



Floor, Sword, Compass, Shield: Evaluating the Contribution of the 1977 Additional Protocols to the Respect of Medical Activities in Line with Medical Ethics

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The Additional Protocols at 40: Achievements and Challenges

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Délégation du CICR auprès de l'UE, de l'OTAN, et du Royaume de Belgique

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FLOOR, SWORD, COMPASS, SHIELD: EVALUATING THE CONTRIBUTION OF THE 1977 ADDITIONAL PROTOCOLS TO THE RESPECT OF MEDICAL ACTIVITIES IN LINE WITH MEDICAL ETHICS

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Résumé

Dustin Lewis examine la contribution des Protocoles additionnels de 1977 à la protection des activités médicales accomplies en conformité avec l'éthique médicale. L'enjeu de cette question réside dans le rôle potentiel du droit international pour fournir au personnel médical une base juridique suffisante afin qu'il puisse – en dépit des turbulences de la guerre – prioriser les intérêts du patient et ce, peu importe à quelle partie ils appartiennent.

Cette question fut déjà traitée – de manière certes insuffisante et inégale – dans les quatre Conventions de Genève (CG). Les Protocoles additionnels ont ensuite constitué l'occasion de développer les protections existantes, notamment au travers de la notion d' « éthique médicale », qui constitue (2) :

- un socle établissant des règles, standards et principes ;*
- une arme permettant de contrer les interférences illégitimes ;*
- un compas pour guider la prise de décisions médicales ;*
- un bouclier de protection contre les demandes et ordres illégitimes.*

Le manque de clarté de la notion d' éthique médicale risque cependant d'en réduire la sécurité juridique (1).

1. Définir la notion d' « éthique médicale » contenue dans les Protocoles additionnels

Dans la littérature académique, deux écoles peuvent être distinguées en ce qui concerne la définition de la notion d' éthique médicale dans les Protocoles additionnels :

- Selon la première école, ce concept concerne les règles, standards et principes juridiques ayant une valeur morale médicale et qui sont intégrés dans les différents traités pertinents de droit humanitaire.*
- Selon la seconde, le concept d' éthique médicale doit être lu non seulement à la lumière des dispositions pertinentes de droit humanitaire, mais également, par exemple, des différentes*

législations, règles et codes de conduite développées par les forces armées, les Etats ou la profession médicale.

Le concept d' éthique médicale paraît ainsi comprendre au minimum des principes moraux guidant les prestataires de soin lorsqu'ils sont impliqués dans le traitement d'un patient.

Avant l'apparition de cette notion via les Protocoles additionnels, certaines règles préexistantes traitaient déjà de la question dans le cas de conflits armés internationaux, comme l'interdiction de condamner le personnel médical pour avoir traité des blessés et malades. Certains principes et standards plus généraux servaient également de base à des considérations liées à l'éthique médicale, comme l'interdiction de distinction non liée à des raisons médicales ou encore l'interdiction des tortures et mutilations, par exemple.

2. La protection prévue par les Protocoles additionnels

Quatre éléments de protection en matière d'éthique médicale peuvent être identifiés dans les Protocoles additionnels :

- l'interdiction du recours à toute procédure médicale qui n'est pas indiquée dans l'état de santé du patient concerné et qui n'est pas conforme aux standards et principes médicaux communément admis ;*
- l'interdiction de l'usage de la contrainte sur du personnel médical afin qu'il accomplisse des actes contraires aux règles de l'éthique médicale, ou toute autre interdiction relative au traitement des blessés et malades ;*
- l'interdiction de toute sanction à l'encontre du personnel médical pour avoir accompli des actes médicaux conformes aux principes et standards en vigueur ;*
- enfin, des dispositions traitent également de certains aspects de confidentialité vis-à-vis des patients. Leur champ d'application est cependant limité étant donné qu'elles dépendent, dans la majorité des cas, du droit national.*

3. Problèmes persistants, problèmes nouveaux

Quarante ans après la signature des Protocoles additionnels, deux types de problèmes peuvent être identifiés en ce qui concerne les protections liées à l'éthique médicale.

Le premier est lié au concept d'éthique médicale au sein même du droit humanitaire et du manque de clarté quant à son contenu, ce qui pourrait porter préjudice aux différentes formes de protections qu'il entend apporter. Ensuite, une deuxième question porte sur les interactions entre le droit humanitaire et les législations mises en place dans la lutte contre le terrorisme.

