the Detaining Power.
4. Persons who accompany the armed forces without actually being members thereof, such as civilian members of military aircraft crews, war correspondents, supply contractors, members of labour units or of services responsible for the welfare of the armed forces. provided that they have received authorization from the armed forces which they accompany.
5. Members of crews, including masters, pilots and apprentices of the merchant marine and the crews of civil aircraft of the Parties to the conflict, who do not benefit by more favourable treatment under any other provisions of international law.
6. Inhabitants of a non-occupied territory who, on the approach of the enemy, spontaneously take up arms to resist the invading forces, without having had time to form themselves into regular armed units, provided they carry arms openly and respect the laws and customs of war.

ARTICLE 14

All warships of a belligerent Party shall have the right to demand that the wounded, sick or shipwrecked on board military hospital ships, and hospital ships belonging to relief societies or to private individuals, as well as merchant vessels, yachts and other craft shall be surrendered, whatever their nationality, provided that the wounded and sick are in a fit state to be moved and that the warship can provide adequate facilities for necessary medical treatment.

ARTICLE 15

If wounded, sick or shipwrecked persons are taken on board a neutral warship or a neutral military aircraft, it shall be ensured, where so required by international law, that they can take no further part in operations of war.

ARTICLE 16

Subject to the provisions of Article 12, the wounded, sick and shipwrecked of a belligerent who fall into enemy hands shall be prisoners of war, and the provisions of international law concerning prisoners of war shall apply to them. The captor may decide,

according to circumstances, whether it is expedient to hold them, or to convey them to a port in the captor's own country, to a neutral port or even to a port in enemy territory. In the last case, prisoners of war thus returned to their home country may not serve for the duration of the war.

ARTICLE 17

Wounded, sick or shipwrecked persons who are landed in neutral ports with the consent of the local authorities, shall, failing arrangements to the contrary between the neutral and the belligerent Powers, be so guarded by the neutral Power, where so required by international law, that the said persons cannot again take part in operations of war.

The costs of hospital accommodation and internment shall be borne by the Power on whom the wounded, sick or shipwrecked persons depend.

ARTICLE 18

After each engagement, Parties to the conflict shall, without delay, take all possible measures to search for and collect the shipwrecked, wounded and sick, to protect them against pillage and ill-treatment, to ensure their adequate care, and to search for the dead and prevent their being despoiled.

Whenever circumstances permit, the Parties to the conflict shall conclude local arrangements for the removal of the wounded and sick by sea from a besieged or encircled area and for the passage of medical and religious personnel and equipment on their way to that area.

ARTICLE 19

The Parties to the conflict shall record as soon as possible, in respect of each shipwrecked, wounded, sick or dead person of the adverse Party falling into their hands, any particulars which may assist in his identification. These records should if possible include:

- (a) Designation of the Power on which he depends;
- (b) Army, regimental, personal or serial number;
- (c) Surname;
- (d) First name or names;
- (e) Date of birth;
- (f) Any other particulars shown on his identity card or disc; (g) Date and place of capture or death;
- (h) Particulars concerning wounds or illness, or cause of death. As soon as possible the above-mentioned information shall be forwarded to the information bureau described in Article 122 of the Geneva Convention relative to the Treatment of Prisoners of War of August 12, 1949, which shall transmit this information to the Power on which these persons depend through the intermediary of the Protecting Power and of the Central Prisoners of War Agency.

Parties to the conflict shall prepare and forward to each other, through the same bureau, certificates of death or duly authenticated lists of the dead. They shall likewise collect and forward through the same bureau one half of the double identity disc, or the identity disc itself if it is a single disc, last wills or other documents of importance to the next of kin, money and in general all articles of an intrinsic or sentimental value, which are found on the dead. These articles, together with unidentified articles, shall be sent in sealed packets, accompanied by statements giving all particulars necessary for the identification of the deceased owners, as well as by a complete list of the contents of the parcel.

[...]

ARTICLE 21

The Parties to the conflict may appeal to the charity of commanders of neutral merchant vessels, yachts or other craft, to take on board and care for wounded, sick or shipwrecked persons, and to collect the dead.

Vessels of any kind responding to this appeal, and those having of their own accord collected wounded, sick or shipwrecked persons, shall enjoy special protection and facilities to carry out such assistance.

They may, in no case, be captured on account of any such transport; but, in the absence of any promise to the contrary, they shall remain liable to capture for any violations of neutrality they may have committed.

CHAPTER III HOSPITAL SHIPS

ARTICLE 22

Military hospital ships, that is to say, ships built or equipped by the Powers specially and solely with a view to assisting the wounded, sick and shipwrecked, to treating them and to transporting them, may in no circumstances be attacked or captured, but shall at all times be respected and protected, on condition that their names and descriptions have been notified to the Parties to the conflict ten days before those ships are employed.

The characteristics which must appear in the notification shall include registered gross tonnage, the length from stem to stern and

the number of masts and funnels.

ARTICLE 23

Establishments ashore entitled to the protection of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949, shall be protected from bombardment or attack from the sea.

ARTICLE 24

Hospital ships utilized by National Red Cross Societies, by officially recognized relief societies or by private persons shall have the same protection as military hospital ships and shall be exempt from capture, if the Party to the conflict on which they depend has given them an official commission and in so far as the provisions of Article 22 concerning notification have been complied with.

These ships must be provided with certificates from the responsible authorities, stating that the vessels have been under their control while fitting out and on departure.

ARTICLE 25

Hospital ships utilized by National Red Cross Societies, officially recognized relief societies, or private persons of neutral countries shall have the same protection as military hospital ships and shall be exempt from capture, on condition that they have placed themselves under the control of one of the Parties to the conflict, with the previous consent of their own governments and with the authorization of the Party to the conflict concerned, in so far as the provisions of Article 22 concerning notification have been complied with.

ARTICLE 26

The protection mentioned in Articles 22, 24 and 25 shall apply to hospital ships of any tonnage and to their lifeboats, wherever they are operating. Nevertheless, to ensure the maximum comfort and security, the Parties to the conflict shall endeavour to utilize, for the transport of wounded, sick and shipwrecked over long distances and on the high seas, only hospital ships of over 2,000 tons gross.

ARTICLE 27

Under the same conditions as those provided for in Articles 22 and 24, small craft employed by the State or by the officially recognized lifeboat institutions for coastal rescue operations shall also be respected and protected, so far as operational requirements permit.

The same shall apply so far as possible to fixed coastal installations used exclusively by these craft for their humanitarian missions.

ARTICLE 28

Should fighting occur on board a warship, the sick-bays shall be respected and spared as far as possible. Sick-bays and their equipment shall remain subject to the laws of warfare, but may not be diverted from their purpose so long as they are required for the wounded and sick. Nevertheless, the commander into whose power they have fallen may, after ensuring the proper care of the wounded and sick who are accommodated therein, apply them to other purposes in case of urgent military necessity.

ARTICLE 29

Any hospital ship in a port which falls into the hands of the enemy shall be authorized to leave the said port.

ARTICLE 30

The vessels described in Articles 22, 24, 25 and 27 shall afford relief and assistance to the wounded, sick and shipwrecked without distinction of nationality.

The High Contracting Parties undertake not to use these vessels for any military purpose.

Such vessels shall in no wise hamper the movements of the combatants.

During and after an engagement, they will act at their own risk.

ARTICLE 31

The Parties to the conflict shall have the right to control and search the vessels mentioned in Articles 22, 24, 25 and 27. They can refuse assistance from these vessels order them off, make them take a certain course, control the use of their wireless and other means of communication, and even detain them for a period not exceeding seven days from the time of interception, if the gravity of the circumstances so requires.

They may put a commissioner temporarily on board whose sole task shall be to see that orders given in virtue of the provisions of the preceding paragraph are carried out

As far as possible, the Parties to the conflict shall enter in the log of the hospital ship, in a language he can understand, the orders they have given the captain of the vessel.

Parties to the conflict may, either unilaterally or by particular agreements, put on board their ships neutral observers who shall

verify the strict observation of the provisions contained in the present Convention.

ARTICLE 32

Vessels described in Articles 22, 24, 25 and 27 are not classed as warships as regards their stay in a neutral port.

ARTICLE 33

Merchant vessels which have been transformed into hospital ships cannot be put to any other use throughout the duration of hostilities.

ARTICLE 34

The protection to which hospital ships and sick-bays are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy. Protection may, however, cease only after due warning has been given, warning in all appropriate cases a reasonable time limit, and after such warning has remained unheeded.

In particular, hospital ships may not possess or use a secret code for their wireless or other means of communication.

ARTICLE 35

The following conditions shall not be considered as depriving hospital ships or sick-bays of vessels of the protection due to them:

1. The fact that the crews of ships or sick-bays are armed for the maintenance of order, for their own defence or that of the sick and wounded.
2. The presence on board of apparatus exclusively intended to facilitate navigation or communication.
3. The discovery on board hospital ships or in sick-bays of portable arms and ammunition taken from the wounded, sick and shipwrecked and not yet handed to the proper service.
4. The fact that the humanitarian activities of hospital ships and sickbays of vessels or of the crews extend to the care of wounded, sick or shipwrecked civilians.
5. The transport of equipment and of personnel intended exclusively for medical duties, over and above the normal requirements.

CHAPTER IV PERSONNEL

ARTICLE 36

The religious, medical and hospital personnel of hospital ships and their crews shall be respected and protected; they may not be captured during the time they are in the service of the hospital ship, whether or not there are wounded and sick on board.

ARTICLE 37

The religious, medical and hospital personnel assigned to the medical or spiritual care of the persons designated in Articles 12 and 13 shall, if they fall into the hands of the enemy, be respected and protected; they may continue to carry out their duties as long as this is necessary for the care of the wounded and sick. They shall afterwards be sent back as soon as the Commander-in-Chief, under whose authority they are, considers it practicable. They may take with them, on leaving the ship, their personal property.

If, however, it proves necessary to retain some of this personnel owing to the medical or spiritual needs of prisoners of war, everything possible shall be done for their earliest possible landing.

Retained personnel shall be subject, on landing, to the provisions of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949.

CHAPTER V MEDICAL TRANSPORTS

ARTICLE 38

Ships chartered for that purpose shall be authorized to transport equipment exclusively intended for the treatment of wounded and sick members of armed forces or for the prevention of disease, provided that the particulars regarding their voyage have been notified to the adverse Power and approved by the latter. The adverse Power shall preserve the right to board the carrier ships, but not to capture them or seize the equipment carried.

By agreement amongst the Parties to the conflict, neutral observers may be placed on board such ships to verify the equipment carried. For this purpose, free access to the equipment shall be given.

ARTICLE 39

Medical aircraft, that is to say, aircraft exclusively employed for the removal of wounded, sick and shipwrecked, and for the transport of medical personnel and equipment, may not be the object of attack, but shall be respected by the Parties to the conflict, while flying at heights, at times and on routes specifically agreed upon between the Parties to the conflict concerned.

They shall be clearly marked with the distinctive emblem prescribed in Article 41, together with their national colours, on their

lower, upper and lateral surfaces. They shall be provided with any other markings or means of identification which may be agreed upon between the Parties to the conflict upon the outbreak or during the course of hostilities.

Unless agreed otherwise, flights over enemy or enemy-occupied territory are prohibited.

Medical aircraft shall obey every summons to alight on land or water. In the event of having thus to alight, the aircraft with its occupants may continue its flight after examination, if any.

In the event of alighting involuntarily on land or water in enemy or enemy-occupied territory, the wounded, sick and shipwrecked, as well as the crew of the aircraft shall be prisoners of war. The medical personnel shall be treated according to Articles 36 and 37.

ARTICLE 40

Subject to the provisions of the second paragraph, medical aircraft of Parties to the conflict may fly over the territory of neutral Powers, land thereon in case of necessity, or use it as a port of call. They shall give neutral Powers prior notice of their passage over the said territory, and obey every summons to alight, on land or water. They will be immune from attack only when flying on routes, at heights and at times specifically agreed upon between the Parties to the conflict and the neutral Power concerned.

The neutral Powers may, however, place conditions or restrictions on the passage or landing of medical aircraft on their territory. Such possible conditions or restrictions shall be applied equally to all Parties to the conflict.

Unless otherwise agreed between the neutral Powers and the Parties to the conflict, the wounded, sick or shipwrecked who are disembarked with the consent of the local authorities on neutral territory by medical aircraft shall be detained by the neutral Power, where so required by international law, in such a manner that they cannot again take part in operations of war. The cost of their accommodation and internment shall be borne by the Power on which they depend.

CHAPTER VI THE DISTINCTIVE EMBLEM

ARTICLE 41

Under the direction of the competent military authority, the emblem of the Red Cross on a white ground shall be displayed on the flags, armlets and on all equipment employed in the Medical Service.

Nevertheless, in the case of countries which already use as emblem, in place of the red cross, the red crescent or the red lion and sun on a white ground, these emblems are also recognized by the terms of the present Convention.

ARTICLE 42

The personnel designated in Articles 36 and 37 shall wear, affixed to the left arm, a water-resistant armlet bearing the distinctive emblem, issued and stamped by the military authority.

Such personnel, in addition to wearing the identity disc mentioned in Article 19, shall also carry a special identity card bearing the distinctive emblem. This card shall be water-resistant and of such size that it can be carried in the pocket. It shall be worded in the national language, shall mention at least the surname and first names, the date of birth, the rank and the service number of the bearer, and shall state in what capacity he is entitled to the protection of the present Convention. The card shall bear the photograph of the owner and also either his signature or his finger-prints or both. It shall be embossed with the stamp of the military authority.

The identity card shall be uniform throughout the same armed forces and, as far as possible, of a similar type in the armed forces of the High Contracting Parties. The Parties to the conflict may be guided by the model which is annexed, by way of example, to the present Convention. They shall inform each other, at the outbreak of hostilities, of the model they are using. Identity cards should be made out, if possible, at least in duplicate, one copy being kept by the home country.

In no circumstances may the said personnel be deprived of their insignia or identity cards nor of the right to wear the armlet. In cases of loss they shall be entitled to receive duplicates of the cards and to have the insignia replaced.

ARTICLE 43

The ships designated in Articles 22, 24, 25 and 27 shall be distinctively marked as follows:

(a) All exterior surfaces shall be white.

(b) One or more dark red crosses, as large as possible, shall be painted and displayed on each side of the hull and on the horizontal surfaces, so placed as to afford the greatest possible visibility from the sea and from the air.

All hospital ships shall make themselves known by hoisting their national flag and further, if they belong to a neutral state, the flag of the Party to the conflict whose direction they have accepted. A white flag with a red cross shall be flown at the mainmast as high as possible.

Lifeboats of hospital ships, coastal lifeboats and all small craft used by the Medical Service shall be painted white with dark red crosses prominently displayed and shall, in general, comply with the identification system prescribed above for hospital ships.

The above-mentioned ships and craft, which may wish to ensure by night and in times of reduced visibility the protection to which they are entitled, must, subject to the assent of the Party to the conflict under whose power they are, take the necessary measures to render their painting and distinctive emblems sufficiently apparent.

Hospital ships which, in accordance with Article 31, are provisionally detained by the enemy, must haul down the flag of the Party to the conflict in whose service they are or whose direction they have accepted.

Coastal lifeboats, if they continue to operate with the consent of the Occupying Power from a base which is occupied, may be allowed, when away from their base, to continue to fly their own national colours along with a flag carrying a red cross on a white ground, subject to prior notification to all the Parties to the conflict concerned. All the provisions in this Article relating to the Red Cross shall apply equally to the other emblems mentioned in Article 41.

Parties to the conflict shall at all times endeavour to conclude mutual agreements, in order to use the most modern methods available to facilitate the identification of hospital ships.

ARTICLE 44

The distinguishing signs referred to in Article 43 can only be used, whether in time of peace or war, for indicating or protecting the ships therein mentioned, except as may be provided in any other international Convention or by agreement between all the Parties to the conflict concerned.

ARTICLE 45

The High Contracting Parties shall, if their legislation is not already adequate, take the measures necessary for the prevention and repression, at all times, of any abuse of the distinctive signs provided for under Article 43.

CHAPTER VII EXECUTION OF THE CONVENTION

[...]

ARTICLE 47

Reprisals against the wounded, sick and shipwrecked persons, the personnel, the vessels or the equipment protected by the Convention are prohibited.

[...]

CHAPTER VIII REPRESSION OF ABUSES AND INFRACTIONS

ARTICLE 50

The High Contracting Parties undertake to enact any legislation necessary to provide effective penal sanctions for persons committing, or ordering to be committed, any of the grave breaches of the present Convention defined in the following Article.

Each High Contracting Party shall be under the obligation to search for persons alleged to have committed, or to have ordered to be committed, such grave breaches, and shall bring such persons, regardless of their nationality, before its own courts. It may also, if it prefers, and in accordance with the provisions of its own legislation, hand such persons over for trial to another High Contracting Party concerned, provided such High Contracting Party has made out a prima facie case.

Each High Contracting Party shall take measures necessary for the suppression of all acts contrary to the provisions of the present Convention other than the grave breaches defined in the following Article.

In all circumstances, the accused persons shall benefit by safeguards of proper trial and defence, which shall not be less favourable than those provided by Article 105 and those following of the Geneva Convention relative to the Treatment of Prisoners of War of August 12, 1949.

ARTICLE 51

Grave breaches to which the preceding Article relates shall be those involving any of the following acts, if committed against persons or property protected by the Convention: willful killing, torture or inhuman treatment, including biological experiments, willfully causing great suffering or serious injury to body or health, and extensive destruction and appropriation of property, not justified by military necessity and carried out unlawfully and wantonly.

[...]

FINAL PROVISIONS

[...]

ARTICLE 58

The present Convention replaces the Xth Hague Convention of October 18, 1907, for the adaptation to Maritime Warfare of the principles of the Geneva Convention of 1906, in relations between the High Contracting Parties.

[...].

ANNEX IDENTITY CARD FOR MEMBERS OF MEDICAL AND RELIGIOUS PERSONNEL ATTACHED TO THE ARMED FORCES AT SEA

[...]

1949 Geneva Convention (III) relative to the Treatment of Prisoners of War

[...]

PART I GENERAL PROVISIONS

[...]

Article 3

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria. To this end the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- (a) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
- (b) Taking of hostages;
- (c) Outrages upon personal dignity, in particular, humiliating and degrading treatment;
- (d) The passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded and sick shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

[...]

Article 4

A. Prisoners of war, in the sense of the present Convention, are persons belonging to one of the following categories, who have fallen into the power of the enemy:

1. Members of the armed forces of a Party to the conflict as well as members of militias or volunteer corps forming part of such armed forces.
2. Members of other militias and members of other volunteer corps, including those of organized resistance movements, belonging to a Party to the conflict and operating in or outside their own territory, even if this territory is occupied, provided that such militias or volunteer corps, including such organized resistance movements, fulfil the following conditions:
 - (a) That of being commanded by a person responsible for his subordinates;
 - (b) That of having a fixed distinctive sign recognizable at a distance;
 - (c) That of carrying arms openly;
 - (d) That of conducting their operations in accordance with the laws and customs of war.
3. Members of regular armed forces who profess allegiance to a government or an authority not recognized by the Detaining Power.
4. Persons who accompany the armed forces without actually being members thereof, such as civilian members of military aircraft crews, war correspondents, supply contractors, members of labour units or of services responsible for the welfare of the armed forces, provided that they have received authorization from the armed forces which they accompany, who shall provide them for that purpose with an identity card similar to the annexed model.

5. Members of crews, including masters, pilots and apprentices, of the merchant marine and the crews of civil aircraft of the Parties to the conflict, who do not benefit by more favourable treatment under any other provisions of international law.

6. Inhabitants of a non-occupied territory, who on the approach of the enemy spontaneously take up arms to resist the invading forces, without having had time to form themselves into regular armed units, provided they carry arms openly and respect the laws and customs of war.

B. The following shall likewise be treated as prisoners of war under the present Convention:

1. Persons belonging, or having belonged, to the armed forces of the occupied country, if the occupying Power considers it necessary by reason of such allegiance to intern them, even though it has originally liberated them while hostilities were going on outside the territory it occupies, in particular where such persons have made an unsuccessful attempt to rejoin the armed forces to which they belong and which are engaged in combat, or where they fail to comply with a summons made to them with a view to internment.

2. The persons belonging to one of the categories enumerated in the present Article, who have been received by neutral or non-belligerent Powers on their territory and whom these Powers are required to intern under international law, without prejudice to any more favourable treatment which these Powers may choose to give and with the exception of Articles 8, 10, 15, 30, fifth paragraph, 58-67, 92, 126 and, where diplomatic relations exist between the Parties to the conflict and the neutral or non-belligerent Power concerned, those Articles concerning the Protecting Power. Where such diplomatic relations exist, the Parties to a conflict on whom these persons depend shall be allowed to perform towards them the functions of a Protecting Power as provided in the present Convention, without prejudice to the functions which these Parties normally exercise in conformity with diplomatic and consular usage and treaties.

C. This Article shall in no way affect the status of medical personnel and chaplains as provided for in Article 33 of the present Convention.

Article 5

The present Convention shall apply to the persons referred to in Article 4 from the time they fall into the power of the enemy and until their final release and repatriation.

Should any doubt arise as to whether persons, having committed a belligerent act and having fallen into the hands of the enemy, belong to any of the categories enumerated in Article 4, such persons shall enjoy the protection of the present Convention until such time as their status has been determined by a competent tribunal.

Article 6

In addition to the agreements expressly provided for in Articles 10, 23, 28, 33, 60, 65, 66, 67, 72, 73, 75, 109, 110, 118, 119, 122 and 132, the High Contracting Parties may conclude other special agreements for all matters concerning which they may deem it suitable to make separate provision. No special agreement shall adversely affect the situation of prisoners of war, as defined by the present Convention, nor restrict the rights which it confers upon them.

Prisoners of war shall continue to have the benefit of such agreements as long as the Convention is applicable to them, except where express provisions to the contrary are contained in the aforesaid or in subsequent agreements, or where more favourable measures have been taken with regard to them by one or other of the Parties to the conflict.

Article 7

Prisoners of war may in no circumstances renounce in part or in entirety the rights secured to them by the present Convention, and by the special agreements referred to in the foregoing Article, if such there be.

Article 8

The present Convention shall be applied with the cooperation and under the scrutiny of the Protecting Powers whose duty it is to safeguard the interests of the Parties to the conflict. For this purpose, the Protecting Powers may appoint, apart from their diplomatic or consular staff, delegates from amongst their own nationals or the nationals of other neutral Powers. The said delegates shall be subject to the approval of the Power with which they are to carry out their duties.

The Parties to the conflict shall facilitate to the greatest extent possible the task of the representatives or delegates of the Protecting Powers.

The representatives or delegates of the Protecting Powers shall not in any case exceed their mission under the present Convention. They shall, in particular, take account of the imperative necessities of security of the State wherein they carry out their duties.

Article 9

The provisions of the present Convention constitute no obstacle to the humanitarian activities which the International Committee of the Red Cross or any other impartial humanitarian organization may, subject to the consent of the Parties to the conflict concerned, undertake for the protection of prisoners of war and for their relief.

Article 10

The High Contracting Parties may at any time agree to entrust to an organization which offers all guarantees of impartiality and efficacy the duties incumbent on the Protecting Powers by virtue of the present Convention.

When prisoners of war do not benefit or cease to benefit, no matter for what reason, by the activities of a Protecting Power or of an organization provided for in the first paragraph above, the Detaining Power shall request a neutral State, or such an organization, to undertake the functions performed under the present Convention by a Protecting Power designated by the Parties to a conflict.

If protection cannot be arranged accordingly, the Detaining Power shall request or shall accept, subject to the provisions of this Article, the offer of the services of a humanitarian organization, such as the International Committee of the Red Cross, to assume the humanitarian functions performed by Protecting Powers under the present Convention.

Any neutral Power or any organization invited by the Power concerned or offering itself for these purposes, shall be required to act with a sense of responsibility towards the Party to the conflict on which persons protected by the present Convention depend, and shall be required to furnish sufficient assurances that it is in a position to undertake the appropriate functions and to discharge them impartially.

No derogation from the preceding provisions shall be made by special agreements between Powers one of which is restricted, even temporarily, in its freedom to negotiate with the other Power or its allies by reason of military events, more particularly where the whole, or a substantial part, of the territory of the said Power is occupied.

Whenever in the present Convention mention is made of a Protecting Power, such mention applies to substitute organizations in the sense of the present Article.

Article 11

In cases where they deem it advisable in the interest of protected persons, particularly in cases of disagreement between the Parties to the conflict as to the application or interpretation of the provisions of the present Convention, the Protecting Powers shall lend their good offices with a view to settling the disagreement.

For this purpose, each of the Protecting Powers may, either at the invitation of one Party or on its own initiative, -propose to the Parties to the conflict a meeting of their representatives, and in particular of the authorities responsible for prisoners of war, possibly on neutral territory suitably chosen. The Parties to the conflict shall be bound to give effect to the proposals made to them for this purpose. The Protecting Powers may, if necessary, propose for approval by the Parties to the conflict a person belonging to a neutral Power, or delegated by the International Committee of the Red Cross, who shall be invited to take part in such a meeting.

PART II GENERAL PROTECTION OF PRISONERS OF WAR

Article 12

Prisoners of war are in the hands of the enemy Power, but not of the individuals or military units who have captured them. Irrespective of the individual responsibilities that may exist, the Detaining Power is responsible for the treatment given them.

Prisoners of war may only be transferred by the Detaining Power to a Power which is a party to the Convention and after the Detaining Power has satisfied itself of the willingness and ability of such transferee Power to apply the Convention. When prisoners of war are transferred under such circumstances, responsibility for the application of the Convention rests on the Power accepting them while they are in its custody.

Nevertheless if that Power fails to carry out the provisions of the Convention in any important respect, the Power by whom the prisoners of war were transferred shall, upon being notified by the Protecting Power, take effective measures to correct the situation or shall request the return of the prisoners of war. Such requests must be complied with.

Article 13

Prisoners of war must at all times be humanely treated. Any unlawful act or omission by the Detaining Power causing death or seriously endangering the health of a prisoner of war in its custody is prohibited, and will be regarded as a serious breach of the present Convention. In particular, no prisoner of war may be subjected to physical mutilation or to medical or scientific experiments of any kind which are not justified by the medical, dental or hospital treatment of the prisoner concerned and carried out in his interest.

Likewise, prisoners of war must at all times be protected, particularly against acts of violence or intimidation and against insults and public curiosity

Measures of reprisal against prisoners of war are prohibited.

[...]

Article 15

The Power detaining prisoners of war shall be bound to provide free of charge for their maintenance and for the medical attention required by their state of health.

Article 16

Taking into consideration the provisions of the present Convention relating to rank and sex, and subject to any privileged treatment which may be accorded to them by reason of their state of health, age or professional qualifications, all prisoners of war shall

be treated alike by the Detaining Power, without any adverse distinction based on race, nationality, religious belief or political opinions, or any other distinction founded on similar criteria.

PART III CAPTIVITY

SECTION I BEGINNING OF CAPTIVITY

Article 17

[...]

No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind.

Prisoners of war, who, owing to their physical or mental condition, are unable to state their identity, shall be handed over to the medical service. The identity of such prisoners shall be established by all possible means, subject to the provisions of the preceding paragraph.

[...]

Article 19

Prisoners of war shall be evacuated, as soon as possible after their capture, to camps situated in an area far enough from the combat zone for them to be out of danger.

Only those prisoners of war who, owing to wounds or sickness, would run greater risks by being evacuated than by remaining where they are, may be temporarily kept back in a danger zone.

Prisoners of war shall not be unnecessarily exposed to danger while awaiting evacuation from a fighting zone.

Article 20

The evacuation of prisoners of war shall always be effected humanely and in conditions similar to those for the forces of the Detaining Power in their changes of station.

The Detaining Power shall supply prisoners of war who are being evacuated with sufficient food and potable water, and with the necessary clothing and medical attention. The Detaining Power shall take all suitable precautions to ensure their safety during evacuation, and shall establish as soon as possible a list of the prisoners of war who are evacuated.

[...]

SECTION II INTERNMENT OF PRISONERS OF WAR

CHAPTER I GENERAL OBSERVATIONS

Article 21

The Detaining Power may subject prisoners of war to internment. It may impose on them the obligation of not leaving, beyond certain limits, the camp where they are interned, or if the said camp is fenced in, of not going outside its perimeter. Subject to the provisions of the present Convention relative to penal and disciplinary sanctions, prisoners of war may not be held in close confinement except where necessary to safeguard their health and then only during the continuation of the circumstances which make such confinement necessary.

Prisoners of war may be partially or wholly released on parole or promise, in so far as is allowed by the laws of the Power on which they depend. Such measures shall be taken particularly in cases where this may contribute to the improvement of their state of health. No prisoner of war shall be compelled to accept liberty on parole or promise.

[...]

Article 22

Prisoners of war may be interned only in premises located on land and affording every guarantee of hygiene and healthfulness. Except in particular cases which are justified by the interest of the prisoners themselves, they shall not be interned in penitentiaries.

Prisoners of war interned in unhealthy areas, or where the climate is injurious for them, shall be removed as soon as possible to a more favourable climate.

[...]

Article 24

Transit or screening camps of a permanent kind shall be fitted out under conditions similar to those described in the present Section, and the prisoners therein shall have the same treatment as in other camps.

CHAPTER II QUARTERS FOOD AND CLOTHING OF PRISONERS OF WAR

[...]

CHAPTER III HYGIENE AND MEDICAL ATTENTION

[...]

Article 30

Every camp shall have an adequate infirmary where prisoners of war may have the attention they require, as well as appropriate diet. Isolation wards shall, if necessary, be set aside for cases of contagious or mental disease.

Prisoners of war suffering from serious disease, or whose condition necessitates special treatment, a surgical operation or hospital care, must be admitted to any military or civilian medical unit where such treatment can be given, even if their repatriation is contemplated in the near future. Special facilities shall be afforded for the care to be given to the disabled, in particular to the blind, and for their rehabilitation, pending repatriation.

Prisoners of war shall have the attention, preferably, of medical personnel of the Power on which they depend and, if possible, of their nationality.

Prisoners of war may not be prevented from presenting themselves to the medical authorities for examination. The detaining authorities shall, upon request, issue to every prisoner who has undergone treatment, an official certificate indicating the nature of his illness or injury, and the duration and kind of treatment received. A duplicate of this certificate shall be forwarded to the Central Prisoners of War Agency.

The costs of treatment, including those of any apparatus necessary for the maintenance of prisoners of war in good health, particularly dentures and other artificial appliances, and spectacles, shall be borne by the Detaining Power.

Article 31

Medical inspections of prisoners of war shall be held at least once a month. They shall include the checking and the recording of the weight of each prisoner of war.

Their purpose shall be, in particular, to supervise the general state of health, nutrition and cleanliness of prisoners and to detect contagious diseases, especially tuberculosis, malaria and venereal disease. For this purpose the most efficient methods available shall be employed, e.g. periodic mass miniature radiography for the early detection of tuberculosis.

Article 32

Prisoners of war who, though not attached to the medical service of their armed forces, are physicians, surgeons, dentists, nurses or medical orderlies, may be required by the Detaining Power to exercise their medical functions in the interests of prisoners of war dependent on the same Power. In that case they shall continue to be prisoners of war, but shall receive the same treatment as corresponding medical personnel retained by the Detaining Power. They shall be exempted from any other work under Article 49.

CHAPTER IV MEDICAL PERSONNEL AND CHAPLAINS RETAINED TO ASSIST PRISONERS OF WAR

Article 33

Members of the medical personnel and chaplains while retained by the Detaining Power with a view to assisting prisoners of war, shall not be considered as prisoners of war. They shall, however, receive as a minimum the benefits and protection of the present Convention, and shall also be granted all facilities necessary to provide for the medical care of, and religious ministrations to prisoners of war.

They shall continue to exercise their medical and spiritual functions for the benefit of prisoners of war, preferably those belonging to the armed forces upon which they depend, within the scope of the military laws and regulations of the Detaining Power and under the control of its competent services, in accordance with their professional etiquette. They shall also benefit by the following facilities in the exercise of their medical or spiritual functions:

(a) They shall be authorized to visit periodically prisoners of war situated in working detachments or in hospitals outside the camp. For this purpose, the Detaining Power shall place at their disposal the necessary means of transport.

(b) The senior medical officer in each camp shall be responsible to the camp military authorities for everything connected with the activities of retained medical personnel. For this purpose, Parties to the conflict shall agree at the outbreak of hostilities on the subject of the corresponding ranks of the medical personnel, including that of societies mentioned in Article 26 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949. This senior medical officer, as well as chaplains, shall have the right to deal with the competent authorities of the camp on all questions relating to their duties. Such authorities shall afford them all necessary facilities for correspondence relating to these questions.

(c) Although they shall be subject to the internal discipline of the camp in which they are retained, such personnel may not be compelled to carry out any work other than that concerned with their medical or religious duties.

During hostilities, the Parties to the conflict shall agree concerning the possible relief of retained personnel and shall settle the procedure to be followed.

None of the preceding provisions shall relieve the Detaining Power of its obligations with regard to prisoners of war from the medical or spiritual point of view.

CHAPTER V RELIGIOUS INTELLECTUAL AND PHYSICAL ACTIVITIES

[...]

CHAPTER VI DISCIPLINE

[...]

CHAPTER VII RANK OF PRISONERS OF WAR

[...]

CHAPTER VIII TRANSFER OF PRISONERS OF WAR AFTER THEIR ARRIVAL IN CAMP**Article 46**

The Detaining Power, when deciding upon the transfer of prisoners of war, shall take into account the interests of the prisoners themselves, more especially so as not to increase the difficulty of their repatriation.

The transfer of prisoners of war shall always be effected humanely and in conditions not less favourable than those under which the forces of the Detaining Power are transferred. Account shall always be taken of the climatic conditions to which the prisoners of war are accustomed and the conditions of transfer shall in no case be prejudicial to their health.

The Detaining Power shall supply prisoners of war during transfer with sufficient food and drinking water to keep them in good health, likewise with the necessary clothing, shelter and medical attention. The Detaining Power shall take adequate precautions especially in case of transport by sea or by air, to ensure their safety during transfer, and shall draw up a complete list of all transferred prisoners before their departure.

Article 47

Sick or wounded prisoners of war shall not be transferred as long as their recovery may be endangered by the journey, unless their safety imperatively demands it.

[...]

SECTION III LABOUR OF PRISONERS OF WAR**Article 49**

The Detaining Power may utilize the labour of prisoners of war who are physically fit, taking into account their age, sex, rank and physical aptitude, and with a view particularly to maintaining them in a good state of physical and mental health.

[...]

Article 52

Unless he be a volunteer, no prisoner of war may be employed on labour which is of an unhealthy or dangerous nature.

[...]

Article 54

[...]

Prisoners of war who sustain accidents in connection with work, or who contract a disease in the course, or in consequence of their work, shall receive all the care their condition may require. The Detaining Power shall furthermore deliver to such prisoners of war a medical certificate enabling them to submit their claims to the Power on which they depend, and shall send a duplicate to the Central Prisoners of War Agency provided for in Article 123.

Article 55

The fitness of prisoners of war for work shall be periodically verified by medical examinations at least once a month. The examinations shall have particular regard to the nature of the work which prisoners of war are required to do.

If any prisoner of war considers himself incapable of working, he shall be permitted to appear before the medical authorities of his camp. Physicians or surgeons may recommend that the prisoners who are, in their opinion, unfit for work, be exempted therefrom.

[...]

SECTION IV FINANCIAL RESOURCES OF PRISONERS OF WAR

[...]

Article 62

[...]

Working pay shall likewise be paid by the detaining authorities to prisoners of war permanently detailed to duties or to a skilled or semi-skilled occupation in connection with the administration, installation or maintenance of camps, and to the prisoners who are required to carry out spiritual or medical duties on behalf of their comrades.

[...]

Article 68

Any claim by a prisoner of war for compensation in respect of any injury or other disability arising out of work shall be referred to the Power on which he depends, through the Protecting Power. In accordance with Article 54, the Detaining Power will, in all cases, provide the prisoner of war concerned with a statement showing the nature of the injury or disability, the circumstances in which it arose and particulars of medical or hospital treatment given for it. This statement will be signed by a responsible officer of the Detaining Power and the medical particulars certified by a medical officer.

[...]

SECTION V RELATIONS OF PRISONERS OF WAR WITH THE EXTERIOR

[...]

Article 70

Immediately upon capture, or not more than one week after arrival at a camp, even if it is a transit camp, likewise in case of sickness or transfer to hospital or another camp, every prisoner of war shall be enabled to write direct to his family, on the one hand, and to the Central Prisoners of War Agency provided for in Article 123, on the other hand, a card similar, if possible, to the model annexed to the present Convention, informing his relatives of his capture, address and state of health. The said cards shall be forwarded as rapidly as possible and may not be delayed in any manner.

[...]

Article 72

Prisoners of war shall be allowed to receive by post or by any other means individual parcels or collective shipments containing, in particular, foodstuffs, clothing, medical supplies and articles of a religious, educational or recreational character which may meet their needs, including books, devotional articles, scientific equipment, examination papers, musical instruments, sports outfits and materials allowing prisoners of war to pursue their studies or their cultural activities.