Ces dernières, en effet, tendent à remettre en cause la légitimité des soins médicaux prodigués de manière impartiale et normalement protégés par le droit humanitaire.

1. Introduction

I have been asked to evaluate the contribution of the 1977 Additional Protocols (AP) I and II to the protection of medical activities in line with medical ethics.¹

What is at stake in this question? In essence, the key concerns are whether international law can, should, and does provide a sufficient basis for a medical health care provider – amid the tumult of war – to prioritise the interests of the patient irrespective of their affiliation, to guide decision-making aimed at effective and equitable care, and to not face illegitimate risks in pursuing those objectives. Those concerns had already been addressed, though at uneven levels of depth and breadth, in the four 1949 Geneva Conventions (GC). Due partly to perceived insufficiencies in existing rules, many delegations sought during the drafting of the APs, to work out more extensive protections of impartial medical care in relation to both international and non-international armed conflicts.²

I argue that the APs contributed to the protection of medical activities in line with medical ethics essentially by laying down a concept of ‘medical ethics’ that can be understood figuratively as:

- a *floor* of minimal rules, standards, and principles;
- a *sword* to overcome illegitimate interference;
- a *compass* to guide medically related decision-making; and
- a *shield* to protect against illegitimate requests or commands.

At least in some key respects, however, lack of specificity as to what constitutes ‘medical ethics’ in the APs may undermine legal certainty and comprehensiveness, and, in doing so, may impede

1 I am grateful to Naz K. Modirzadeh and Jessica S. Burniske for feedback on an initial draft; to Hayley Evans and Yang Liu for research assistance; and to Thomas Ewing, Yang Liu, and Andrew March for translation assistance. This presentation draws on the work of the Harvard Law School Program on International Law and Armed Conflict, including the September 2015 Legal Briefing titled “Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism” by Dustin A. Lewis, Naz K. Modirzadeh, and Gabriella Blum, at: <<https://pilac.law.harvard.edu/medical-care-in-armed-conflict-international-humanitarian-law-and-state-responses-to-terrorism/>>, archived at: <<https://perma.cc/GQ6U-A8EE>>.

2 See especially Volumes XI and XII of the *Official Records of the Diplomatic Conference on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts, Geneva (1974–77)*, Bern, 1978 (O.R.).

the realisation of corresponding protections. Those protections may be most fragile where different regulatory regimes, including counter-terrorism frameworks, do not share, or even reject, certain foundational normative commitments in International Humanitarian Law (IHL).

2. Defining the APs' Concept of Medical Ethics

What is entailed in the concept of medical ethics set down in the APs? A useful starting point is to note the different nature of *ethical* frameworks on the one hand, and international *legal* frameworks, on the other. In broad brush strokes, the former primarily address the formulation and weighing of moral principles and the elaboration of models of moral reasoning, while the latter primarily aim to establish and impose legally binding rules internationally. The two frameworks may intersect in some respects, but they are not coterminous. That may matter especially where an international legal protection pivots, at least in part, on the purported content of an ethical framework.

In the English text of the APs, express reference is made to 'medical ethics' in relation to *non-punishment of ethically sound medical care* (Article 16(1) of AP I and Article 10(1) of AP II) and to *prohibitions on certain forms of illegitimate compulsion* of those involved in medical care (Article 16(2) of AP I and Article 10(2) of AP II). Furthermore, two additional, related concepts are laid down in the APs: namely, 'generally accepted medical standards' that must be adhered to in respect of certain conduct (Article 11(1) and (3) of AP I and Article 5(2)(e) of AP II), as well as certain protections pertaining to confidentiality (or non-denunciation) (Article 16(3) AP I and Article 10(3)–(4) of AP II). 'Medical ethics' is not one of the medically related concepts expressly defined in Article 8 of AP I.