Such shipments shall in no way free the Detaining Power from the obligations imposed upon it by virtue of the present Convention.

The only limits which may be placed on these shipments shall be those proposed by the Protecting Power in the interest of the prisoners themselves, or by the International Committee of the Red Cross or any other organization giving assistance to the prisoners, in respect of their own shipments only, on account of exceptional strain on transport or communications.

The conditions for the sending of individual parcels and collective relief shall, if necessary, be the subject of special agreements between the Powers concerned, which may in no case delay the receipt by the prisoners of relief supplies. Books may not be included in parcels of clothing and foodstuffs. Medical supplies shall, as a rule, be sent in collective parcels.

[...]

SECTION VI RELATIONS BETWEEN PRISONERS OF WAR AND THE AUTHORITIES

[...]

CHAPTER II PRISONER OF WAR REPRESENTATIVES

[...]

Article 81

[...]

All facilities shall likewise be accorded to the prisoners' representatives for communication by post and telegraph with the detaining authorities, the Protecting Powers, the International Committee of the Red Cross and their delegates, the Mixed Medical Commissions and with the bodies which give assistance to prisoners of war. Prisoners' representatives of labour detachments shall enjoy the same facilities for communication with the prisoners' representatives of the principal camp. Such communications shall not be restricted, nor considered as forming a part of the quota mentioned in Article 7 1.

[...]

PART IV TERMINATION OF CAPTIVITY

SECTION I DIRECT REPATRIATION AND ACCOMMODATION IN NEUTRAL COUNTRIES

Article 109

Subject to the provisions of the third paragraph of this Article, Parties to the conflict are bound to send back to their own country, regardless of number or rank, seriously wounded and seriously sick prisoners of war, after having cared for them until they are fit to travel, in accordance with the first paragraph of the following Article.

Throughout the duration of hostilities, Parties to the conflict shall endeavour, with the cooperation of the neutral Powers concerned, to make arrangements for the accommodation in neutral countries of the sick and wounded prisoners of war referred to in the

second paragraph of the following Article. They may, in addition, conclude agreements with a view to the direct repatriation or internment in a neutral country of able-bodied prisoners of war who have undergone a long period of captivity.

No sick or injured prisoner of war who is eligible for repatriation under the first paragraph of this Article may be repatriated against his will during hostilities.

Article 110

The following shall be repatriated directly:

1. Incurably wounded and sick whose mental or physical fitness seems to have been gravely diminished.
2. Wounded and sick who, according to medical opinion, are not likely to recover within one year, whose condition requires treatment and whose mental or physical fitness seems to have been gravely diminished.
3. Wounded and sick who have recovered, but whose mental or physical fitness seems to have been gravely and permanently diminished.

The following may be accommodated in a neutral country:

1. Wounded and sick whose recovery may be expected within one year of the date of the wound or the beginning of the illness, if treatment in a neutral country might increase the prospects of a more certain and speedy recovery.
2. Prisoners of war whose mental or physical health, according to medical opinion, is seriously threatened by continued captivity, but whose accommodation in a neutral country might remove such a threat.

The conditions which prisoners of war accommodated in a neutral country must fulfil in order to permit their repatriation shall be fixed, as shall likewise their status, by agreement between the Powers concerned. In general, prisoners of war who have been accommodated in a neutral country, and who belong to the following categories, should be repatriated:

1. Those whose state of health has deteriorated so as to fulfil the conditions laid down for direct repatriation;
2. Those whose mental or physical powers remain, even after treatment, considerably impaired.

If no special agreements are concluded between the Parties to the conflict concerned, to determine the cases of disablement or sickness entailing direct repatriation or accommodation in a neutral country, such cases shall be settled in accordance with the principles laid down in the Model Agreement concerning direct repatriation and accommodation in neutral countries of wounded and sick prisoners of war and in the Regulations concerning Mixed Medical Commissions annexed to the present Convention.

[...]

Article 112

Upon the outbreak of hostilities, Mixed Medical Commissions shall be appointed to examine sick and wounded prisoners of war, and to make all appropriate decisions regarding them. The appointment, duties and functioning of these Commissions shall be in conformity with the provisions of the Regulations annexed to the present Convention.

However, prisoners of war who, in the opinion of the medical authorities of the Detaining Power, are manifestly seriously injured or seriously sick, may be repatriated without having to be examined by a Mixed Medical Commission.

Article 113

Besides those who are designated by the medical authorities of the Detaining Power, wounded or sick prisoners of war belonging to the categories listed below shall be entitled to present themselves for examination by the Mixed Medical Commissions provided for in the foregoing Article:

1. Wounded and sick proposed by a physician or surgeon who is of the same nationality, or a national of a Party to the conflict allied with the Power on which the said prisoners depend, and who exercises his functions in the camp.
2. Wounded and sick proposed by their prisoners' representative.
3. Wounded and sick proposed by the Power on which they depend, or by an organization duly recognized by the said Power and giving assistance to the prisoners.

Prisoners of war who do not belong to one of the three foregoing categories may nevertheless present themselves for examination by Mixed Medical Commissions, but shall be examined only after those belonging to the said categories.

The physician or surgeon of the same nationality as the prisoners who present themselves for examination by the Mixed Medical Commission, likewise the prisoners' representative of the said prisoners, shall have permission to be present at the examination.

Article 114

Prisoners of war who meet with accidents shall, unless the injury is self-inflicted, have the benefit of the provisions of this Convention as regards repatriation or accommodation in a neutral country.

[...]

PART V INFORMATION BUREAUX AND RELIEF SOCIETIES FOR PRISONERS OF WAR

[...]

PART VI EXECUTION OF THE CONVENTION

SECTION I GENERAL PROVISIONS

[...]

Article 130

Grave breaches to which the preceding Article relates shall be those involving any of the following acts, if committed against persons or property protected by the Convention: wilful killing, torture or inhuman treatment, including biological experiments, wilfully causing great suffering or serious injury to body or health, compelling a prisoner of war to serve in the forces of the hostile Power, or wilfully depriving a prisoner of war of the rights of fair and regular trial prescribed in this Convention.

[...]

SECTION II FINAL PROVISIONS

[...]

Article 134

The present Convention replaces the Convention of 27 July 1929, in relations between the High Contracting Parties.

Article 135

In the relations between the Powers which are bound by The Hague Convention respecting the Laws and Customs of War on Land, whether that of July 29, 1899, or that of October 18, 1907, and which are parties to the present Convention, this last Convention shall be complementary to Chapter II of the Regulations annexed to the above-mentioned Conventions of The Hague.

[...]

ANNEX I MODEL AGREEMENT CONCERNING DIRECT REPATRIATION AND ACCOMMODATION IN NEUTRAL COUNTRIES OF WOUNDED AND SICK PRISONERS OF WAR (SEE ARTICLE 110)

I PRINCIPLES FOR DIRECT REPATRIATION AND ACCOMMODATION IN NEUTRAL COUNTRIES

A DIRECT REPATRIATION

The following shall be repatriated direct:

(1) All prisoners of war suffering from the following disabilities as the result of trauma: loss of a limb, paralysis, articular or other disabilities, when this disability is at least the loss of a hand or a foot, or the equivalent of the loss of a hand or a foot.

Without prejudice to a more generous interpretation, the following shall be considered as equivalent to the loss of a hand or a foot:

- (a) Loss of a hand or of all the fingers, or of the thumb and forefinger of one hand; loss of a foot, or of all the toes and metatarsals of one foot.
- (b) Ankylosis, loss of osseous tissue, cicatricial contracture preventing the functioning of one of the large articulations or of all the digital joints of one hand.
- (c) Pseudarthrosis of the long bones.
- (d) Deformities due to fracture or other injury which seriously interfere with function and weight-bearing power.

(2) All wounded prisoners of war whose condition has become chronic, to the extent that prognosis appears to exclude recovery—in spite of treatment—within one year from the date of the injury, as, for example, in case of:

- (a) Projectile in the heart, even if the Mixed Medical Commission should fail, at the time of their examination, to detect any serious disorders.
- (b) Metallic splinter in the brain or the lungs, even if the Mixed Medical Commission cannot, at the time of examination, detect any local or general reaction.
- (c) Osteomyelitis, when recovery cannot be foreseen in the course of the year following the injury, and which seems likely to result in ankylosis of a joint, or other impairments equivalent to the loss of a hand or a foot.
- (d) Perforating and suppurating injury to the large joints.
- (e) Injury to the skull, with loss or shifting of bony tissue.
- (f) Injury or burning of the face with loss of tissue and functional lesions.
- (g) Injury to the spinal cord.
- (h) Lesion of the peripheral nerves, the sequelae of which are equivalent to the loss of a hand or foot, and the cure of which requires more than a year from the date of injury, for example: injury to the brachial or lumbosacral plexus median or sciatic nerves, likewise combined injury to the radial and cubital nerves or to the lateral popliteal nerve (N. peroneus).

communis) and medial popliteal nerve (N. tibialis); etc. The separate injury of the radial (musculo-spiral), cubital, lateral or medial popliteal nerves shall not, however, warrant repatriation except in case of contractures or of serious neurotrophic disturbance.

(i) Injury to the urinary system, with incapacitating results.

(3) All sick prisoners of war whose condition has become chronic to the extent that prognosis seems to exclude recovery--in, spite of treatment-- within one year from the inception of the disease, as, for example, in case of:

(a) Progressive tuberculosis of any organ which, according to medical prognosis, cannot be cured or at least considerably improved by treatment in a neutral country.

(b) Exudate pleurisy.

(c) Serious diseases of the respiratory organs of non-tubercular etiology, presumed incurable, for example: serious pulmonary emphysema, with or without bronchitis; chronic asthma*; chronic bronchitis* lasting more than one year in captivity; bronchiectasis¹; etc.

(d) Serious chronic affections of the circulatory system, for example: valvular lesions and myocarditis, which have shown signs of circulatory failure during captivity, even though the Mixed Medical Commission cannot detect any such signs at the time of examination; affections of the pericardium and the vessels (Buerger's disease, aneurisms of the large vessels); etc.

(e) Serious chronic affections of the digestive organs, for example: gastric or duodenal ulcer; sequelae of gastric operations performed in captivity; chronic gastritis, enteritis or colitis, having lasted more than one year and seriously affecting the general condition; cirrhosis of the liver; chronic cholecystopathy i; etc.

(f) Serious chronic affections of the genito-urinary organs, for example: chronic diseases of the kidney with consequent disorders; nephrectomy because of a tubercular kidney; chronic pyelitis or chronic cystitis; hydronephrosis or pyonephrosis; chronic grave gynaecological conditions; normal pregnancy and obstetrical disorder, where it is impossible to accommodate in a neutral country; etc.

(g) Serious chronic diseases of the central and peripheral nervous system, for example: all obvious psychoses and psychoneuroses, such as serious hysteria, serious captivity psychoneurosis, etc., duly verified by a specialist*; any epilepsy duly verified by the camp physician*; cerebral arteriosclerosis; chronic neuritis lasting more than one year; etc.

(h) Serious chronic diseases of the neuro-vegetative system, with considerable diminution of mental or physical fitness, noticeable loss of weight and general asthenia.

(i) Blindness of both eyes, or of one eye when the vision of the other is less than 1 in spite of the use of corrective glasses; diminution of visual acuity in cases where it is impossible to restore it by correction to an acuity of 1/2 in at least one eye ; other grave ocular affections, for example: glaucoma, iritis, choroiditis; trachoma; etc.

(k) Auditive disorders, such as total unilateral deafness, if the other ear does not discern the ordinary spoken word at a distance of one metre*; etc.

(l) Serious affections of metabolism, for example: diabetes mellitus requiring insulin treatment; etc.

(m) Serious disorders of the endocrine glands, for example: thyrotoxicosis; hypothyrosis; Addison's disease; Simmonds' cachexia; tetany; etc.

(n) Grave and chronic disorders of the blood-forming organs.

(o) Serious cases of chronic intoxication, for example: lead poisoning, mercury poisoning, morphinism, cocaineism, alcoholism; gas or radiation poisoning; etc.

(p) Chronic affections of locomotion, with obvious functional disorders, for example: arthritis deformans; primary and secondary progressive chronic polyarthritis; rheumatism with serious clinical symptoms; etc.

(q) Serious chronic skin diseases, not amenable to treatment.

(r) Any malignant growth.

(s) Serious chronic infectious diseases, persisting for one year after their inception, for example: malaria with decided organic impairment, amoebic or bacillary dysentery with grave disorders; tertiary visceral syphilis resistant to treatment; leprosy; etc.

(t) Serious avitaminosis or serious inanition.

B ACCOMMODATION IN NEUTRAL COUNTRIES

The following shall be eligible for accommodation in a neutral country:

(1) All wounded prisoners of war who are not likely to recover in captivity, but who might be cured or whose condition might be considerably improved by accommodation in a neutral country.

(2) Prisoners of war suffering from any form of tuberculosis, of whatever organ, and whose treatment in a neutral country would be likely to lead to recovery or at least to considerable improvement, with the exception of primary tuberculosis cured before captivity.

1. The decision of the Mixed Medical Commission shall be based to a great extent on the records kept by camp physicians and surgeons of the same nationality as the prisoners of war, or on an examination by medical specialists of the Detaining Power.

(3) Prisoners of war suffering from affections requiring treatment of the respiratory, circulatory, digestive, nervous, sensory, genito-urinary, cutaneous, locomotive organs, etc., if such treatment would clearly have better results in a neutral country than in captivity.

(4) Prisoners of war who have undergone a nephrectomy in captivity for a non-tubercular renal affection; cases of osteomyelitis, on the way to recovery or latent; diabetes mellitus not requiring insulin treatment; etc.

(5) Prisoners of war suffering from war or captivity neuroses. Cases of captivity neurosis which are not cured after three months of accommodation in a neutral country, or which after that length of time are not clearly on the way to complete cure, shall be repatriated. (6) All prisoners of war suffering from chronic intoxication (gases, metals, alkaloids, etc.), for whom the prospects of cure in a neutral country are especially favourable.

(7) All women prisoners of war who are pregnant or mothers with infants and small children.

The following cases shall not be eligible for accommodation in a neutral country:

(1) All duly verified chronic psychoses.

(2) All organic or functional nervous affections considered to be incurable.

(3) All contagious diseases during the period in which they are transmissible, with the exception of tuberculosis.

II GENERAL OBSERVATIONS

(1) The conditions given shall, in a general way, be interpreted and applied in as broad a spirit as possible. Neuropathic and psychopathic conditions caused by war or captivity, as well as cases of tuberculosis in all stages, shall above all benefit by such liberal interpretation. Prisoners of war who have sustained several wounds, none of which, considered by itself, justifies repatriation, shall be examined in the same spirit, with due regard for the psychic traumatism due to the number of their wounds.

(2) All unquestionable cases giving the right to direct repatriation (amputation, total blindness or deafness, open pulmonary tuberculosis, mental disorder, malignant growth, etc.) shall be examined and repatriated as soon as possible by the camp physicians or by military medical commissions appointed by the Detaining Power.

(3) Injuries and diseases which existed before the war and which have not become worse, as well as war injuries which have not prevented subsequent military service, shall not entitle to direct repatriation.

(4) The provisions of this Annex shall be interpreted and applied in a similar manner in all countries party to the conflict. The Powers and authorities concerned shall grant to Mixed Medical Commissions all the facilities necessary for the accomplishment of their task.

(5) The examples quoted under (1) above represent only typical cases. Cases which do not correspond exactly to these provisions shall be judged in the spirit of the provisions of Article 110 of the present Convention, and of the principles embodied in the present Agreement.

ANNEX II REGULATIONS CONCERNING MIXED MEDICAL COMMISSIONS (SEE ARTICLE. 112)

Article 1

The Mixed Medical Commissions provided for in Article 112 of the Convention shall be composed of three members, two of whom shall belong to a neutral country, the third being appointed by the Detaining Power. One of the neutral members shall take the chair.

Article 2

The two neutral members shall be appointed by the International Committee of the Red Cross, acting in agreement with the Protecting Power, at the request of the Detaining Power. They may be domiciled either in their country of origin, in any other neutral country, or in the territory of the Detaining Power.

Article 3

The neutral members shall be approved by the Parties to the conflict concerned, who shall notify their approval to the International Committee of the Red Cross and to the Protecting Power. Upon such notification, the neutral members shall be considered as effectively appointed.

Article 4

Deputy members shall also be appointed in sufficient number to replace the regular members in case of need. They shall be appointed at the same time as the regular members or, at least, as soon as possible.

Article 5

If for any reason the International Committee of the Red Cross cannot arrange for the appointment of the neutral members, this shall be done by the Power protecting the interests of the prisoners of war to be examined.

Article 6

So far as possible, one of the two neutral members shall be a surgeon and the other a physician.

Article 7

The neutral members shall be entirely independent of the Parties to the conflict, which shall grant them all facilities in the accomplishment of their duties.

Article 8

By agreement with the Detaining Power, the International Committee of the Red Cross, when making the appointments provided for in Articles 2 and 4 of the present Regulations, shall settle the terms of service of the nominees.

Article 9

The Mixed Medical Commissions shall begin their work as soon as possible after the neutral members have been approved, and in any case within a period of three months from the date of such approval.

Article 10

The Mixed Medical Commissions shall examine all the prisoners designated in Article 113 of the Convention. They shall propose repatriation, rejection, or reference to a later examination. Their decisions shall be made by a majority vote.

Article 11

The decisions made by the Mixed Medical Commissions in each specific case shall be communicated, during the month following their visit, to the Detaining Power, the Protecting Power and the International Committee of the Red Cross. The Mixed Medical Commissions shall also inform each prisoner of war examined of the decision made, and shall issue to those whose repatriation has been proposed, certificates similar to the model appended to the present Convention.

Article 12

The Detaining Power shall be required to carry out the decisions of the Mixed Medical Commissions within three months of the time when it receives due notification of such decisions.

Article 13

If there is no neutral physician in a country where the services of a Mixed Medical Commission seem to be required, and if it is for any reason impossible to appoint neutral doctors who are resident in another country, the Detaining Power, acting in agreement with the Protecting Power, shall set up a Medical Commission which shall undertake the same duties as a Mixed Medical Commission, subject to the provisions of Articles 1, 2, 3, 4, 5 and 8 of the present Regulations.

Article 14

Mixed Medical Commissions shall function permanently and shall visit each camp at intervals of not more than six months.

ANNEX III REGULATIONS CONCERNING COLLECTIVE RELIEF (SEE ARTICLE 73)

[...]

Article 2

The distribution of collective relief shipments shall be effected in accordance with the instructions of the donors and with a plan drawn up by the prisoners' representatives. The issue of medical stores shall, however, be made for preference in agreement with the senior medical officers, and the latter may, in hospitals and infirmaries, waive the said instructions, if the needs of their patients so demand. Within the limits thus defined, the distribution shall always be carried out equitably.

[...]

ANNEX V MODEL REGULATIONS CONCERNING PAYMENTS SENT BY PRISONERS TO THEIR OWN COUNTRY (SEE ARTICLE 63)

(1) The notification referred to in the third paragraph of Article 63 will show:

- (a) number as specified in Article 17, rank, surname and first names of the prisoner of war who is the payer;
- (b) the name and address of the payee in the country of origin;
- (c) the amount to be so paid in the currency of the country in which he is detained.

(2) The notification will be signed by the prisoner of war, or his witnessed mark made upon it if he cannot write, and shall be countersigned by the prisoners' representative.

(3) The camp commander will add to this notification a certificate that the prisoner of war concerned has a credit balance of not less than the amount registered as payable.

(4) The notification may be made up in lists, each sheet of such lists being witnessed by the prisoners' representative and certified by the camp commander.

1949 Convention (IV) relative to the Protection of Civilian Persons in Time of War

PART I GENERAL PROVISIONS

[...]

Article 3

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- (a) Violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
- (b) Taking of hostages;
- (c) Outrages upon personal dignity, in particular humiliating and degrading treatment;
- (d) The passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded and sick shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

[...]

Article 4

Persons protected by the Convention are those who, at a given moment and in any manner whatsoever, find themselves, in case of a conflict or occupation, in the hands of a Party to the conflict or Occupying Power of which they are not nationals.

Nationals of a State which is not bound by the Convention are not protected by it. Nationals of a neutral State, who find themselves in the territory of a belligerent State, and nationals of a co-belligerent State, shall not be regarded as protected persons while the State of which they are nationals has normal diplomatic representation in the State in whose hands they are.

The provisions of Part II are, however, wider in application, as defined in Article 13.

Persons protected by the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949, or by the Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of August 12, 1949, or by the Geneva Convention relative to the Treatment of Prisoners of War of August 12, 1949, shall not be considered as protected persons within the meaning of the present Convention.

[...]

Article 7

In addition to the agreements expressly provided for in Articles 11, 14, 15, 17, 36, 108, 109, 132, 133 and 149, the High Contracting Parties may conclude other special agreements for all matters concerning which they may deem it suitable to make separate provision. No special agreement shall adversely affect the situation of protected persons, as defined by the present Convention, nor restrict the rights which it confers upon them.

Protected persons shall continue to have the benefit of such agreements as long as the Convention is applicable to them, except where express provisions to the contrary are contained in the aforesaid or in subsequent agreements, or where more favourable measures have been taken with regard to them by one or other of the Parties to the conflict.

Article 8

Protected persons may in no circumstances renounce in part or in entirety the rights secured to them by the present Convention, and by the special agreements referred to in the foregoing Article, if such there be.

Article 9

The present Convention shall be applied with the cooperation and under the scrutiny of the Protecting Powers whose duty it is to safeguard the interests of the Parties to the conflict. For this purpose, the Protecting Powers may appoint, apart from their diplomatic or consular staff, delegates from amongst their own nationals or the nationals of other neutral Powers. The said delegates shall be subject to the approval of the Power with which they are to carry out their duties.

The Parties to the conflict shall facilitate to the greatest extent possible the task of the representatives or delegates of the

Protecting Powers.

The representatives or delegates of the Protecting Powers shall not in any case exceed their mission under the present Convention. They shall, in particular, take account of the imperative necessities of security of the State wherein they carry out their duties.

Article 10

The provisions of the present Convention constitute no obstacle to the humanitarian activities which the International Committee of the Red Cross or any other impartial humanitarian organization may, subject to the consent of the Parties to the conflict concerned, undertake for the protection of civilian persons and for their relief.

[...]

PART II GENERAL PROTECTION OF POPULATIONS AGAINST CERTAIN CONSEQUENCES OF WAR**Article 13**

The provisions of Part II cover the whole of the populations of the countries in conflict, without any adverse distinction based, in particular, on race, nationality, religion or political opinion, and are intended to alleviate the sufferings caused by war.

Article 14

In time of peace, the High Contracting Parties and, after the outbreak of hostilities, the Parties thereto, may establish in their own territory and, if the need arises, in occupied areas, hospital and safety zones and localities so organized as to protect from the effects of war, wounded, sick and aged persons, children under fifteen, expectant mothers and mothers of children under seven. Upon the outbreak and during the course of hostilities, the Parties concerned may conclude agreements on mutual recognition of the zones and localities they have created. They may for this purpose implement the provisions of the Draft Agreement annexed to the present Convention, with such amendments as they may consider necessary.

The Protecting Powers and the International Committee of the Red Cross are invited to lend their good offices in order to facilitate the institution and recognition of these hospital and safety zones and localities.

Article 15

Any Party to the conflict may, either directly or through a neutral State or some humanitarian organization, propose to the adverse Party to establish, in the regions where fighting is taking place, neutralized zones intended to shelter from the effects of war the following persons, without distinction:

- (a) Wounded and sick combatants or non-combatants;
- (b) Civilian persons who take no part in hostilities, and who, while they reside in the zones, perform no work of a military character.

When the Parties concerned have agreed upon the geographical position, administration, food supply and supervision of the proposed neutralized zone, a written agreement shall be concluded and signed by the representatives of the Parties to the conflict. The agreement shall fix the beginning and the duration of the neutralization of the zone.

Article 16

The wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect.

As far as military considerations allow, each Party to the conflict shall facilitate the steps taken to search for the killed and wounded, to assist the shipwrecked and other persons exposed to grave danger, and to protect them against pillage and ill-treatment.

Article 17

The Parties to the conflict shall endeavour to conclude local agreements for the removal from besieged or encircled areas, of wounded, sick, infirm, and aged persons, children and maternity cases, and for the passage of ministers of all religions, medical personnel and medical equipment on their way to such areas.

Article 18

Civilian hospitals organized to give care to the wounded and sick, the infirm and maternity cases, may in no circumstances be the object of attack, but shall at all times be respected and protected by the Parties to the conflict.

States which are Parties to a conflict shall provide all civilian hospitals with certificates showing that they are civilian hospitals and that the buildings which they occupy are not used for any purpose which would deprive these hospitals of protection in accordance with Article 19.

Civilian hospitals shall be marked by means of the emblem provided for in Article 38 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949, but only if so authorized by the State. The Parties to the conflict shall, in so far as military considerations permit, take the necessary steps to make the distinctive emblems indicating civilian hospitals clearly visible to the enemy land, air and naval forces in order to obviate the possibility of any hostile action.

In view of the dangers to which hospitals may be exposed by being close to military objectives, it is recommended that such

hospitals be situated as far as possible from such objectives.

Article 19

The protection to which civilian hospitals are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy. Protection may, however, cease only after due warning has been given, naming, in all appropriate cases, a reasonable time limit, and after such warning has remained unheeded.

The fact that sick or wounded members of the armed forces are nursed in these hospitals, or the presence of small arms and ammunition taken from such combatants which have not yet been handed to the proper service, shall not be considered to be acts harmful to the enemy.

Article 20

Persons regularly and solely engaged in the operation and administration of civilian hospitals, including the personnel engaged in the search for, removal and transporting of and caring for wounded and sick civilians, the infirm and maternity cases, shall be respected and protected.

In occupied territory and in zones of military operations, the above personnel shall be recognizable by means of an identity card certifying their status, bearing the photograph of the holder and embossed with the stamp of the responsible authority, and also by means of a stamped, water-resistant armlet which they shall wear on the left arm while carrying out their duties. This armlet shall be issued by the State and shall bear the emblem provided for in Article 38 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949.

Other personnel who are engaged in the operation and administration of civilian hospitals shall be entitled to respect and protection and to wear the armlet, as provided in and under the conditions prescribed in this Article, while they are employed on such duties. The identity card shall state the duties on which they are employed.

The management of each hospital shall at all times hold at the disposal of the competent national or occupying authorities an up-to-date list of such personnel.

Article 21

Convoys of vehicles or hospital trains on land or specially provided vessels on sea, conveying wounded and sick civilians, the infirm and maternity cases, shall be respected and protected in the same manner as the hospitals provided for in Article 18, and shall be marked, with the consent of the State, by the display of the distinctive emblem provided for in Article 38 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949.

Article 22

Aircraft exclusively employed for the removal of wounded and sick civilians, the infirm and maternity cases, or for the transport of medical personnel and equipment, shall not be attacked, but shall be respected while flying at heights, times and on routes specifically agreed upon between all the Parties to the conflict concerned.

They may be marked with the distinctive emblem provided for in Article 38 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949.

Unless agreed otherwise, flights over enemy or enemy-occupied territory are prohibited.

Such aircraft shall obey every summons to land. In the event of a landing thus imposed, the aircraft with its occupants may continue its flight after examination, if any.

Article 23

Each High Contracting Party shall allow the free passage of all consignments of medical and hospital stores and objects necessary for religious worship intended only for civilians of another High Contracting Party, even if the latter is its adversary. It shall likewise permit the free passage of all consignments of essential foodstuffs, clothing and tonics intended for children under fifteen, expectant mothers and maternity cases.

The obligation of a High Contracting Party to allow the free passage of the consignments indicated in the preceding paragraph is subject to the condition that this Party is satisfied that there are no serious reasons for fearing:

- (a) That the consignments may be diverted from their destination;
- (b) That the control may not be effective; or
- (c) That a definite advantage may accrue to the military efforts or economy of the enemy through the substitution of the above-mentioned consignments for goods which would otherwise be provided or produced by the enemy or through the release of such material, services or facilities as would otherwise be required for the production of such goods.

The Power which allows the passage of the consignments indicated in the first paragraph of this Article may make such permission conditional on the distribution to the persons benefited there by being made under the local supervision of the Protecting Powers. Such consignments shall be forwarded as rapidly as possible, and the Power which permits their free passage shall have the right to prescribe the technical arrangements under which such passage is allowed.

Article 24

The Parties to the conflict shall take the necessary measures to ensure that children under fifteen, who are orphaned or are

separated from their families as a result of the war, are not left to their own resources, and that their maintenance, the exercise of their religion and their education are facilitated in all circumstances. [...]

PART III STATUS AND TREATMENT OF PROTECTED PERSONS

SECTION I PROVISIONS COMMON TO THE TERRITORIES OF THE PARTIES TO THE CONFLICT AND TO OCCUPIED TERRITORIES

Article 27

Protected persons are entitled, in all circumstances, to respect for their persons, their honour, their family rights, their religious convictions and practices, and their manners and customs. They shall at all times be humanely treated, and shall be protected especially against all acts of violence or threats thereof and against insults and public curiosity.

[...]

Without prejudice to the provisions relating to their state of health, age and sex, all protected persons shall be treated with the same consideration by the Party to the conflict in whose power they are, without any adverse distinction based, in particular, on race, religion or political opinion.

[...]

Article 30

Protected persons shall have every facility for making application to the Protecting Powers, the International Committee of the Red Cross, the National Red Cross (Red Crescent, Red Lion and Sun) Society of the country where they may be, as well as to any organization that might assist them.

These several organizations shall be granted all facilities for that purpose by the authorities, within the bounds set by military or security considerations.

Apart from the visits of the delegates of the Protecting Powers and of the International Committee of the Red Cross, provided for by Article 143, the Detaining or Occupying Powers shall facilitate as much as possible visits to protected persons by the representatives of other organizations whose object is to give spiritual aid or material relief to such persons.

[...]

Article 32

The High Contracting Parties specifically agree that each of them is prohibited from taking any measure of such a character as to cause the physical suffering or extermination of protected persons in their hands. This prohibition applies not only to murder, torture, corporal punishment, mutilation and medical or scientific experiments not necessitated by the medical treatment of a protected person but also to any other measures of brutality whether applied by civilian or military agents.

Article 33

[...]

Reprisals against protected persons and their property are prohibited.

[...]

SECTION II ALIENS IN THE TERRITORY OF A PARTY TO THE CONFLICT

[...]

Article 38

With the exception of special measures authorized by the present Convention, in particular by Articles 27 and 41 thereof, the situation of protected persons shall continue to be regulated, in principle, by the provisions concerning aliens in time of peace. In any case, the following rights shall be granted to them:

2. They shall, if their state of health so requires, receive medical attention and hospital treatment to the same extent as the nationals of the State concerned.

[...]

SECTION III OCCUPIED TERRITORIES

[...]

Article 50

The Occupying Power shall, with the cooperation of the national and local authorities, facilitate the proper working of all

institutions devoted to the care and education of children.

[...]

Should the local institutions be inadequate for the purpose, the Occupying Power shall make arrangements for the maintenance and education, if possible by persons of their own nationality, language and religion, of children who are orphaned or separated from their parents as a result of the war and who cannot be adequately cared for by a near relative or friend.

[...]

Article 55

To the fullest extent of the means available to it the Occupying Power has the duty of ensuring the food and medical supplies of the population; it should, in particular, bring in the necessary foodstuffs, medical stores and other articles if the resources of the occupied territory are inadequate.

The Occupying Power may not requisition foodstuffs, articles or medical supplies available in the occupied territory, except for use by the occupation forces and administration personnel, and then only if the requirements of the civilian population have been taken into account. Subject to the provisions of other international Conventions, the Occupying Power shall make arrangements to ensure that fair value is paid for any requisitioned goods.

The Protecting Power shall, at any time, be at liberty to verify the state of the food and medical supplies in occupied territories, except where temporary restrictions are made necessary by imperative military requirements.

Article 56

To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health and hygiene in the occupied territory, with particular reference to the adoption and application of the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. Medical personnel of all categories shall be allowed to carry out their duties.

If new hospitals are set up in occupied territory and if the competent organs of the occupied State are not operating there, the occupying authorities shall, if necessary, grant them the recognition provided for in Article 18. In similar circumstances, the occupying authorities shall also grant recognition to hospital personnel and transport vehicles under the provisions of Articles 20 and 21.

In adopting measures of health and hygiene and in their implementation, the Occupying Power shall take into consideration the moral and ethical susceptibilities of the population of the occupied territory.

Article 57

The Occupying Power may requisition civilian hospitals only temporarily and only in cases of urgent necessity for the care of military wounded and sick, and then on condition that suitable arrangements are made in due time for the care and treatment of the patients and for the needs of the civilian population for hospital accommodation.

The material and stores of civilian hospitals cannot be requisitioned so long as they are necessary for the needs of the civilian population.

[...]

Article 59

If the whole or part of the population of an occupied territory is inadequately supplied, the Occupying Power shall agree to relief schemes on behalf of the said population, and shall facilitate them by all the means at its disposal.

Such schemes, which may be undertaken either by States or by impartial humanitarian organizations such as the International Committee of the Red Cross, shall consist, in particular, of the provision of consignments of foodstuffs, medical supplies and clothing.

All Contracting Parties shall permit the free passage of these consignments and shall guarantee their protection.

A Power granting free passage to consignments on their way to territory occupied by an adverse Party to the conflict shall, however, have the right to search the consignments, to regulate their passage according to prescribed times and routes, and to be reasonably satisfied through the Protecting Power that these consignments are to be used for the relief of the needy population and are not to be used for the benefit of the Occupying Power.

Article 60

Relief consignments shall in no way relieve the Occupying Power of any of its responsibilities under Articles 55, 56 and 59. The Occupying Power shall in no way whatsoever divert relief consignments from the purpose for which they are intended, except in cases of urgent necessity, in the interests of the population of the occupied territory and with the consent of the Protecting Power.

Article 61

The distribution of the relief consignments referred to in the foregoing Articles shall be carried out with the cooperation and under the supervision of the Protecting Power. This duty may also be delegated, by agreement between the Occupying Power and the Protecting Power, to a neutral Power, to the International Committee of the Red Cross or to any other impartial humanitarian

body.

Such consignments shall be exempt in occupied territory from all charges, taxes or customs duties unless these are necessary in the interests of the economy of the territory. The Occupying Power shall facilitate the rapid distribution of these consignments.

All Contracting Parties shall endeavour to permit the transit and transport, free of charge, of such relief consignments on their way to occupied territories.

Article 62

Subject to imperative reasons of security, protected persons in occupied territories shall be permitted to receive the individual relief consignments sent to them.

Article 63

Subject to temporary and exceptional measures imposed for urgent reasons of security by the Occupying Power:

(a) Recognized National Red Cross (Red Crescent, Red Lion and Sun) Societies shall be able to pursue their activities in accordance with Red Cross principles, as defined by the International Red Cross Conferences. Other relief societies shall be permitted to continue their humanitarian activities under similar conditions;

(b) The Occupying Power may not require any changes in the personnel or structure of these societies, which would prejudice the aforesaid activities.

The same principles shall apply to the activities and personnel of special organizations of a non-military character, which already exist or which may be established, for the purpose of ensuring the living conditions of the civilian population by the maintenance of the essential public utility services, by the distribution of relief and by the organization of rescues.

[...]

Article 76

Protected persons accused of offences shall be detained in the occupied country, and if convicted they shall serve their sentences therein. They shall, if possible, be separated from other detainees and shall enjoy conditions of food and hygiene which will be sufficient to keep them in good health, and which will be at least equal to those obtaining in prisons in the occupied country.

They shall receive the medical attention required by their state of health.

[...]

SECTION IV REGULATIONS FOR THE TREATMENT OF INTERNEES

Chapter I General Provisions

[...]

Article 81

Parties to the conflict who intern protected persons shall be bound to provide free of charge for their maintenance, and to grant them also the medical attention required by their state of health.

No deduction from the allowances, salaries or credits due to the internees shall be made for the repayment of these costs.

[...]

Chapter II PLACES OF INTERNMENT

[...]

Article 85

The Detaining Power is bound to take all necessary and possible measures to ensure that protected persons shall, from the outset of their internment, be accommodated in buildings or quarters which afford every possible safeguard as regards hygiene and health, and provide efficient protection against the rigours of the climate and the effects of the war. In no case shall permanent places of internment be situated in unhealthy areas or in districts the climate of which is injurious to the internees. In all cases where the district, in which a protected person is temporarily interned, is in an unhealthy area or has a climate which is harmful to his health, he shall be removed to a more suitable place of internment as rapidly as circumstances permit.

[...]

Chapter III Food and Clothing

[...]

Chapter IV Hygiene and Medical Attention

Article 91

Every place of internment shall have an adequate infirmary, under the direction of a qualified doctor, where internees may have the attention they require, as well as an appropriate diet. Isolation wards shall be set aside for cases of contagious or mental diseases.

Maternity cases and internees suffering from serious diseases, or whose condition requires special treatment, a surgical operation

or hospital care, must be admitted to any institution where adequate treatment can be given and shall receive care not inferior to that provided for the general population.

Internees shall, for preference, have the attention of medical personnel of their own nationality.