A review of the six authentic texts³ of the four provisions that expressly refer in the English text to '[the rules of] medical ethics' reveals certain differences – at least through unofficial translations of the authentic texts – in how the relevant concept is formulated:

- The Chinese text refers in three instances to 'medical ethics' ('医疗道德'), but in a fourth instance (Article 10(1) of AP II) the Chinese text refers to 'medical responsibilities' ('医疗职责');
- The French text refers across the board to a concept ('déontologie') seeming to more closely approximate 'ethics' generally (without the 'medical' qualifier), as does the Spanish text ('deontología'); and
- The Arabic text refers to the 'honor [*sharaf*] of the medical profession' ('هَيِّبْ طَلَاةَ نَهْمَلَا فَرَش').⁴

3 See Vienna Convention on the Law of Treaties (1969), Article 33 (VCLT).

4 Of the five other (non-English) texts, the Russian text – 'медицинская этика' ('medical ethics') in Article 16(1) of AP I and Article 10(1) of AP II and 'нормы медицинской этики' ('rules/norms of medical ethics') in Article 16(2) of AP I and Article 10(2) of AP II – appears to align most closely with the English text.

Whether these possible textual differences – at least in appearance – give rise to distinctions in legal meaning⁵ merits analysis that is beyond this presentation’s scope.

In academic literature, two general schools of thought emerge regarding the definition of ‘medical ethics’ in the APs. According to one school, which might be dubbed the ‘intra-IHL’ approach, the concept of ‘medical ethics’ in the APs concerns legal rules, standards, and principles with a medical moral valence that are ‘built into’⁶ the framework established in relevant IHL treaties, especially the GCs and APs, including relevant grave breaches.⁷ According to the second school,⁸ which might be dubbed the ‘intra-and-extra-IHL’ approach, the concept of ‘medical ethics’ in the APs may be discerned by reference not only to provisions of IHL but also to, for example, armed forces’ policies,⁹ national-level codes of ethics,¹⁰ other codes of ethics, as well as tool kits designed for medical practitioners¹¹ and International Human Rights Law.¹²

Bearing those considerations in mind, the concept of medical ethics laid down in the APs appears to encompass, at a minimum, moral principles that guide medical care providers when involved in the medical treatment of patients and that are discernible by reference at least to

5 See Articles 33(3) and 33(4) of the VCLT.

6 See M.J. Gunn and H. McCoubrey, “Medical Ethics and the Laws of Armed Conflict”, in: *Journal of Armed Conflict Law* 133, 133 (1998); see also H. McCoubrey, “Medical Ethics, Negligence and the Battlefield”, in: *Military Law and Law of War Review* 103, 104–105 (1995).

7 On the concept of medical war crimes, see Sigrid Mehring, “Medical War Crimes”, in: *Max Planck Yearbook of United Nations Law* 229 (2011).

8 See, e.g., Alexander Breitegger, “The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies”, in: *International Review of the Red Cross* 83, 118–22 (2013); Françoise J. Hampson, “Conscience in Conflict: The Doctor’s Dilemma”, in: *Canadian Yearbook of International Law* 203, 211–13 (1989).

9 See, e.g., U.S. Dep’t of Def., *Instruction on Medical Program Support for Detainee Operations*, No. 2310.08E, June 2006.

10 See, e.g., Australian Medical Association, *Code of Ethics* 2004, revised 2016.

11 See, e.g., UN General Assembly, “Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture, and other cruel, inhuman or degrading treatment or punishment”, Annex of Resolution 37/194, U.N. doc. A/RES/37/194, Dec. 18, 1982; World Medical Association, “Regulations in Times of Armed Conflict and Other Situations of Violence”, revised at the 63rd WMA General Assembly, Bangkok, Thailand, Oct. 2012; World Medical Association, “International Code of Medical Ethics”, amended by the 57th WMA General Assembly, Piñanesberg, South Africa, Oct. 2006; World Medical Association, “Declaration of Geneva”, revised by the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006; World Medical Association, International Committee of Military Medicine, International Council of Nurses, International Pharmaceutical Federation, and International Committee of the Red Cross, “Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies”, 2015; British Medical Association, “Armed Forces Ethics Tool Kit”, 2016.

12 See, e.g., Article 7 International Covenant on Civil and Political Rights (1966). See generally Breitegger, *op. cit.* note 8.

relevant rules, standards, and principles established in the GCs and APs for the benefit of the wounded, sick, and shipwrecked *hors de combat*.¹³ Those IHL provisions concern, for example, humane treatment, provision of medical care on an impartial basis, and prohibitions of various forms of maltreatment.