Internees may not be prevented from presenting themselves to the medical authorities for examination. The medical authorities of the Detaining Power shall, upon request, issue to every internee who has undergone treatment an official certificate showing the nature of his illness or injury, and the duration and nature of the treatment given. A duplicate of this certificate shall be forwarded to the Central Agency provided for in Article 140.

Treatment, including the provision of any apparatus necessary for the maintenance of internees in good health, particularly dentures and other artificial appliances and spectacles, shall be free of charge to the internee.

Article 92

Medical inspections of internees shall be made at least once a month. Their purpose shall be, in particular, to supervise the general state of health, nutrition and cleanliness of internees, and to detect contagious diseases, especially tuberculosis, malaria, and venereal diseases. Such inspections shall include, in particular, the checking of weight of each internee and, at least once a year, radioscopic examination.

Chapter V Religious, Intellectual and Physical Activities

[...]

Chapter VI Personal Proper and Financial Resources

[...]

Chapter VII Administration and Discipline

[...]

Chapter VIII Relations with the Exterior

[...]

Article 106

As soon as he is interned, or at the latest not more than one week after his arrival in a place of internment, and likewise in cases of sickness or transfer to another place of internment or to a hospital, every internee shall be enabled to send direct to his family, on the one hand, and to the Central Agency provided for by Article 140, on the other, an internment card similar, if possible, to the model annexed to the present Convention, informing his relatives of his detention, address and state of health. The said cards shall be forwarded as rapidly as possible and may not be delayed in any way.

[...]

Article 108

Internees shall be allowed to receive, by post or by any other means, individual parcels or collective shipments containing in particular foodstuffs, clothing, medical supplies, as well as books and objects of a devotional, educational or recreational character which may meet their needs. Such shipments shall in no way free the Detaining Power from the obligations imposed upon it by virtue of the present Convention.

Should military necessity require the quantity of such shipments to be limited, due notice thereof shall be given to the Protecting Power and to the International Committee of the Red Cross, or to any other organization giving assistance to the internees and responsible for the forwarding of such shipments.

The conditions for the sending of individual parcels and collective shipments shall, if necessary, be the subject of special agreements between the Powers concerned, which may in no case delay the receipt by the internees of relief supplies. Parcels of clothing and foodstuffs may not include books. Medical relief supplies shall, as a rule, be sent in collective parcels.

Article 109

In the absence of special agreements between Parties to the conflict regarding the conditions for the receipt and distribution of collective relief shipments, the regulations concerning collective relief which are annexed to the present Convention shall be applied.

The special agreements provided for above shall in no case restrict the right of Internee Committees to take possession of collective relief shipments intended for internees, to undertake their distribution and to dispose of them in the interests of the recipients.

Nor shall such agreements restrict the right of representatives of the Protecting Powers, the International Committee of the Red Cross, or any other organization giving assistance to internees and responsible for the forwarding of collective shipments, to supervise their distribution to the recipients.

Article 110

All relief shipments for internees shall be exempt from import, customs and other dues.

[...]

Chapter IX Penal and Disciplinary Sanctions

[...]

Chapter X Transfers of Internees**Article 127**

The transfer of internees shall always be effected humanely. As a general rule, it shall be carried out by rail or other means of transport, and under conditions at least equal to those obtaining for the forces of the Detaining Power in their changes of station. If, as an exceptional measure, such removals have to be effected on foot, they may not take place unless the internees are in a fit state of health, and may not in any case expose them to excessive fatigue.

The Detaining Power shall supply internees during transfer with drinking water and food sufficient in quantity, quality and variety to maintain them in good health, and also with the necessary clothing, adequate shelter and the necessary medical attention. The Detaining Power shall take all suitable precautions to ensure their safety during transfer, and shall establish before their departure a complete list of all internees transferred.

Sick, wounded or infirm internees and maternity cases shall not be transferred if the journey would be seriously detrimental to them, unless their safety imperatively so demands.

[...]

Chapter XI Deaths

[...]

Chapter XII Release, Repatriation and Accommodation in Neutral Countries

[...]

SECTION V INFORMATION BUREAUX AND CENTRAL AGENCY

[...]

PART IV EXECUTION OF THE CONVENTION**SECTION I GENERAL PROVISIONS**

[...]

Article 147

Grave breaches to which the preceding Article relates shall be those involving any of the following acts, if committed against persons or property protected by the present Convention: wilful killing, torture or inhuman treatment, including biological experiments, wilfully causing great suffering or serious injury to body or health, unlawful deportation or transfer or unlawful confinement of a protected person, compelling a protected person to serve in the forces of a hostile Power, or wilfully depriving a protected person of the rights of fair and regular trial prescribed in the present Convention, taking of hostages and extensive destruction and appropriation of property, not justified by military necessity and carried out unlawfully and wantonly.

[...]

SECTION II FINAL PROVISIONS

[...]

Article 154

In the relations between the Powers who are bound by The Hague Conventions respecting the Laws and Customs of War on Land, whether that of 29 July, 1899, or that of 18 October, 1907, and who are parties to the present Convention, this last Convention shall be supplementary to Sections II and III of the Regulations annexed to the above-mentioned Conventions of The Hague.

[...]

ANNEX I

Draft agreement relating to hospital and safety zones and localities

Article I

Hospital and safety zones shall be strictly reserved for the persons mentioned in Article 23 of the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August, 1949, and in Article 14 of the Geneva Convention relative to the Protection of Civilian Persons in Time of War of 12 August, 1949, and for the personnel entrusted with the organization and administration of these zones and localities and with the care of the persons therein assembled.

Nevertheless, persons whose permanent residence is within such zones shall have the right to stay there.

Article 2

No persons residing, in whatever capacity, in a hospital and safety zone shall perform any work, either within or without the zone, directly connected with military operations or the production of war material.

Article 3

The Power establishing a hospital and safety zone shall take all necessary measures to prohibit access to all persons who have no right of residence or entry therein.

Article 4

Hospital and safety zones shall fulfil the following conditions:

- (a) They shall comprise only a small part of the territory governed by the Power which has established them.
- (b) They shall be thinly populated in relation to the possibilities of accommodation.
- (c) They shall be far removed and free from all military objectives, or large industrial or administrative establishments.
- (d) They shall not be situated in areas which, according to every probability, may become important for the conduct of the war.

Article 5

Hospital and safety zones shall be subject to the following obligations:

- (a) The lines of communication and means of transport which they possess shall not be used for the transport of military personnel or material, even in transit.
- (b) They shall in no case be defended by military means.

Article 6

Hospital and safety zones shall be marked by means of oblique red bands on a white ground, placed on the buildings and outer precincts.

Zones reserved exclusively for the wounded and sick may be marked by means of the Red Cross (Red Crescent, Red Lion and Sun) emblem on a white ground.

They may be similarly marked at night by means of appropriate illumination.

Article 7

The Powers shall communicate to all the High Contracting Parties in peacetime or on the outbreak of hostilities, a list of the hospital and safety zones in the territories governed by them. They shall also give notice of any new zones set up during hostilities. As soon as the adverse Party has received the above-mentioned notification, the zone shall be regularly established.

If, however, the adverse Party considers that the conditions of the present agreement have not been fulfilled, it may refuse to recognize the zone by giving immediate notice thereof to the Party responsible for the said zone, or may make its recognition of such zone dependent upon the institution of the control provided for in Article 8.

Article 8

Any Power having recognized one or several hospital and safety zones instituted by the adverse Party shall be entitled to demand control by one or more Special Commissions. for the purpose of ascertaining if the zones fulfil the conditions and obligations stipulated in the present agreement.

For this purpose, members of the Special Commissions shall at all times have free access to the various zones and may even reside there permanently. They shall be given all facilities for their duties of inspection.

Article 9

Should the Special Commissions note any facts which they consider contrary to the stipulations of the present agreement, they shall at once draw the attention of the Power governing the said zone to these facts, and shall fix a time limit of five days within which the matter should be rectified. They shall duly notify the Power who has recognized the zone.

If, when the time limit has expired, the Power governing the zone has not complied with the warning, the adverse Party may declare that it is no longer bound by the present agreement in respect of the said zone.

Article 10

Any Power setting up one or more hospital and safety zones, and the adverse Parties to whom their existence has been notified, shall nominate or have nominated by the Protecting Powers or by other neutral Powers, persons eligible to be members of the Special Commissions mentioned in Articles 8 and 9.

Article 11

In no circumstances may hospital and safety zones be the object of attack. They shall be protected and respected at all times by the Parties to the conflict.

Article 12

In the case of occupation of a territory, the hospital and safety zones therein shall continue to be respected and utilized as such.

Their purpose may, however, be modified by the Occupying Power, on condition that all measures are taken to ensure the safety of the persons accommodated.

Article 13

The present agreement shall also apply to localities which the Powers may utilize for the same purposes as hospital and safety zones.

ANNEX II

Draft regulations concerning collective relief

Article 1

The Internee Committees shall be allowed to distribute collective relief shipments for which they are responsible to all internees who are dependent for administration on the said Committee's place of internment, including those internees who are in hospitals, or in prisons or other penitentiary establishments.

Article 2

The distribution of collective relief shipments shall be effected in accordance with the instructions of the donors and with a plan drawn up by the Internee Committees. The issue of medical stores shall, however, be made for preference in agreement with the senior medical officers, and the latter may, in hospitals and infirmaries, waive the said instructions, if the needs of their patients so demand. Within the limits thus defined, the distribution shall always be carried out equitably.

Article 3

Members of Internee Committees shall be allowed to go to the railway stations or other points of arrival of relief supplies near their places of internment so as to enable them to verify the quantity as well as the quality of the goods received and to make out detailed reports thereon for the donors.

Article 4

Internee Committees shall be given the facilities necessary for verifying whether the distribution of collective relief in all subdivisions and annexes of their places of internment has been carried out in accordance with their instructions.

Article 5

Internee Committees shall be allowed to complete, and to cause to be completed by members of the Internee Committees in labour detachments or by the senior medical officers of infirmaries and hospitals, forms or questionnaires intended for the donors, relating to collective relief supplies (distribution, requirements, quantities, etc.). Such forms and questionnaires, duly completed, shall be forwarded to the donors without delay.

Article 6

In order to secure the regular distribution of collective relief supplies to the internees in their place of internment, and to meet any needs that may arise through the arrival of fresh parties of internees, the Internee Committees shall be allowed to create and maintain sufficient reserve stocks of collective relief. For this purpose, they shall have suitable warehouses at their disposal; each warehouse shall be provided with two locks, the Internee Committee holding the keys of one lock, and the commandant of the place of internment the keys of the other.

Article 7

The High Contracting Parties, and the Detaining Powers in particular, shall, so far as is in any way possible and subject to the regulations governing the food supply of the population, authorize purchases of goods to be made in their territories for the distribution of collective relief to the internees. They shall likewise facilitate the transfer of funds and other financial measures of a technical or administrative nature taken for the purpose of making such purchases.

Article 8

The foregoing provisions shall not constitute an obstacle to the right of internees to receive collective relief before their arrival in a place of internment or in the course of their transfer, nor to the possibility of representatives of the Protecting Power, or of the International Committee of the Red Cross or any other humanitarian organization giving assistance to internees and responsible for forwarding such supplies, ensuring the distribution thereof to the recipients by any other means they may deem suitable.

1977 Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I)

PART I GENERAL PROVISIONS

Article 1 General Principles and Scope of Application

1. The High Contracting Parties undertake to respect and to ensure respect for this Protocol in all circumstances.

[...]

3. This Protocol, which supplements the Geneva Conventions of 12 August 1949 for the protection of war victims, shall apply in the situations referred to in Article 2 common to those Conventions.

4. The situations referred to in the preceding paragraph include armed conflicts in which peoples are fighting against colonial domination and alien occupation and against racist regimes in the exercise of their right of self-determination, as enshrined in the Charter of the United Nations and the Declaration on Principles of International Law concerning Friendly Relations and Co-operation among States in accordance with the Charter of the United Nations.

[...]

Article 5 Appointment of Protecting Powers and of Their Substitute

1. It is the duty of the Parties to a conflict from the beginning of that conflict to secure the supervision and implementation of the Conventions and of this Protocol by the application of the system of Protecting Powers, including inter alia the designation and acceptance of those Powers, in accordance with the following paragraphs. Protecting Powers shall have the duty of safeguarding the interests of the Parties to the conflict.

2. From the beginning of a situation referred to in Article each Party to the conflict shall without delay designate a Protecting Power for the purpose of applying the Conventions and this Protocol and shall, likewise without delay and for the same purpose, permit the activities of a Protecting Power which has been accepted by it as such after designation by the adverse Party.

3. If a Protecting Power has not been designated or accepted from the beginning of a situation referred to in Article 1, the International Committee of the Red Cross, without prejudice to the right of any other impartial humanitarian organization to do likewise, shall offer its good offices to the Parties to the conflict with a view to the designation without delay of a Protecting Power to which the Parties to the conflict consent. For that purpose it may, inter alia, ask each Party to provide it with a list of at least five States which that Party considers acceptable to act as Protecting Power on its behalf in relation to an adverse Party, and ask each adverse Party to provide a list of at least five States which it would accept as the Protecting Power of the first Party; these lists shall be communicated to the Committee within two weeks after the receipt of the request; it shall compare them and seek the agreement of any proposed State named on both lists.

4. If, despite the foregoing, there is no Protecting Power, the Parties to the conflict shall accept without delay an offer which may be made by the International Committee of the Red Cross or by any other organization which offers all guarantees of impartiality and efficacy, after due consultations with the said Parties and taking into account the result of these consultations, to act as a substitute. The functioning of such a substitute is subject to the consent of the Parties to the conflict; every effort shall be made by the Parties to the conflict to facilitate the operations of the substitute in the performance of its tasks under the Conventions and this Protocol.

5. In accordance with Article 4, the designation and acceptance of Protecting Powers for the purpose of applying the Conventions and this Protocol shall not affect the legal status of the Parties to the conflict or of any territory, including occupied territory.

6. The maintenance of diplomatic relations between Parties to the conflict or the entrusting of the protection of a Party's interests and those of its nationals to a third State in accordance with the rules of international law relating to diplomatic relations is no obstacle to the designation of Protecting Powers for the purpose of applying the Conventions and this Protocol.

7. Any subsequent mention in this Protocol of a Protecting Power includes also a substitute.

Article 6 Qualified Persons

1. The High Contracting Parties shall, also in peacetime, endeavour, with the assistance of the national Red Cross (Red Crescent, Red Lion and Sun) Societies, to train qualified personnel to facilitate the application of the Conventions and of this Protocol, and in particular the activities of the Protecting Powers.

2. The recruitment and training of such personnel are within domestic jurisdiction.

3. The International Committee of the Red Cross shall hold at the disposal of the High Contracting Parties the lists of persons so trained which the High Contracting Parties may have established and may have transmitted to it for that purpose.

4. The conditions governing the employment of such personnel outside the national territory shall, in each case, be the subject of special agreements between the Parties concerned.

[...]

PART II WOUNDED, SICK AND SHIPWRECKED

SECTION I GENERAL PROTECTION

Article 8 Terminology

For the purposes of this Protocol:

- (a) “Wounded” and “sick” mean persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility. These terms also cover maternity cases, new-born babies and other persons who may be in need of immediate medical assistance or care, such as the infirm or expectant mothers, and who refrain from any act of hostility;
- (b) “Shipwrecked” means persons, whether military or civilian, who are in peril at sea or in other waters as a result of misfortune affecting them or the vessel or aircraft carrying them and who refrain from any act of hostility. These persons, provided that they continue to refrain from any act of hostility, shall continue to be considered shipwrecked during their rescue until they acquire another status under the Conventions or this Protocol;
- (c) “Medical personnel” means those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under subparagraph (e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary. The term includes:
 - (i) Medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organizations;
 - (ii) Medical personnel of national Red Cross (Red Crescent, Red Lion and Sun) Societies and other national voluntary aid societies duly recognized and authorized by a Party to the conflict;
 - (iii) Medical personnel of medical units or medical transports described in Article 9, paragraph 2;
- (d) “Religious personnel” means military or civilian persons, such as chaplains, who are exclusively engaged in the work of their ministry and attached:
 - (i) To the armed forces of a Party to the conflict;
 - (ii) To medical units or medical transports of a Party to the conflict;
 - (iii) To medical units or medical transports described in Article 9, paragraph 2; or
 - (iv) To civil defence organizations of a Party to the conflict.

The attachment of religious personnel may be either permanent or temporary, and the relevant provisions mentioned under subparagraph (k) apply to them;

- (e) “Medical units” means establishments and other units, whether military or civilian, organized for medical purposes, namely the search for, collection, transportation, diagnosis or treatment-including first-aid treatment-of the wounded, sick and shipwrecked, or for the prevention of disease. The term includes, for example, hospitals and other similar units, blood transfusion centres, preventive medicine centres and institutes, medical depots and the medical and pharmaceutical stores of such units. Medical units may be fixed or mobile, permanent or temporary;
- (f) “Medical transportation” means the conveyance by land, water or air of the wounded, sick, shipwrecked, medical personnel, religious personnel, medical equipment or medical supplies protected by the Conventions and by this Protocol;
- (g) “Medical transports” means any means of transportation, whether military or civilian, permanent or temporary, as signed exclusively to medical transportation and under the control of a competent authority of a Party to the conflict;
- (h) “Medical vehicles” means any medical transports by land;
- (i) “Medical ships and craft” means any medical transports by water;
- (j) “Medical aircraft” means any medical transports by air;
- (k) “Permanent medical personnel”, “permanent medical units” and “permanent medical transports” mean those assigned exclusively to medical purposes for an indeterminate period. “Temporary medical personnel”, “temporary medical units” and “temporary medical transports” mean those devoted exclusively to medical purposes for limited periods during the whole of such periods. Unless otherwise specified, the terms “medical personnel”, “medical units” and “medical transports” cover both permanent and temporary categories;
- (l) “Distinctive emblem” means the distinctive emblem of the red cross, red crescent or red lion and sun on a white ground when used for the protection of medical units and transports, or medical and religious personnel, equipment or supplies;
- (m) “Distinctive signal” means any signal or message specified for the identification exclusively of medical units or transports in Chapter III of Annex I to this Protocol.

Article 9 Field of Application

1. This Part, the provisions of which are intended to ameliorate the condition of the wounded, sick and shipwrecked, shall apply

to all those affected by a situation referred to in Article 1, without any adverse distinction founded on race, colour, sex, language, religion or belief, political or other opinion, national or social origin, wealth, birth or other status, or on any other similar criteria.

2. The relevant provisions of Articles 27 and 32 of the First Convention shall apply to permanent medical units and transports (other than hospital ships, to which Article 25 of the Second Convention applies) and their personnel made available to a Party to the conflict for humanitarian purposes:

- (a) By a neutral or other State which is not a Party to that conflict;
- (b) By a recognized and authorized aid society of such a State;
- (c) By an impartial international humanitarian organization.

Article 10 Protection and Care

1. All the wounded, sick and shipwrecked, to whichever Party they belong, shall be respected and protected.

2. In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.

Article 11 Protection of Persons

1. The physical or mental health and integrity of persons who are in the power of the adverse Party or who are interned, detained or otherwise deprived of liberty as a result of a situation referred to in Article 1 shall not be endangered by any unjustified act or omission. Accordingly, it is prohibited to subject the persons described in this Article to any medical procedure which is not indicated by the state of health of the person concerned and which is not consistent with generally accepted medical standards which would be applied under similar medical circumstances to persons who are nationals of the Party conducting the procedure and who are in no way deprived of liberty.

2. It is, in particular, prohibited to carry out on such persons, even with their consent:

- (a) Physical mutilations;
- (b) Medical or scientific experiments;
- (c) Removal of tissue or organs for transplantation, except where these acts are justified in conformity with the conditions provided for in paragraph 1.

3. Exceptions to the prohibition in paragraph 2 (c) may be made only in the case of donations of blood for transfusion or of skin for grafting, provided that they are given voluntarily and without any coercion or inducement, and then only for therapeutic purposes, under conditions consistent with generally accepted medical standards and controls designed for the benefit of both the donor and the recipient.

4. Any wilful act or omission which seriously endangers the physical or mental health or integrity of any person who is in the power of a Party other than the one on which he depends and which either violates any of the prohibitions in paragraphs 1 and 2 or fails to comply with the requirements of paragraph 3 shall be a grave breach of this Protocol.

5. The persons described in paragraph 1 have the right to refuse any surgical operation. In case of refusal, medical personnel shall endeavour to obtain a written statement to that effect, signed or acknowledged by the patient.

6. Each Party to the conflict shall keep a medical record for every donation of blood for transfusion or skin for grafting by persons referred to in paragraph 1, if that donation is made under the responsibility of that Party. In addition, each Party to the conflict shall endeavour to keep a record of all medical procedures undertaken with respect to any person who is interned, detained or otherwise deprived of liberty as a result of a situation referred to in Article 1. These records shall be available at all times for inspection by the Protecting Power.

Article 12 Protection of Medical Units

1. Medical units shall be respected and protected at all times and shall not be the object of attack.

2. Paragraph 1 shall apply to civilian medical units provided that they:

- (a) Belong to one of the Parties to the conflict;
- (b) Are recognized and authorized by the competent authority of one of the Parties to the conflict; or
- (c) Are authorized in conformity with Article 9, paragraph 2, of this Protocol or Article 27 of the First Convention.

3. The Parties to the conflict are invited to notify each other of the location of their fixed medical units. The absence of such notification shall not exempt any of the Parties from the obligation to comply with the provisions of paragraph 1.

4. Under no circumstances shall medical units be used in an attempt to shield military objectives from attack. Whenever possible, the Parties to the conflict shall ensure that medical units are so sited that attacks against military objectives do not imperil their safety.

Article 13 Discontinuance of Protection of Civilian Medical Units

1. The protection to which civilian medical units are entitled shall not cease unless they are used to commit, outside their humanitarian function, acts harmful to the enemy. Protection may, however, cease only after a warning has been given setting, whenever appropriate, a reasonable time-limit, and after such warning has remained unheeded.

2. The following shall not be considered as acts harmful to the enemy;
 - (a) That the personnel of the unit are equipped with light individual weapons for their own defence or for that of the wounded and sick in their charge;
 - (b) That the unit is guarded by a picket or by sentries or by an escort;
 - (c) That small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service, are found in the units;
 - (d) That members of the armed forces or other combatants are in the unit for medical reasons.

Article 14 Limitations on Requisition of Civilian Medical Units

1. The Occupying Power has the duty to ensure that the medical needs of the civilian population in occupied territory continue to be satisfied.
2. The Occupying Power shall not, therefore, requisition civilian medical units, their equipment, their materiel or the services of their personnel, so long as these resources are necessary for the provision of adequate medical services for the civilian population and for the continuing medical care of any wounded and sick already under treatment.
3. Provided that the general rule in paragraph 2 continues to be observed, the Occupying Power may requisition the said resources, subject to the following particular conditions:
 - (a) That the resources are necessary for the adequate and immediate medical treatment of the wounded and sick members of the armed forces of the Occupying Power or of prisoners of war;
 - (b) That the requisition continues only while such necessity exists; and
 - (c) That immediate arrangements are made to ensure that the medical needs of the civilian population, as well as those of any wounded and sick under treatment who are affected by the requisition, continue to be satisfied.

Article 15 Protection of Civilian Medical and Religious Personnel

1. Civilian medical personnel shall be respected and protected.
2. If needed, all available help shall be afforded to civilian medical personnel in an area where civilian medical services are disrupted by reason of combat activity.
3. The Occupying Power shall afford civilian medical personnel in occupied territories every assistance to enable them to perform, to the best of their ability, their humanitarian functions. The Occupying Power may not require that, in the performance of those functions, such personnel shall give priority to the treatment of any person except on medical grounds. They shall not be compelled to carry out tasks which are not compatible with their humanitarian mission.
4. Civilian medical personnel shall have access to any place where their services are essential, subject to such supervisory and safety measures as the relevant Party to the conflict may deem necessary.
5. Civilian religious personnel shall be respected and protected. The provisions of the Conventions and of this Protocol concerning the protection and identification of medical personnel shall apply equally to such persons.

Article 16 General Protection of Medical Duties

1. Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.
2. Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules and provisions.
3. No person engaged in medical activities shall be compelled to give to anyone belonging either to an adverse Party, or to his own Party except as required by the law of the latter Party, any information concerning the wounded and sick who are, or who have been, under his care, if such information would, in his opinion, prove harmful to the patients concerned or to their families. Regulations for the compulsory notification of communicable diseases shall, however, be respected.

Article 17 Role of the Civilian Population and of Aid Societies

1. The civilian population shall respect the wounded, sick and shipwrecked, even if they belong to the adverse Party, and shall commit no act of violence against them. The civilian population and aid societies, such as national Red Cross (Red Crescent, Red Lion and Sun) Societies, shall be permitted, even on their own initiative, to collect and care for the wounded, sick and shipwrecked, even in invaded or occupied areas. No one shall be harmed, prosecuted, convicted or punished for such humanitarian acts.
2. The Parties to the conflict may appeal to the civilian population and the aid societies referred to in paragraph 1 to collect and care for the wounded, sick and shipwrecked, and to search for the dead and report their location; they shall grant both protection and the necessary facilities to those who respond to this appeal. If the adverse Party gains or regains control of the area, that Party also shall afford the same protection and facilities for so long as they are needed.

Article 18 Identification

1. Each Party to the conflict shall endeavour to ensure that medical and religious personnel and medical units and transports are identifiable.

2. Each Party to the conflict shall also endeavour to adopt and to implement methods and procedures which will make it possible to recognize medical units and transports which use the distinctive emblem and distinctive signals.
3. In occupied territory and in areas where fighting is taking place or is likely to take place, civilian medical personnel and civilian religious personnel should be recognizable by the distinctive emblem and an identity card certifying their status.
4. With the consent of the competent authority, medical units and transports shall be marked by the distinctive emblem. The ships and craft referred to in Article 22 of this Protocol shall be marked in accordance with the provisions of the Second Convention.
5. In addition to the distinctive emblem, a Party to the conflict may, as provided in Chapter III of Annex I to this Protocol, authorize the use of distinctive signals to identify medical units and transports. Exceptionally, in the special cases covered in that Chapter, medical transports may use distinctive signals without displaying the distinctive emblem.
6. The application of the provisions of paragraphs 1 to 5 of this Article is governed by Chapters I to m of Annex I to this Protocol. Signals designated in Chapter m of the Annex for the exclusive use of medical units and transports shall not, except as provided therein, be used for any purpose other than to identify the medical units and transports specified in that Chapter.
7. This Article does not authorize any wider use of the distinctive emblem in peacetime than is prescribed in Article 44 of the First Convention.
8. The provisions of the Conventions and of this Protocol relating to supervision of the use of the distinctive emblem and to the prevention and repression of any misuse thereof shall be applicable to distinctive signals.

Article 19 Neutral and Other States Not Parties to the Conflict

Neutral and other States not Parties to the conflict shall apply the relevant provisions of this Protocol to persons protected by this Part who may be received or interned within their territory, and to any dead of the Parties to that conflict whom they may find.

Article 20 Prohibition of Reprisals

Reprisals against the persons and objects protected by this Part are prohibited.

SECTION II MEDICAL TRANSPORTATION

Article 21 Medical Vehicles

Medical vehicles shall be respected and protected in the same way as mobile medical units under the Conventions and this Protocol.

Article 22 Hospitals Ships and Coastal Rescue Craft

1. The provisions of the Conventions relating to:

- (a) Vessels described in Articles 22, 24, 25 and 27 of the Second Convention,
- (b) Their lifeboats and small craft,
- (c) Their personnel and crews; and
- (d) The wounded, sick and shipwrecked on board,

shall also apply where these vessels carry civilian wounded, sick and shipwrecked who do not belong to any of the categories mentioned in Article 13 of the Second Convention. Such civilians shall not, however, be subject to surrender to any Party which is not their own, or to capture at sea. If they find themselves in the power of a Party to the conflict other than their own they shall be covered by the Fourth Convention and by this Protocol.

2. The protection provided by the Conventions to vessels described in Article 25 of the Second Convention shall extend to hospital ships made available for humanitarian purposes to a Party to the conflict:

- (a) By a neutral or other State which is not a Party to that conflict; or
- (b) By an impartial international humanitarian organization,

provided that, in either case, the requirements set out in that Article are complied with.

3. Small craft described in Article 27 of the Second Convention shall be protected even if the notification envisaged by that Article has not been made. The Parties to the conflict are, nevertheless, invited to inform each other of any details of such craft which will facilitate their identification and recognition.

Article 23 Other Medical Ships and Craft

1. Medical ships and craft other than those referred to in Article 22 of this Protocol and Article 38 of the Second Convention shall, whether at sea or in other waters, be respected and protected in the same way as mobile medical units under the Conventions and this Protocol. Since this protection can only be effective if they can be identified and recognized as medical ships or craft, such vessels should be marked with the distinctive emblem and as far as possible comply with the second paragraph of Article 43 of the Second Convention.

2. The ships and craft referred to in paragraph 1 shall remain subject to the laws of war. Any warship on the surface able immediately to enforce its command may order them to stop, order them off, or make them take a certain course, and they shall obey every such command. Such ships and craft may not in any other way be diverted from their medical mission so long as they are needed for the wounded, sick and shipwrecked on board.

3. The protection provided in paragraph 1 shall cease only under the conditions set out in Articles 34 and 35 of the Second Convention. A clear refusal to obey a command given in accordance with paragraph 2 shall be an act harmful to the enemy under Article 34 of the Second Convention.

4. A Party to the conflict may notify any adverse Party as far in advance of sailing as possible of the name, description, expected time of sailing, course and estimated speed of the medical ship or craft, particularly in the case of ships of over 2,000 gross tons, and may provide any other information which would facilitate identification and recognition. The adverse Party shall acknowledge receipt of such information.

5. The provisions of Article 37 of the Second Convention shall apply to medical and religious personnel in such ships and craft.

6. The provisions of the Second Convention shall apply to the wounded, sick and shipwrecked belonging to the categories referred to in Article 13 of the Second Convention and in Article 44 of this Protocol who may be on board such medical ships and craft. Wounded, sick and shipwrecked civilians who do not belong to any of the categories mentioned in Article 13 of the Second Convention shall not be subject, at sea, either to surrender to any Party which is not their own; or to removal from such ships or craft; if they find themselves in the power of a Party to the conflict other than their own, they shall be covered by the Fourth Convention and by this Protocol.

Article 24 Protection of Medical Aircraft

Medical aircraft shall be respected and protected, subject to the provisions of this Part.

Article 25 Medical Aircraft in Areas Not Controlled by An Adverse Party

In and over land areas physically controlled by friendly forces, or in and over sea areas not physically controlled by an adverse Party, the respect and protection of medical aircraft of a Party to the conflict is not dependent on any agreement with an adverse Party. For greater safety, however, a Party to the conflict operating its medical aircraft in these areas may notify the adverse Party, as provided in Article 29, in particular when such aircraft are making flights bringing them within range of surface-to-air weapons systems of the adverse Party.

Article 26 Medical Aircraft in Contact or Similar Zones

1. In and over those parts of the contact zone which are physically controlled by friendly forces and in and over those areas the physical control of which is not clearly established, protection for medical aircraft can be fully effective only by prior agreement between the competent military authorities of the Parties to the conflict, as provided for in Article 29. Although, in the absence of such an agreement, medical aircraft operate at their own risk, they shall nevertheless be respected after they have been recognized as such.

2. "Contact zone" means any area on land where the forward elements of opposing forces are in contact with each other, especially where they are exposed to direct fire from the ground.

Article 27 Medical Aircraft in Areas Controlled by An Adverse Party

1. The medical aircraft of a Party to the conflict shall continue to be protected while flying over land or sea areas physically controlled by an adverse Party, provided that prior agreement to such flights has been obtained from the competent authority of the adverse Party.

2. A medical aircraft which flies over an area physically controlled by an adverse Party without, or in deviation from the terms of, an agreement provided for in paragraph 1, either through navigational error or because of an emergency affecting the safety of the flight, shall make every effort to identify itself and to inform the adverse Party of the circumstances. As soon as such medical aircraft has been recognized by the adverse Party, that Party shall make all reasonable efforts to give the order to land or to alight on water, referred to in Article 30, paragraph 1, or to take other measures to safeguard its own interests, and, in either case, to allow the aircraft time for compliance, before resorting to an attack against the aircraft.

Article 28 Restrictions on Operations of Medical Aircraft

1. The Parties to the conflict are prohibited from using their medical aircraft to attempt to acquire any military advantage over an adverse Party. The presence of medical aircraft shall not be used in an attempt to render military objectives immune from attack.

2. Medical aircraft shall not be used to collect or transmit intelligence data and shall not carry any equipment intended for such purposes. They are prohibited from carrying any persons or cargo not included within the definition in Article 8, subparagraph (t). The carrying on board of the personal effects of the occupants or of equipment intended solely to facilitate navigation, communication or identification shall not be considered as prohibited.

3. Medical aircraft shall not carry any armament except small arms and ammunition taken from the wounded, sick and shipwrecked on board and not yet handed to the proper service, and such light individual weapons as may be necessary to enable the medical personnel on board to defend themselves and the wounded, sick and shipwrecked in their charge.

4. While carrying out the flights referred to in Articles 26 and 27, medical aircraft shall not, except by prior agreement with the adverse Party, be used to search for the wounded, sick and shipwrecked

Article 29 Notifications and Agreements Concerning Medical Aircraft

1. Notifications under Article 25, or requests for prior agreement under Articles 26, 27, 28 (paragraph 4), or 31 shall state the proposed number of medical aircraft, their flight plans and means of identification, and shall be understood to mean that every

flight will be carried out in compliance with Article 28.

2. A Party which receives a notification given under Article 25 shall at once acknowledge receipt of such notification.
3. A Party which receives a request for prior agreement under Articles 26, 27, 28 (paragraph 4), or 31 shall, as rapidly as possible, notify the requesting Party:
 - (a) That the request is agreed to;
 - (b) That the request is denied; or
 - (c) of reasonable alternative proposals to the request. It may also propose a prohibition or restriction of other flights in the area during the time involved. If the Party which submitted the request accepts the alternative proposals, it shall notify the other Party of such acceptance.
4. The Parties shall take the necessary measures to ensure that notifications and agreements can be made rapidly.
5. The Parties shall also take the necessary measures to disseminate rapidly the substance of any such notifications and agreements to the military units concerned and shall instruct those units regarding the means of identification that will be used by the medical aircraft in question.

Article 30 Landing and Inspection of Medical Aircraft

1. Medical aircraft flying over areas which are physically controlled by an adverse Party, or over areas the physical control of which is not clearly established, may be ordered to land or to alight on water, as appropriate, to permit inspection in accordance with the following paragraphs. Medical aircraft shall obey any such order.
2. If such an aircraft lands or alights on water, whether ordered to do so or for other reasons, it may be subjected to inspection solely to determine the matters referred to in paragraphs 3 and 4. Any such inspection shall be commenced without delay and shall be conducted expeditiously. The inspecting Party shall not require the wounded and sick to be removed from the aircraft unless their removal is essential for the inspection. That Party shall in any event ensure that the condition of the wounded and sick is not adversely affected by the inspection or by the removal.
3. If the inspection discloses that the aircraft:
 - (a) Is a medical aircraft within the meaning of Article 8, subparagraph (i);
 - (b) Is not in violation of the conditions prescribed in Article 28; and
 - (c) Has not flown without or in breach of a prior agreement where such agreement is required;
 the aircraft and those of its occupants who belong to the adverse Party or to a neutral or other State not a Party to the conflict shall be authorized to continue the flight without delay.
4. If the inspection discloses that the aircraft:
 - (a) Is not a medical aircraft within the meaning of Article 8, subparagraph (j);
 - (b) Is in violation of the conditions prescribed in Article 28; or,
 - (c) Has flown without or in breach of a prior agreement where such agreement is required;
 the aircraft may be seized. Its occupants shall be treated in conformity with the relevant provisions of the Conventions and of this Protocol. Any aircraft seized which had been assigned as a permanent medical aircraft may be used thereafter only as a medical aircraft.

Article 31 Neutral or Other States Not Parties to the Conflict

1. Except by prior agreement, medical aircraft shall not fly over or land in the territory of a neutral or other State not a Party to the conflict. However, with such an agreement, they shall be respected throughout their flight and also for the duration of any calls in the territory. Nevertheless they shall obey any summons to land or to alight on water, as appropriate.
2. Should a medical aircraft, in the absence of an agreement or in deviation from the terms of an agreement, fly over the territory of a neutral or other State not a Party to the conflict, either through navigational error or because of an emergency affecting the safety of the flight, it shall make every effort to give notice of the flight and to identify itself. As soon as such medical aircraft is recognized, that State shall make all reasonable efforts to give the order to land or to alight on water referred to in Article 30, paragraph 1, or to take other measures to safeguard its own interests, and in either case, to allow the aircraft time for compliance, before resorting to an attack against the aircraft.
3. If a medical aircraft, either by agreement or in the circumstances mentioned in paragraph 2, lands or alights on water in the territory of a neutral or other State not Party to the conflict, whether ordered to do so or for other reasons, the aircraft shall be subject to inspection for the purposes of determining whether it is in fact a medical aircraft. The inspection shall be commenced without delay and shall be conducted expeditiously. The inspecting Party shall not require the wounded and sick of the Party operating the aircraft to be removed from it unless their removal is essential for the inspection. The inspecting Party shall in any event ensure that the condition of the wounded and sick is not adversely affected by the inspection or the removal. If the inspection discloses that the aircraft is in fact a medical aircraft, the aircraft with its occupants, other than those who must be detained in accordance with the rules of international law applicable in armed conflict, shall be allowed to resume its flight, and reasonable facilities shall be given for the continuation of the flight. If the inspection discloses that the aircraft is not a medical aircraft, it shall be seized and the occupants treated in accordance with paragraph 4.