Partly with a view towards discerning ‘common principles’ of medical ethics, Sigrid Mehring examines, in a 2015 book, legal scholarship, philosophical discourse, national medical associations, sources of international law, and documents of the World Medical Association.¹⁴ In doing so, Mehring identifies, through the most exhaustive review of these issues to date, five such principles:

- *Beneficence*: a moral obligation to act for the benefit of others, with the accompanying implication that medical treatment should always be to the benefit of the person treated.
- *Non-maleficence*: the wounded and sick should always be respected and never harmed.
- *Non-discrimination*: all those seeking or otherwise in need of medical care should be treated equally irrespective of affiliation.
- *Informed consent*: all competent patients who are capable of making a decision on their medical treatment should be given relevant information, in a language they understand, concerning their medical condition and proposed medical treatment, and based on this information those patients should be given an opportunity to voluntarily consent or refuse.
- *Confidentiality*: information attained by a care provider in the medical treatment of a protected person should not be disclosed to third parties, including authorities, though confidentiality may be breached, at least according to Mehring, where the physician is convinced that the person being treated poses an imminent and direct threat to others.¹⁵

13 Compare this formulation with the ICRC’s 1987 *Commentary* on the APs: in relation to Article 16 of AP I, at p. 200, paragraph 655: ‘Thus the phrase [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. However, this should not be confused with the rules of the internal organization of medicine which obviously are not part of ‘medical ethics’ (emphasis added), and, in relation to Article 10 of AP II, at p. 1426, paragraph 4688: ‘It [medical ethics] consists of *moral duties incumbent on the medical profession*. Such duties are defined by the national and international corps of the medical profession’ (citation omitted). The *Commentary* argues that while certain referenced codes adopted by the World Medical Association have no binding force in international law, the rules in those codes nonetheless ‘constitute a valuable instrument of reference and no one contests the principles on which they are laid down. There is no doubt that these are the rules of medical ethics referred to in the context of the provision under consideration here’. *Ibid.* at p. 201, paragraph 656 (citation omitted); see also (concerning AP II). *Ibid.* at p. 1426, n.11.

14 See Sigrid Mehring, *First Do No Harm: Medical Ethics in International Humanitarian Law* (BRILL, 2015).

15 *Ibid.* at 427–33.

Mehring thereby makes a strong argument to (also) include, perhaps at least partly from a *lex ferenda* standpoint, those five medical-ethics principles in the IHL concept of medical ethics.

3. Before the Additional Protocols

While the APs expressly introduced the protective concept of medical ethics into IHL, what relevant IHL protections existed before the adoption of the APs? Several direct or indirect forerunners can be detected. For instance, at least in relation to international armed conflict, such precursors included:

- certain protections regarding ‘professional ethics’ or ‘professional etiquette’ for medical personnel retained by an enemy party;¹⁶
- a prohibition of convictions for nursing the wounded or sick;¹⁷ and
- certain protections regarding medical ‘duties’.¹⁸

In addition, several discrete rules, standards, and principles laid out in IHL treaty provisions can be considered, when read in combination, to reflect a set of relevant baseline normative commitments. Those commitments include the obligation to engage in humane treatment,¹⁹ the guideline that only urgent medical reasons will authorise priority in the order of treatment,²⁰ a prohibition on adverse discrimination not based on medical reasons,²¹ and prohibitions of torture,²² of mutilations,²³ of physical or moral coercion,²⁴ and of certain

16 Article 28(2) GC I (concerning ‘professional ethics’) and Article 33(2) GC III (concerning ‘professional etiquette’); the term is ‘conscience professionnelle’ in the French text of both provisions. Note: paragraph enumerations are added to the GCs in the footnotes here, where relevant, to aid in discerning relevant provisions.

17 Article 18(3) GC I.

18 Article 28(2) GC I; Article 56(1) GC IV (concerning occupation); see also medical ‘functions’ in Article 33(2) GC III.

19 Articles 3(1) and 12(2) GC I; Articles 3(1) and 12(2), GC II; Articles 3(1) and 13(1) GC III; Articles 3(1), 27(1), and 37(1) GC IV. (See also, subsequently, Articles 10(2) and 75(1) AP I; Articles 4(1), 5(3), and 7(2) AP II).

20 Article 12(3) GC I; Article 12(3) GC II. (See also, subsequently, Articles 10(2) and 15(3) AP I; Articles 7(2) and 9(2) AP II).

21 Articles 3(1) and 12(2) GC I; Articles 3(1) and 12(2) GC II; Articles 3(1) and 16 GC III; Articles 3(1) and 27(3) GC IV. See also, subsequently, Articles 9(1), 10(2), 69(1), 70(1), 73, and 75(1) AP I; Articles 2(1), 4(1), 7(2), and 18(2) AP II.