4. The wounded, sick and shipwrecked disembarked, otherwise than temporarily, from a medical aircraft with the consent of the local authorities in the territory of a neutral or other State not a Party to the conflict shall, unless agreed otherwise between that State and the Parties to the conflict, be detained by that State where so required by the rules of international law applicable in armed conflict, in such a manner that they cannot again take part in the hostilities. The cost of hospital treatment and internment shall be borne by the State to which those persons belong.

5. Neutral or other States not Parties to the conflict shall apply any conditions and restrictions on the passage of medical aircraft over, or on the landing of medical aircraft in, their territory equally to all Parties to the conflict.

SECTION III MISSING AND DEAD PERSONS

[...]

PART III METHODS AND MEANS OF WARFARE COMBATANT AND PRISONER-OF-WAR STATUS

SECTION I METHODS AND MEANS OF WARFARE

[...]

Article 37 Prohibition of Perfidy

1. It is prohibited to kill, injure or capture an adversary by resort to perfidy. Acts inviting the confidence of an adversary to lead him to believe that he is entitled to, or is obliged to accord, protection under the rules of international law applicable in armed conflict, with intent to betray that confidence, shall constitute perfidy. The following acts are examples of perfidy:

- (a) The feigning of an intent to negotiate under a flag of truce or of a surrender;
- (b) The feigning of an incapacitation by wounds or sickness;
- (c) The feigning of civilian, non-combatant status; and
- (d) The feigning of protected status by the use of signs, emblems or uniforms of the United Nations or of neutral or other States not Parties to the conflict.

2. Ruses of war are not prohibited. Such ruses are acts which are intended to mislead an adversary or to induce him to act recklessly but which infringe no rule of international law applicable in armed conflict and which are not perfidious because they do not invite the confidence of an adversary with respect to protection under that law. The following are examples of such ruses: the use of camouflage, decoys, mock operations and misinformation.

Article 38 Recognized Emblems

1. It is prohibited to make improper use of the distinctive emblem of the red cross, red crescent or red lion and sun or of other emblems, signs or signals provided for by the Conventions or by this Protocol. It is also prohibited to misuse deliberately in an armed conflict other internationally recognized protective emblems, signs or signals, including the flag of truce, and the protective emblem of cultural property.

2. It is prohibited to make use of the distinctive emblem of the United Nations, except as authorized by that Organization.

[...]

Article 41 Safeguard of An Enemy Hors De Combat

1. A person who is recognized or who, in the circumstances, should be recognized to be hors de combat shall not be made the object of attack.

2. A person is hors de combat if:

- (a) He is in the power of an adverse Party;
- (b) He clearly expresses an intention to surrender; or
- (c) He has been rendered unconscious or is otherwise incapacitated by wounds or sickness, and therefore is incapable of defending himself;

provided that in any of these cases he abstains from any hostile act and does not attempt to escape.

3. When persons entitled to protection as prisoners of war have fallen into the power of an adverse Party under unusual conditions of combat which prevent their evacuation as provided for in Part m, Section I, of the Third Convention, they shall be released and all feasible precautions shall be taken to ensure their safety.

[...]

SECTION II COMBATANT AND PRISONER-OF-WAR STATUS

[...]

PART IV CIVILIAN POPULATION

SECTION I GENERAL PROTECTION AGAINST EFFECTS OF HOSTILITIES

CHAPTER I BASIC RULE AND FIELD OF APPLICATION

[...]

Article 49 Definition of Attacks and Scope of Application

1. "Attacks" means acts of violence against the adversary, whether in offence or in defence.
2. The provisions of this Protocol with respect to attacks apply to all attacks in whatever territory conducted, including the national territory belonging to a Party to the conflict but under the control of an adverse Party.
3. The provisions of this Section apply to any land, air or sea warfare which may affect the civilian population, individual civilians or civilian objects on land. They further apply to all attacks from the sea or from the air against objectives on land but do not otherwise affect the rules of international law applicable in armed conflict at sea or in the air.
4. The provisions of this Section are additional to the rules concerning humanitarian protection contained in the Fourth Convention, particularly in Part II thereof, and in other international agreements binding upon the High Contracting Parties, as well as to other rules of international law relating to the protection of civilians and civilian objects on land, at sea or in the air against the effects of hostilities.

[...]

CHAPTER IV PRECAUTIONARY MEASURES

Article 57 Precautions in Attack

1. In the conduct of military operations, constant care shall be taken to spare the civilian population, civilians and civilian objects.
2. With respect to attacks, the following precautions shall be taken:
 - (a) Those who plan or decide upon an attack shall:
 - (i) Do everything feasible to verify that the objectives to be attacked are neither civilians nor civilian objects and are not subject to special protection but are military objectives within the meaning of paragraph 2 of Article 52 and that it is not prohibited by the provisions of this Protocol to attack them;

[...]

CHAPTER VI CIVIL DEFENCE

Article 61 Definitions and Scope

For the purposes of this Protocol:

- (a) "Civil defence" means the performance of some or all of the undermentioned humanitarian tasks intended to protect the civilian population against the dangers, and to help it to recover from the immediate effects, of hostilities or disasters and also to provide the conditions necessary for its survival. These tasks are:

[...]

- (vi) Medical services, including first aid, and religious assistance;

[...]

- (xv) Complementary activities necessary to carry out any of the tasks mentioned above, including, but not limited to, planning and organization;

- (b) "Civil defence organizations" means those establishments and other units which are organized or authorized by the competent authorities of a Party to the conflict to perform any of the tasks mentioned under subparagraph (a), and which are assigned and devoted exclusively to such tasks;

- (c) "Personnel" of civil defence organizations means those persons assigned by a Party to the conflict exclusively to the performance of the tasks mentioned under sub-paragraph (a), including personnel assigned by the competent authority of that Party exclusively to the administration of these organizations;

- (d) "Mat,riel" of civil defence organizations means equipment, supplies and transports used by these organizations for the performance of the tasks mentioned under sub-paragraph (a).

Article 62 General Protection

1. Civilian civil defence organizations and their personnel shall be respected and protected, subject to the provisions of this Protocol, particularly the provisions of this Section. They shall be entitled to perform their civil defence tasks except in case of imperative military necessity.
2. The provisions of paragraph 1 shall also apply to civilians who, although not members of civilian civil defence organizations, respond to an appeal from the competent authorities and perform civil defence tasks under their control.

3. Buildings and materiel used for civil defence purposes and shelters provided for the civilian population are covered by Article 52. Objects used for civil defence purposes may not be destroyed or diverted from their proper use except by the Party to which they belong.

Article 63 Civil Defence in Occupied Territories

1. In occupied territories, civilian civil defence organizations shall receive from the authorities the facilities necessary for the performance of their tasks. In no circumstances shall their personnel be compelled to perform activities which would interfere with the proper performance of these tasks. The Occupying Power shall not change the structure or personnel of such organizations in any way which might jeopardize the efficient performance of their mission. These organizations shall not be required to give priority to the nationals or interests of that Power.

2. The Occupying Power shall not compel, coerce or induce civilian civil defense organizations to perform their tasks in a manner prejudicial to the interests of the civilian population.

3. The Occupying Power may disarm civil defense personnel for reasons of security.

4. The Occupying Power shall neither divert from their proper use nor requisition buildings or materiel belonging to or used by civil defense organizations if such diversion or requisition would be harmful to the civilian population.

5. Provided that the general rule in paragraph 4 continues to be observed, the occupying Power may requisition or divert these resources, subject to the following particular conditions:

(a) That the buildings or materiel are necessary for other needs of the civilian population; and

(b) That the requisition or diversion continues only while such necessity exists.

6. The Occupying Power shall neither divert nor requisition shelters provided for the use of the civilian population or needed by such population.

Article 64 Civilian Civil Defence Organizations of Neutral or other States not Parties to the Conflict and International Co-ordinating Organizations

1. Articles 62, 63, 65 and 66 shall also apply to the personnel and materiel of civilian civil defence organizations of neutral or other States not Parties to the conflict which perform civil defense tasks mentioned in Article 61 in the territory of a Party to the conflict, with the consent and under the control of that Party. Notification of such assistance shall be given as soon as possible to any adverse Party concerned. In no circumstances shall this activity be deemed to be an interference in the conflict. This activity should, however, be performed with due regard to the security interests of the Parties to the conflict concerned.

2. The Parties to the conflict receiving the assistance referred to in paragraph 1 and the High Contracting Parties granting it should facilitate international co-ordination of such civil defence actions when appropriate. In such cases the relevant international organizations are covered by the provisions of this Chapter.

3. In occupied territories, the Occupying Power may only exclude or restrict the activities of civilian civil defence organizations of neutral or other States not Parties to the conflict and of international co-ordinating organizations if it can ensure the adequate performance of civil defence tasks from its own resources or those of the occupied territory.

Article 65 Cessation of Protection

1. The protection to which civilian civil defence organizations, their personnel, buildings, shelters and materiel are entitled shall not cease unless they commit or are used to commit, outside their proper tasks, acts harmful to the enemy. Protection may, however, cease only after a warning has been given setting, whenever appropriate, a reasonable time-limit, and after such warning has remained unheeded.

2. The following shall not be considered as acts harmful to the enemy:

(a) That civil defence tasks are carried out under the direction or control of military authorities;

(b) That civilian civil defence personnel co-operate with military personnel in the performance of civil defence tasks, or that some military personnel are attached to civilian civil defence organizations;

(c) That the performance of civil defence tasks may incidentally benefit military victims, particularly those who are hors de combat.

3. It shall also not be considered as an act harmful to the enemy that civilian defence personnel bear light individual weapons for the purpose of maintaining order or for self-defence. However, in areas where land fighting is taking place or is likely to take place, the Parties to the conflict shall undertake the appropriate measures to limit these weapons to handguns, such as pistols or revolvers, in order to assist in distinguishing between civil defence personnel and combatants. Although civil defence personnel bear other light individual weapons in such areas, they shall nevertheless be respected and protected as soon as they have been recognized as such.

4. The formation of civilian civil defence organizations along military lines, and compulsory service in them, shall also not deprive them of the protection conferred by this Chapter.

Article 66 Identification

1. Each Party to the conflict shall endeavour to ensure that its civil defence organizations, their personnel, buildings and materiel, are identifiable while they are exclusively devoted to the performance of civil defence tasks. Shelters provided for the civilian

population should be similarly identifiable.

2. Each Party to the conflict shall also endeavour to adopt and implement methods and procedures which will make it possible to recognize civilian shelters as well as civil defence personnel, buildings and materiel on which the international distinctive sign of civil defence is displayed.

3. In occupied territories and in areas where fighting is taking place or is likely to take place, civilian civil defence personnel should be recognizable by the international distinctive sign of civil defence and by an identity and certifying their status.

4. The international distinctive sign of civil defence is an equilateral blue triangle on an orange ground when used for the protection of civil defence organizations, their personnel, buildings and materiel and for civilian shelters.

5. In addition to the distinctive sign, Parties to the conflict may agree upon the use of distinctive signals for civil defence identification purposes.

6. The application of the provisions of paragraphs 1 to 4 is governed by Chapter V of Annex I to this Protocol.

7. In time of peace, the sign described in paragraph 4 may, with the consent of the competent national authorities, be used for civil defence identification purposes.

8. The High Contracting Parties and the Parties to the conflict shall take the measures necessary to supervise the display of the international distinctive sign of civil defence and to prevent and repress any misuse thereof.

9. The identification of civil defence medical and religious personnel, medical units and medical transports is also governed by Article 18.

Article 67 Members of The Armed Forces and Military Units Assigned to Civil Defence Organizations

1. Members of the armed forces and military units assigned to civil defence organizations shall be respected and protected, provided that:

(a) Such personnel and such units are permanently assigned and exclusively devoted to the performance of any of the tasks mentioned in Article 61;

(b) If so assigned, such personnel do not perform any other military duties during the conflict;

(c) Such personnel are clearly distinguishable from the other members of the armed forces by prominently displaying the international distinctive sign of civil defence, which shall be as large as appropriate, and such personnel are provided with the identity card referred to in Chapter V of Annex I to this Protocol certifying their status;

(d) Such personnel and such units are equipped only with light individual weapons for the purpose of maintaining order or for self-defence. The provisions of Article 65, paragraph 3 shall also apply in this case;

(e) Such personnel do not participate directly in hostilities, and do not commit, or are not used to commit, outside their civil defence tasks, acts harmful to the adverse Party;

(f) Such personnel and such units perform their civil defence tasks only within the national territory of their Party.

The non-observance of the conditions stated in (e) above by any member of the armed forces who is bound by the conditions prescribed in (a) and (b) above is prohibited.

2. Military personnel serving within civil defence organizations shall, if they fall into the power of an adverse Party, be prisoners of war. In occupied territory they may, but only in the interest of the civilian population of that territory, be employed on civil defence tasks in so far as the need arises, provided however that, if such work is dangerous, they volunteer for such tasks.

3. The buildings and major items of equipment and transports of military units assigned to civil defence organizations shall be clearly marked with the international distinctive sign of civil defence. This distinctive sign shall be as large as appropriate.

4. The materiel and buildings of military units permanently assigned to civil defence organizations and exclusively devoted to the performance of civil defence tasks shall, if they fall into the hands of an adverse Party, remain subject to the laws of war. They may not be diverted from their civil defence purpose so long as they are required for the performance of civil defence tasks, except in case of imperative military necessity, unless previous arrangements have been made for adequate provision for the needs of the civilian population.

SECTION II RELIEF IN FAVOUR OF THE CIVILIAN POPULATION

Article 68 Field of Application

The provisions of this Section apply to the civilian population as defined in this Protocol and are supplementary to Articles 23, 55, 59, 60, 61 and 62 and other relevant provisions of the Fourth Convention.

Article 69 Basic Needs in Occupied Territories

1. In addition to the duties specified in Article 55 of the Fourth Convention concerning food and medical supplies, the Occupying Power shall, to the fullest extent of the means available to it and without any adverse distinction, also ensure the provision of clothing, bedding, means of shelter, other supplies essential to the survival of the civilian population of the occupied territory and objects necessary for religious worship.

2. Relief actions for the benefit of the civilian population of occupied territories are governed by Articles 59, 60, 61, 62, 108, 109, 110 and 111 of the Fourth Convention, and by Article 71 of this Protocol, and shall be implemented without delay.

Article 70 Relief Actions

1. If the civilian population of any territory under the control of a Party to the conflict, other than occupied territory, is not adequately provided with the supplies mentioned in Article 69, relief actions which are humanitarian and impartial in character and conducted without any adverse distinction shall be undertaken, subject to the agreement of the Parties concerned in such relief actions. Offers of such relief shall not be regarded as interference in the armed conflict or as unfriendly acts. In the distribution of relief consignments, priority shall be given to those persons, such as children, expectant mothers, maternity cases and nursing mothers, who, under the Fourth Convention or under this Protocol, are to be accorded privileged treatment or special protection.
2. The Parties to the conflict and each High Contracting Party shall allow and facilitate rapid and unimpeded passage of all relief consignments, equipment and personnel provided in accordance with this Section, even if such assistance is destined for the civilian population of the adverse Party.
3. The Parties to the conflict and each High Contracting Party which allow the passage of relief consignments, equipment and personnel in accordance with paragraph 2:
 - (a) Shall have the right to prescribe the technical arrangements, including search, under which such passage is permitted;
 - (b) May make such permission conditional on the distribution of this assistance being made under the local supervision of a Protecting Power;
 - (c) Shall, in no way whatsoever, divert relief consignments from the purpose for which they are intended nor delay their forwarding, except in cases of urgent necessity in the interest of the civilian population concerned.
4. The Parties to the conflict shall protect relief consignments and facilitate their rapid distribution.
5. The Parties to the conflict and each High Contracting Party concerned shall encourage and facilitate effective international co-ordination of the relief actions referred to in paragraph 1.

Article 71 Personnel Participating in Relief Actions

1. Where necessary, relief personnel may form part of the assistance provided in any relief action, in particular for the transportation and distribution of relief consignments; the participation of such personnel shall be subject to the approval of the Party in whose territory they will carry out their duties.
2. Such personnel shall be respected and protected.
3. Each Party in receipt of relief consignments shall, to the fullest extent practicable, assist the relief personnel referred to in paragraph 1 in carrying out their relief mission. Only in case of imperative military necessity may the activities of the relief personnel be limited or their movements temporarily restricted.
4. Under no circumstances may relief personnel exceed the terms of their mission under this Protocol. In particular they shall take account of the security requirements of the Party in whose territory they are carrying out their duties. The mission of any of the personnel who do not respect these conditions may be terminated.

SECTION III TREATMENT OF PERSONS IN THE POWER OF A PARTY TO THE CONFLICT**CHAPTER 1 FIELD OF APPLICATION AND PROTECTION OF PERSONS AND OBJECTS**

[...]

Article 75 Fundamental Guarantees

1. In so far as they are affected by a situation referred to in Article 1 of this Protocol, persons who are in the power of a Party to the conflict and who do not benefit from more favourable treatment under the Conventions or under this Protocol shall be treated humanely in all circumstances and shall enjoy, as a minimum, the protection provided by this Article without any adverse distinction based upon race, colour, sex, language, religion or belief, political or other opinion, national or social origin, wealth, birth or other status, or on any other similar criteria. Each Party shall respect the person, honour, convictions and religious practices of all such persons.
2. The following acts are and shall remain prohibited at any time and in any place whatsoever, whether committed by civilian or by military agents:
 - (a) Violence to the life, health, or physical or mental well-being of persons, in particular:
 - (i) Murder;
 - (ii) Torture of all kinds, whether physical or mental;
 - (iii) Corporal punishment; and
 - (iv) Mutilation;
 - (b) Outrages upon personal dignity, in particular humiliating and degrading treatment, enforced prostitution and any form of indecent assault;
 - (c) The taking of hostages;
 - (d) Collective punishments; and
 - (e) Threats to commit any of the foregoing acts.

[...]

CHAPTER II MEASURES IN FAVOUR OF WOMEN AND CHILDREN

[...]