22 Articles 3(1)(a), 12(2), and 50 GC I; Articles 3(1)(a), 12(2), and 51 GC II; Articles 3(1)(a) GC, 17(4), 87(3), and 130 III; Article 3(1)(a), 32, and 147 GC IV. See also, subsequently, Article 75(2)(a)(ii) AP I; Article 4(2)(a) AP II.

23 Article 3(1)(a) GC I; Article 3(1)(a) GC II; Articles 3(1)(a) and 13(1) GC III; Articles 3(1)(a) and 32 GC IV. See also, subsequently, Articles 11(2)(a) and 75(2)(a)(iv) AP I; Article 4(2)(a) AP II.

24 Articles 17(4) and 99(2) GC III; Article 31 GC IV. See also, subsequently, Article 11(3) AP I.

(unjustified) biological, medical, and scientific experiments or other acts or omissions not in the patient's interest.²⁵

4. Medical Ethics-related Protections Strengthened or Established in the Additional Protocols

In what ways did the APs strengthen or establish protections related to a protective notion of medical ethics? At least four sets of such protections can be perceived.

First, Article 11(1) of AP I and Article 5(2)(e) of AP II establish protections against certain forms of *unjustified endangerment*, through acts or omissions, of certain persons deprived of liberty. Both provisions prohibit subjecting a relevant person '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 applicable to certain other persons under similar medical circumstances.²⁶

Second, a provision in each of the APs prohibits certain forms of *illegitimate compulsion*. In particular, both Article 16(2) of AP I and Article 10(2) of AP II – despite slightly different wording – establish that persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to, nor to 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 by a referred-to instrument.²⁷ These and other provisions help medical care providers, perhaps especially those subject to military discipline, avoid being impaled on the horns of a dilemma, namely, follow military ethics mandating the paramountcy of allegiance to one's party, or fol-

25 Articles 12(2) and 50 GC I; Article 12(2) and 51 GC II; Article 13(1) and 130 GC III; Articles 32 and 147 GC IV. See also, subsequently, Article 11 AP I; Article 5(2)(e) AP II.

26 Article 11(2) AP I also establishes that 'in particular' it is prohibited 'to carry out on such persons, even with their consent (...), physical mutilations, medical or scientific experiments, or removal of tissue or organs for transplantation, except where these acts are justified in conformity with the certain conditions'. Article 11(3) of AP I provides that '[e]xceptions to the prohibition in paragraph [11]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'. Under Article 11(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'. Article 11(4) establishes that '[a]ny 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'.

27 See also Article 15(3) of AP I; Article 9(1) of AP II.

low medical ethics dictating impartial care guided first and foremost by medical need and by the interests of the patient.²⁸

Third, a provision in both AP I and AP II *prohibits punishment* of ethically sound medical care. In particular, pursuant to Article 16(1) of AP I and Article 10(1) of AP II, '[u]nder no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom'.²⁹ The protection encompasses not only doctors and nurses but also others, such as secretaries and pharmacists, involved in medical activities.³⁰

Fourth and finally, both APs contain provisions protecting certain aspects of *confidentiality* or otherwise (not) informing on or against patients. Yet these protections – established in particular in Article 16(3) of AP I and Article 10(3)–(4) of AP II – are, in effect, significantly limited in scope because they are, with one exception in AP I, subject to certain *national law*.³¹ (That AP I exception concerns health care providers in relation to an international armed conflict governed by that Protocol; in such situations, including in a situation of occupation, the detaining power of an adverse side may not provide information protected by that provision.)

In summary, the APs thus contributed to the protection of medical activities in line with medical ethics by laying down a broad concept of medical ethics that can be understood figuratively as aiming to function in relation to armed conflict as:

28 Seen in this light, such protections may be most salient in relation to those care providers who are subject to military discipline and who face this so-called 'dual loyalty' challenge where simultaneous obligations, express or implied, to a patient and to a third party, often the State, may arise.

29 See also Article 18(3) GC I; Article 17(1) AP I.

30 See ICRC *Commentary* on the APs (1987), pp. 202–203, paragraph 664 (concerning Article 16(1) of AP I) and p. 1426, paragraph 4686 (concerning Article 10(1) of AP II).

31 Information concerning communicable diseases can be compelled, as expressly recognised in AP I and as implicitly permitted in AP II. Article 16(3) of AP I and Article 10(3)–(4) of AP II impose limitations on providing certain information (not only medical information) about patients to authorities. Obliging those involved in medical activities to inform against patients – also known as denunciation – was one of the most disputed issues of the diplomatic conference. Indeed, Norway seemed to consider threatening to withdraw from the proceedings if the international legal protection was subjected to national law. O.R. Vol. XI, CDDH/II/SR.46, p. 513, paragraph 2. The upshot is that these non-denunciation protections are, with one important exception in AP I, subject to national law – whether that 'national law' is, in relation to AP I, the 'national law' of the Party of the person engaged in medical activities or whether that 'national law' is, in relation to AP II, the law of the relevant High Contracting Party or, perhaps, the 'national law' of the rebels (at least to the extent that such 'law' might be juridically cognisable). See 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*, Den Haag, Martinus Nijhoff (2nd ed., 2013), pp. 140–42, 760–61.

- a *floor* of minimal normative rules, standards, and principles that no one may act under;³²
- a *sword* to wield to overcome illegitimate interference in valid medical activities;³³
- a *compass* to help guide medically related decision-making;³⁴ and
- a *shield* to protect against illegitimate requests or commands.³⁵

5. Some Enduring and Emerging Challenges

Four decades after the APs were initially signed, both enduring and emerging challenges concerning the realisation of protections linked to medical ethics can be discerned. One set of challenges is largely internal to IHL, while another set arises at intersections between certain IHL protections and some counter-terrorism approaches.

With respect to intra-IHL concerns, despite consensus that the concept of medical ethics entails at least protections established in (other) IHL provisions, a lack of agreement on what that concept may additionally encompass may frustrate appeals to the universality, uniformity, and comprehensiveness of the corresponding protections.³⁶ In addition, the applicability of at least some of the APs' provisions concerning medical ethics in relation to non-contracting parties – on the theory that those provisions are now reflective of customary IHL – is currently

32 For example: no torture; no inhumane treatment; no adverse distinction other than prioritisation of care based on medical grounds; and no unjustified endangerment.

33 For example: prohibition of compelling a medical care provider not to act where medical ethics requires acting; prohibition of unwarranted procedures; and prohibition of compelling a medical care provider to prioritise care to her own side where medical ethics dictate prioritisation of treatment of others first. Note that despite the 'sword' metaphor, in general medical care is *not* considered under IHL to constitute a hostile act.

34 For example: medical decisions shall be guided by medical grounds; there shall be no (other) adverse discrimination; care shall be provided based on the interests of the patient; and informed consent shall at least be sought.

35 For example: prohibition of torture as well as of certain other forms of ill-treatment, including biological experiments, mutilations, and non-therapeutic scientific or medical experiments not in the interest of the patient; and only urgent medical reasons may authorise priority in the order of treatment. This set of protections may be especially relevant for care providers subject to military discipline.

36 On a recent elaboration of the 'common denominator' approach, see WMA, ICMM, ICN, IPF, and ICRC, *Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies*, 2015.

disputable.³⁷ Furthermore, as noted above, the APs reflect an uneven level of commitment to some relevant protective interests. In particular, protections concerning confidentiality (or non-denunciation) are hampered by a key weakness: they are, with the one exception noted above, subject to certain national law.

With respect to challenges arising at the intersection of IHL and some counter-terrorism frameworks, the legitimacy of impartial medical care protected under IHL may be contested where counter-terrorism is central to the situation.³⁸ That is because many of those frameworks reject at least two premises underlying protections for such care. First, under IHL, impartial medical care to wounded *hors de combat* is not only legitimate, it is an *obligation* imposed on parties. Yet under at least some counter-terrorism frameworks, such support may be perceived primarily as dangerous because the provision of such care can, according to this theory, help free up the resources of the terrorist group. Second, certain IHL treaty provisions anticipate that all parties to an armed conflict (irrespective of an extra-IHL 'terrorist' designation) may assign their own medical personnel. Yet some counter-terrorism approaches implicitly or explicitly preclude medical care providers from acting under the control of a designated entity. In at least these ways, the ethical values and normative commitments entailed in these regimes are different.