Article 78 Evacuation of Children

1. No Party to the conflict shall arrange for the evacuation of children, other than its own nationals, to a foreign country except for a temporary evacuation where compelling reasons of the health or medical treatment of the children or, except in occupied territory, their safety, so require. Where the parents or legal guardians can be found, their written consent to such evacuation is required. If these persons cannot be found, the written consent to such evacuation of the persons who by law or custom are primarily responsible for the care of the children is required. Any such evacuation shall be supervised by the Protecting Power in agreement with the Parties concerned, namely, the Party arranging for the evacuation, the Party receiving the children and any Parties whose nationals are being evacuated. In each case, all Parties to the conflict shall take all feasible precautions to avoid endangering the evacuation.

[...]

PART V EXECUTION OF THE CONVENTIONS AND OF THIS PROTOCOL

SECTION I GENERAL PROVISIONS

[...]

Article 81 Activities of the Red Cross and Other Humanitarian Organizations

1. The Parties to the conflict shall grant to the International Committee of the Red Cross all facilities within their power so as to enable it to carry out the humanitarian functions assigned to it by the Conventions and this Protocol in order to ensure protection and assistance to the victims of conflicts; the International Committee of the Red Cross may also carry out any other humanitarian activities in favour of these victims, subject to the consent of the Parties to the conflict concerned.

2. The Parties to the conflict shall grant to their respective Red Cross (Red Crescent, Red Lion and Sun) organizations the facilities necessary for carrying out their humanitarian activities in favour of the victims of the conflict, in accordance with the provisions of the Conventions and this Protocol and the fundamental principles of the Red Cross as formulated by the International Conferences of the Red Cross.

3. The High Contracting Parties and the Parties to the conflict shall facilitate in every possible way the assistance which Red Cross (Red Crescent, Red Lion and Sun) organizations and the League of Red Cross Societies extend to the victims of conflicts in accordance with the provisions of the Conventions and this Protocol and with the fundamental principles of the Red Cross as formulated by the International Conferences of the Red Cross.

4. The High Contracting Parties and the Parties to the conflict shall, as far as possible, make facilities similar to those mentioned in paragraphs 2 and 3 available to the other humanitarian organizations referred to in the Conventions and this Protocol which are duly authorized by the respective Parties to the conflict and which perform their humanitarian activities in accordance with the provisions of the Conventions and this Protocol.

[...]

SECTION II REPRESSION OF BREACHES OF THE CONVENTIONS AND OF THIS PROTOCOL

Article 85 Repression of Breaches of This Protocol

1. The provisions of the Conventions relating to the repression of breaches and grave breaches, supplemented by this Section, shall apply to the repression of breaches and grave breaches of this Protocol.

2. Acts described as grave breaches in the Conventions are grave breaches of this Protocol if committed against persons in the power of an adverse Party protected by Articles 44, 45 and 73 of this Protocol, or against the wounded, sick and shipwrecked of the adverse Party who are protected by this Protocol, or against those medical or religious personnel, medical units or medical transports which are under the control of the adverse Party and are protected by this Protocol.

3. In addition to the grave breaches defined in Article 11, the following acts shall be regarded as grave breaches of this Protocol, when committed wilfully, in violation of the relevant provisions of this Protocol, and causing death or serious injury to body or health:

[...]

(e) Making a person the object of attack in the knowledge that he is hors de combat;

(f) The perfidious use, in violation of Article 37, of the distinctive emblem of the red cross, red crescent or red lion and sun or of other protective signs recognized by the Conventions or this Protocol.

[...]

5. Without prejudice to the application of the Conventions and of this Protocol, grave breaches of these instruments shall be

regarded as war crimes.

Article 86 Failure to Act

1. The High Contracting Parties and the Parties to the conflict shall repress grave breaches, and take measures necessary to suppress all other breaches, of the Conventions or of this Protocol which result from a failure to act when under a duty to do so.
2. The fact that a breach of the Conventions or of this Protocol was committed by a subordinate does not absolve his superiors from penal or disciplinary responsibility, as the case may be, if they knew, or had information which should have enabled them to conclude in the circumstances at the time, that he was committing or was going to commit such a breach and if they did not take all feasible measures within their power to prevent or repress the breach.

Article 87 Duty of Commanders

1. The High Contracting Parties and the Parties to the conflict shall require military commanders, with respect to members of the armed forces under their command and other persons under their control, to prevent and, where necessary, to suppress and to report to competent authorities breaches of the Conventions and of this Protocol.
2. In order to prevent and suppress breaches, High Contracting Parties and Parties to the conflict shall require that, commensurate with their level of responsibility, commanders ensure that members of the armed forces under their command are aware of their obligations under the Conventions and this Protocol.
3. The High Contracting Parties and Parties to the conflict shall require any commander who is aware that subordinates or other persons under his control are going to commit or have committed a breach of the Conventions or of this Protocol, to initiate such steps as are necessary to prevent such violations of the Conventions or this Protocol, and, where appropriate, to initiate disciplinary or penal action against violators thereof.

[...]

PART VI FINAL PROVISIONS

[...]

ANNEX I

Regulations concerning identification

CHAPTER I IDENTITY CARDS

Article I Identity Card For Permanent Civilian Medical and Religious Personnel

1. The identity card for permanent civilian medical and religious personnel referred to in Article 18, paragraph 3, of the Protocol should:

- (a) Bear the distinctive emblem and be of such size that it can be carried in the pocket;
- (b) Be as durable as practicable;
- (c) Be worded in the national or official language (and may in addition be worded in other languages);
- (d) Mention the name, the date of birth (or, if that date is not available, the age at the time of issue) and the identity number, if any, of the holder;
- (e) State in what capacity the holder is entitled to the protection of the Conventions and of the Protocol;
- (f) Bear the photograph of the holder as well as his signature or this thumbprint, or both;
- (g) Bear the stamp and signature of the competent authority;
- (h) State the date of issue and date of expiry of the card.

2. The identity card shall be uniform throughout the territory of each High Contracting Party and, as far as possible, of the same type for all Parties to the conflict. The Parties to the conflict may be guided by the single-language model shown in Figure 1. At the outbreak of hostilities, they shall transmit to each other a specimen of the model they are using, if such model differs from that shown in Figure 1. The identity card shall be made out, if possible, in duplicate, one copy being kept by the issuing authority, which should maintain control of the cards which it has issued.

3. In no circumstances may permanent civilian medical and religious personnel be deprived of their identity cards. In the event of the loss of a card, they shall be entitled to obtain a duplicate copy.

Article 2 Identity Card for Temporary Civilian Medical and Religious Personnel

1. The identity card for temporary civilian medical and religious personnel should, whenever possible, be similar to that provided for in Article I of these Regulations. The Parties to the conflict may be guided by the model shown in Figure 1.

2. When circumstances preclude the provision to temporary civilian medical and religious personnel of identity cards similar to those described in Article I of these Regulations, the said personnel may be provided with a certificate signed by the competent authority certifying that the person to whom it is issued is assigned to duty as temporary personnel and stating, if possible, the

duration of such assignment and his right to wear the distinctive emblem. The certificate should mention the holder's name and date of birth (or if that date is not available, his age at the time when the certificate was issued), his function and identity number, if any. It shall bear his signature or his thumbprint, or both.

CHAPTER II THE DISTINCTIVE EMBLEM

Article 3 Shape and Nature

1. The distinctive emblem (red on a white ground) shall be as large as appropriate under the circumstances. For the shapes of the cross, the crescent or the lion and sun, the High Contracting Parties may be guided by the models shown in Figure 2.
2. At night or when visibility is reduced, the distinctive emblem may be lighted or illuminated; it may also be made of materials rendering it recognizable by technical means of detection.

Article 4 Use

1. The distinctive emblem shall, whenever possible, be displayed on a flat surface or on flags visible from as many directions and from as far away as possible.
2. Subject to the instructions of the competent authority, medical and religious personnel carrying out their duties in the battle area shall, as far as possible, wear headgear and clothing bearing the distinctive emblem.

CHAPTER III DISTINCTIVE SIGNALS

[...]

CHAPTER IV COMMUNICATIONS

[...]

CHAPTER V CIVIL DEFENCE

[...]

1977 Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II)

PREAMBLE

[...]

PART I. SCOPE OF THIS PROTOCOL

ART 1. MATERIAL FIELD OF APPLICATION

[...]

ART 2. PERSONAL FIELD OF APPLICATION

1. This Protocol shall be applied without any adverse distinction founded on race, colour, sex, language, religion or belief, political or other opinion, national or social origin, wealth, birth or other status, or on any other similar criteria (hereinafter referred to as "adverse distinction") to all persons affected by an armed conflict as defined in Article 1.
 2. At the end of the armed conflict, all the persons who have been deprived of their liberty or whose liberty has been restricted for reasons related to such conflict, as well as those deprived of their liberty or whose liberty is restricted after the conflict for the same reasons, shall enjoy the protection of Articles 5 and 6 until the end of such deprivation or restriction of liberty.
- [...]

PART II. HUMANE TREATMENT

ART 4 FUNDAMENTAL GUARANTEES

1. All persons who do not take a direct part or who have ceased to take part in hostilities, whether or not their liberty has been

restricted, are entitled to respect for their person, honour and convictions and religious practices. They shall in all circumstances be treated humanely, without any adverse distinction. It is prohibited to order that there shall be no survivors.

2. Without prejudice to the generality of the foregoing, the following acts against the persons referred to in paragraph 1 are and shall remain prohibited at any time and in any place whatsoever:

(a) violence to the life, health and physical or mental well-being of persons, in particular murder as well as cruel treatment such as torture, mutilation or any form of corporal punishment;

[...]

(g) pillage;

(h) threats to commit any of the foregoing acts.

[...]

ART 5. PERSONS WHOSE LIBERTY HAS BEEN RESTRICTED

1. In addition to the provisions of Article 4 the following provisions shall be respected as a minimum with regard to persons deprived of their liberty for reasons related to the armed conflict, whether they are interned or detained;

(a) the wounded and the sick shall be treated in accordance with Article 7;

[...]

(c) they shall be allowed to receive individual or collective relief;

[...]

2. Those who are responsible for the internment or detention of the persons referred to in paragraph 1 shall also, within the limits of their capabilities, respect the following provisions relating to such persons:

[...]

(d) they shall have the benefit of medical examinations;

(e) their physical or mental health and integrity shall not be endangered by any unjustified act or omission. Accordingly, it is prohibited to subject the persons described in this Article to any medical procedure which is not indicated by the state of health of the person concerned, and which is not consistent with the generally accepted medical standards applied to free persons under similar medical circumstances.

3. Persons who are not covered by paragraph 1 but whose liberty has been restricted in any way whatsoever for reasons related to the armed conflict shall be treated humanely in accordance with Article 4 and with paragraphs 1 (a), (c) and (d), and 2 (b) of this Article.

[...]

PART III. WOUNDED, SICK AND SHIPWRECKED

ART 7. PROTECTION AND CARE

1. All the wounded, sick and shipwrecked, whether or not they have taken part in the armed conflict, shall be respected and protected.

2. In all circumstances they shall be treated humanely and shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.

ART 8. SEARCH

Whenever circumstances permit and particularly after an engagement, all possible measures shall be taken, without delay, to search for and collect the wounded, sick and shipwrecked, to protect them against pillage and ill-treatment, to ensure their adequate care, and to search for the dead, prevent their being despoiled, and decently dispose of them.

ART 9. PROTECTION OF MEDICAL AND RELIGIOUS PERSONNEL

1. Medical and religious personnel shall be respected and protected and shall be granted all available help for the performance of their duties. They shall not be compelled to carry out tasks which are not compatible with their humanitarian mission.

2. In the performance of their duties medical personnel may not be required to give priority to any person except on medical grounds.

ART 10. GENERAL PROTECTION OF MEDICAL DUTIES

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

2. Persons engaged in medical activities shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and

sick, or this Protocol.

3. The professional obligations of persons engaged in medical activities regarding information which they may acquire concerning the wounded and sick under their care shall, subject to national law, be respected.

4. Subject to national law, no person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care.

ART 11. PROTECTION OF MEDICAL UNITS AND TRANSPORTS

1. Medical units and transports shall be respected and protected at all times and shall not be the object of attack.

2. The protection to which medical units and transports are entitled shall not cease unless they are used to commit hostile acts, outside their humanitarian function. Protection may, however, cease only after a warning has been given, setting, whenever appropriate, a reasonable time-limit, and after such warning has remained unheeded.

ART 12. THE DISTINCTIVE EMBLEM

Under the direction of the competent authority concerned, the distinctive emblem of the red cross, red crescent or red lion and sun on a white ground shall be displayed by medical and religious personnel and medical units, and on medical transports. It shall be respected in all circumstances. It shall not be used improperly.

PART IV. CIVILIAN POPULATION

[...]

ART 18. RELIEF SOCIETIES AND RELIEF ACTIONS

1. Relief societies located in the territory of the High Contracting Party, such as Red Cross (Red Crescent, Red Lion and Sun) organizations may offer their services for the performance of their traditional functions in relation to the victims of the armed conflict. The civilian population may, even on its own initiative, offer to collect and care for the wounded, sick and shipwrecked.

2. If the civilian population is suffering undue hardship owing to a lack of the supplies essential for its survival, such as food-stuffs and medical supplies, relief actions for the civilian population which are of an exclusively humanitarian and impartial nature and which are conducted without any adverse distinction shall be undertaken subject to the consent of the High Contracting Party concerned.

PART V. FINAL PROVISIONS

[...]

2005 Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem (Protocol III)

PREAMBLE

THE HIGH CONTRACTING PARTIES,

REAFFIRMING the provisions of the Geneva Conventions of 12 August 1949 (in particular Articles 26, 38, 42 and 44 of the First Geneva Convention) and, where applicable, their Additional Protocols of 8 June 1977 (in particular Articles 18 and 38 of Additional Protocol I and Article 12 of Additional Protocol II), concerning the use of distinctive emblems,

DESIRING to supplement the aforementioned provisions so as to enhance their protective value and universal character,

NOTING that this Protocol is without prejudice to the recognized right of High Contracting Parties to continue to use the emblems they are using in conformity with their obligations under the Geneva Conventions and, where applicable, the Protocols additional thereto,

RECALLING that the obligation to respect persons and objects protected by the Geneva Conventions and the Protocols additional thereto derives from their protected status under international law and is not dependent on use of the distinctive emblems, signs or signals,

STRESSING that the distinctive emblems are not intended to have any religious, ethnic, racial, regional or political significance,

EMPHASIZING the importance of ensuring full respect for the obligations relating to the distinctive emblems recognized in the

Geneva Conventions, and, where applicable, the Protocols additional thereto,

RECALLING that Article 44 of the First Geneva Convention makes the distinction between the protective use and the indicative use of the distinctive emblems,

RECALLING further that National Societies undertaking activities on the territory of another State must ensure that the emblems they intend to use within the framework of such activities may be used in the country where the activity takes place and in the country or countries of transit,

RECOGNIZING the difficulties that certain States and National Societies may have with the use of the existing distinctive emblems,

NOTING the determination of the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies and the International Red Cross and Red Crescent Movement to retain their current names and emblems,

Have agreed on the following:

ARTICLE 1 RESPECT FOR AND SCOPE OF APPLICATION OF THIS PROTOCOL

1. The High Contracting Parties undertake to respect and to ensure respect for this Protocol in all circumstances.
2. This Protocol reaffirms and supplements the provisions of the four Geneva Conventions of 12 August 1949 (“the Geneva Conventions”) and, where applicable, of their two Additional Protocols of 8 June 1977 (“the 1977 Additional Protocols”) relating to the distinctive emblems, namely the red cross, the red crescent and the red lion and sun, and shall apply in the same situations as those referred to in these provisions.

ARTICLE 2 DISTINCTIVE EMBLEMS

1. This Protocol recognizes an additional distinctive emblem in addition to, and for the same purposes as, the distinctive emblems of the Geneva Conventions. The distinctive emblems shall enjoy equal status.
2. This additional distinctive emblem, composed of a red frame in the shape of a square on edge on a white ground, shall conform to the illustration in the Annex to this Protocol. This distinctive emblem is referred to in this Protocol as the “third Protocol emblem”.
3. The conditions for use of and respect for the third Protocol emblem are identical to those for the distinctive emblems established by the Geneva Conventions and, where applicable, the 1977 Additional Protocols.
4. The medical services and religious personnel of armed forces of High Contracting Parties may, without prejudice to their current emblems, make temporary use of any distinctive emblem referred to in paragraph 1 of this Article where this may enhance protection.

ARTICLE 3 INDICATIVE USE OF THE THIRD PROTOCOL EMBLEM

1. National Societies of those High Contracting Parties which decide to use the third Protocol emblem may, in using the emblem in conformity with relevant national legislation, choose to incorporate within it, for indicative purposes:
 - a) a distinctive emblem recognized by the Geneva Conventions or a combination of these emblems; or
 - b) another emblem which has been in effective use by a High Contracting Party and was the subject of a communication to the other High Contracting Parties and the International Committee of the Red Cross through the depositary prior to the adoption of this Protocol. Incorporation shall conform to the illustration in the Annex to this Protocol.
2. A National Society which chooses to incorporate within the third Protocol emblem another emblem in accordance with paragraph 1 above, may, in conformity with national legislation, use the designation of that emblem and display it within its national territory.
3. National Societies may, in accordance with national legislation and in exceptional circumstances and to facilitate their work, make temporary use of the distinctive emblem referred to in Article 2 of this Protocol.
4. This Article does not affect the legal status of the distinctive emblems recognized in the Geneva Conventions and in this Protocol, nor does it affect the legal status of any particular emblem when incorporated for indicative purposes in accordance with paragraph 1 of this Article.

ARTICLE 4 INTERNATIONAL COMMITTEE OF THE RED CROSS AND INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES

The International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies, and their duly authorized personnel, may use, in exceptional circumstances and to facilitate their work, the distinctive emblem referred to in Article 2 of this Protocol.

ARTICLE 5 MISSIONS UNDER UNITED NATIONS AUSPICES.

The medical services and religious personnel participating in operations under the auspices of the United Nations may, with the

agreement of participating States, use one of the distinctive emblems mentioned in Articles 1 and 2.

ARTICLE 6 PREVENTION AND REPRESSION OF MISUSE

1. The provisions of the Geneva Conventions and, where applicable, the 1977 Additional Protocols, governing prevention and repression of misuse of the distinctive emblems shall apply equally to the third Protocol emblem. In particular, the High Contracting Parties shall take measures necessary for the prevention and repression, at all times, of any misuse of the distinctive emblems mentioned in Articles 1 and 2 and their designations, including the perfidious use and the use of any sign or designation constituting an imitation thereof

2. Notwithstanding paragraph 1 above, High Contracting Parties may permit prior users of the third Protocol emblem, or of any sign constituting an imitation thereof, to continue such use, provided that the said use shall not be such as would appear, in time of armed conflict, to confer the protection of the Geneva Conventions and, where applicable, the 1977 Additional Protocols, and provided that the rights to such use were acquired before the adoption of this Protocol.

[...]

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