Certain State responses to terrorism thus recast medical care, even care considered sound under a relatively narrow definition of medical ethics, as a form of illegitimate support to the enemy. Such instances have arisen at the international level as well as in some national systems. Examples of the former include references by the United Nations Security Council al-Qaida and ISIS Sanctions Committee to medical care, among other indicators, as a listing

37 For instance, compare, on one side, Rules 26 and 92 (and the evidence adduced in support of those rules) of the ICRC's 2005 *Customary International Humanitarian Law Study* as well as portions of the preamble of U.N. Security Council Resolution 2286, May 3, 2016 ('Recalling that under international humanitarian law, 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 the sick' and 'Noting that medical personnel, and humanitarian personnel exclusively engaged in medical duties, in an armed conflict situation, continue to be under a duty to provide competent medical service in full professional and moral independence, with compassion and respect for human dignity, and always to bear in mind human life and to act in the patient's best interest and *stressing* the need to uphold their respective professional codes of ethics, and further noting the applicable rules of international humanitarian law relating to the non-punishment of any person for carrying out medical activities compatible with medical ethics') with, on the other side, the analysis in Mehring, *First Do No Harm*, op.cit. note 14, at pp. 189–235, and the absence of recognition in the December 2016 update of the 2015 U.S. Department of Defense *Law of War Manual* of the protections laid down in Article 16 of AP I and in Article 10 of AP II.

38 See generally Lewis et al., op.cit. note 1.

criterion for two individuals and two organisations.³⁹ And examples of the latter include anti-terrorism laws in Syria that ‘effectively criminalised medical aid to the opposition’,⁴⁰ as well as legal proceedings in, among other national jurisdictions, Australia,⁴¹ Peru,⁴² and the United States⁴³ that raise concerns, at the very least, about the risk of eroding foundational normative commitments laid down in IHL.

39 See Dustin A. Lewis, “Humanitarian Exemptions from Counter-terrorism Measures: A Brief Introduction”, in: *Proceedings of the Bruges Colloquium*, No. 47 (2017), pp. 147–48, fns 34–35 and corresponding text.

40 See 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, Annex VII, “Assaults on Medical Care”, paragraph 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’); see also Aryn Baker, “Syria’s Health Crisis Spirals As Doctors Flee”, in: *Time Blog*, February 4, 2014, available at <<https://time.com/3968/syrias-health-crisis-spirals-as-doctors-flee/>>, archived at <<https://perma.cc/LQ9F-G2KN>> (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[, a medical resident,] 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?’).

41 See Phoebe Wynn-Pope, Yvette Zegenhagen and Fauve Kurnadi, “Legislating against humanitarian principles: A case study on the humanitarian implications of Australian counter-terrorism legislation”, in: *International Review of the Red Cross* 235, 250–51 (2016).

42 *De La Cruz-Flores v. Peru*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 115, paragraph 102 (Nov. 18, 2004) (concluding that Peru had, in its November 21, 1996 judgment 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’).

43 See, e.g., *United States v. Warsame*, 651 F. Supp. 2d 978, 980 (D. Minn. 2009) (prosecution of a Canadian, Mohamed Abdullah Warsame, in part for providing English lessons in an al-Qaeda clinic in Afghanistan in order to assist nurses in reading medicine labels). On the involvement of medical practitioners in aspects of interrogation and other custodial circumstances in relation to the U.S. ‘War on Terror’, see, e.g., Mehring, *First Do No Harm*, op. cit., note 14, at pp. 49–76.

Q&A SESSION

At the end of this first session of the Colloquium, speakers were asked to elaborate on the following issues:

1. The Assignment by a Public Authority to Perform Medical Care

A speaker who participated in the negotiations prior to the adoption of the Additional Protocols (AP), underlined how technical the health care issue was. This is important as the protection of civilian medical units and personnel is based on several technical concepts, a delicate issue that the negotiators had to bear in mind. That is why the idea was discussed to create a special emblem for medical activities not carried out by the Red Cross. That was abandoned, but the problem has still not gone away: no party can allow just anyone who has medical training to wander around claiming protection under International Humanitarian Law (IHL). There must be some order and that is the reason why there has to be an 'assignment', i.e. an act by a public authority which gives that function to certain persons or units. The use of the emblem then requires an additional act, as it is open to abuse and misuse. However, this has not been implemented and the acts that must be taken by public authorities are usually not performed.

2. The Military Medical Facilities Embedded into Military Units

A participant noted that military medical facilities are embedded in all sizes of military units and usually as close to the front as possible. How can medical assets that are embedded at low levels be differentiated from large medical facilities for which the situation would be different?

According to a speaker, while the principle of proportionality is in theory absolute, its practical implementation requires the application of the concept of 'feasible precautions'. This allows taking various practical circumstances into account but not putting into question the fundamental balance between humanitarian needs and military necessity.

3. The Case of non-State Armed Groups that do not have Medical Facilities

In the case of non-State armed groups supported by third States and which do not possess their own medical facilities, a participant asked whether the State is obliged to provide medical care to the non-State armed group as part of the obligation to ensure respect.

According to a speaker, there is flexibility in terms of obligations related to medical care. The non-State armed group might possess medical facilities itself, that is a possibility which is

recognised by Additional Protocol (AP) II. But there is also the possibility to commit others to undertake these tasks, so it is conceivable.

Another speaker added that in practice, non-State armed groups do not have military medical personnel. His position, nurtured by the common State scepticism against armed groups, is, rather than exhorting the latter in having their own medical facilities, to consider members of these groups that perform medical action as no more participating in hostilities and therefore protected by IHL against attacks. This is a minority position, but it is reconciling the law with practical considerations and taking advantage of the fact that AP II is less detailed than AP I.

4. The Status of Military Sites in General

A participant emphasised that besides medical units, military facilities can also comprise education facilities that would not meet the requirements of the definition of a military objective.

If they are used to perform acts harmful to the enemy, they lose their protection and still cannot be granted the protection that civilian medical objects receive. It is then interesting to think of the unwanted consequences of this situation and it would be laudable to increase the protection of these kinds of military sites.

There might also be unwanted consequences if we increase the protection – i.e. if we grant temporary protection as suggested in the International Committee of the Red Cross's (ICRC) Commentary, which might increase the misuse of the facilities by non-State armed groups.

There are needs to be considered when we are trying to uphold the balance between military considerations and humanitarian needs. Some solutions might not be feasible in practice for States involved in a conflict.

5. The Concept of 'Feasible Precautions' and its Application in Practice

An ICRC representative admitted struggling to find concrete examples of the application of the notion of 'feasible precaution' and 'mandatory warning' presented during the session. Has a mandatory warning ever led to enhanced protection or respect of the provisions of the Protocols?

A speaker uttered the conviction that these rules work in practice, although it is very difficult to find practical examples. One should look at the ICRC's data base 'IHL in Action', where it is still very difficult to find examples, as newspapers do not usually pass on information about

warnings. One then always has the feeling that hospitals are destroyed without any prior warning – this gives the impression that IHL is never complied with.

6. The Issue of Armed Medical Units

A participant wished to share Denmark's experience in terms of arming its military medical facilities on the ground.

The country has started to armour its medical transport with light machine guns – which go beyond the light individual weapons – for two different reasons:

- Denmark thought about placing armoured units closer to its military medical facilities, but it might have been more harmful to the distinction than a slightly larger calibre weapon in the medical unit.
- Denmark took off the emblem in some instances, but that brought on another consideration about the care of civilian patients in units that are not marked as medical units, which might have been victims of lawful attacks by the enemy.

That is why Denmark is not taking off the emblem, and still providing those units with heavier armouries.

A speaker emphasised that what matters more than the kind of weapons, is the kind of use that is made of the weapons – i.e. this should remain a strictly defensive purpose no matter the type of weapons.

7. The Criminalisation of Medical Care Provided to 'Terrorist' Organisations

A participant asked whether there is any recommendation for States on how to avoid the potential use of medical care by terrorists to get access to some areas.

The speaker considered this issue as one of the most challenging aspects in contemporary IHL. Today there is no clear approach of the law with respect to specific cases of people providing medical care in the context of an armed conflict. The speaker therefore did not have any specific recommendation, other than to think carefully about what the ethical commitments are.

An ICRC Representative asked how to argue against new ideas such as not providing the enemy with medical care so as to not assist them getting back to the battlefield.

In one of the speakers' view, providing medical care to the enemy does contribute to military efforts – which contradicts the view of the majority on this question. But there is a *lex specialis* that should be applied, it is the special protection granted to medical units under IHL. For

another speaker, the protection that wounded and sick fighters enjoy is temporary and once soldiers have healed and returned to the battlefield, they are again a military target.