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by Cord von Einem

Some worrying developments appear to be taking place regarding the self-image of military medical personnel. My observations from training programs on International Humanitarian Law (IHL) and military medical ethics indicate that participating military doctors and medics often struggle with a lack of legal clarity as well as ethical concerns during their missions and training. So in this article I will elaborate on the rights and obligations of military doctors and medics in the law of war, and highlight the legal problems that arise during deployments.

The observations described in this article are taken from education and training events as well as conferences and discussions involving the ICMM Center of Reference for Education on IHL and Ethics (International Committee of Military Medicine, ICMM), whose participants are comprised in large part of military medical personnel representing all rank groups and specializations. The events were held in Europe and Africa as well as in the Middle and Far East. With regard to these observations, it makes no difference what cultural backgrounds the participants have, which countries they come from, or what levels of development or kind of education system exist in their countries of origin. Furthermore, for this illustration, it is very often immaterial how long participants have been in the service, or what rank group they belong to.

Conflict in the self-image of military medical personnel is becoming increasingly apparent. In contrast to those medics who see their role as having a strictly humanitarian character, this is affecting ever-increasing numbers, who, for example

- staunchly and actively participate in combat operations, or are willing to do so;
- regard it as their duty as a soldier to attend to their own military personnel before other people;
- or think it is legitimate, if needs must, to subject prisoners to harsher interrogation methods and, as a physician, merely to ensure the survival of the interrogated person.

These experiences and conversations among medical personnel at the training events led to some general considerations about how appropriate current methods are for teaching IHL in the medical service and for ensuring that this knowledge is retained. Are these legally worrying developments in the self-image and deployment of military medical personnel the result of an educational deficiency?

One thing is for sure: on their own, the Geneva Conventions and their protocols set out a host of rules that are of significant importance, especially for military medical personnel.

In the German armed forces (*Bundeswehr*), we know about problematic points of view, not least because of Afghanistan, but also via the NATO "lessons learned" process. The reality of deployment and the manner in which medical service assistance was handled in some cases in Afghanistan, created a particular emotional closeness between combat troops and medical personnel. For example, participation in

Back to Contents

patrols and sentry duty at forward operation bases (FOBs) brought demands for heavier weapons, combat training, and for protection symbols to be disguised. Readiness for self-defense changed into readiness to fight, so as not to have to leave fellow soldiers "in the lurch".

Who is a combatant and who is not? The Afghanistan example

"The enemy has changed the rules of the battlefield": An argument that medical personnel use to legitimize their own actions during operations. This justification is challenging both for instructors and in terms of planning exercises and operations involving medical personnel, since the conflicts referred to and the parties to the conflict first need to be subject to IHL before the topic can be discussed in legal terms.

The problem becomes clear with the example of Afghanistan:

While the nations that provided troops for the International Security Assistance Force (ISAF) unilaterally undertook to observe the humanitarian standards of IHL, in the opinion of many participants at events and among all rank groups, the inhuman behavior of the insurgents apparently created new requirements for the definition of combatants.

It was almost impossible to define front lines and enemy groups in Afghanistan and many actors with unclear motivations benefited from continual violent conflicts. The insurgents' irregular combatants ignored the standards of IHL and used perfidious tools of war. Moreover, they moved in small dynamic groups without uniforms, barely identifiable amid the Afghan civilian population.

Not only combat troops but also military and civilian medical personnel evidently came under repeated attack by insurgents.

Yet to legally modify or change the definition of combatants, the forces deployed by the parties to a conflict must be or have acted as combatants in the first place, as defined in IHL.

However, IHL only provides for combatant status in international armed conflicts. A combatant here is a person who has the right to participate directly in hostilities (Additional Protocol I to the Geneva Conventions, Art. 43 (2)). Under IHL, only combatants – outside the bounds of self-defense – may carry out acts of harm based on the law of war.

Since it is a non-international conflict in Afghanistan, however, there is no combatant status under international law in this conflict.

It would be different if the insurgents in this non-international armed conflict were fighting against colonial domination and alien occupation or against a racist regime and exercising their right to self-determination (Additional Protocol I to the Geneva Conventions, Art. 1 (4)), in which case it would be necessary to assign a combatant status if certain minimum standards were met. But then the insurgents would need to have armed forces which are subject to an internal disciplinary system, which, inter alia, enforces compliance with the rules of international law applicable in armed conflict (Additional Protocol I to the Geneva Conventions, Art. 43 (1)). However, this is not the case.

One should therefore regard the insurgents in Afghanistan as terrorists or criminals who are breaking national Afghan law. Occasionally they are described as "illegitimate, illegal, unlawful or illicit combatants." However, no such special category is recognized or indeed necessary in IHL, either for international armed conflict or for non-international armed conflict.

Thus in the example of Afghanistan, the insurgents do not have the right to be legally clas-

Back to Contents

sified as combatants. If the situation were different, it would not be possible to punish them for their attacks, since combatants cannot be punished simply for participating in hostilities (Additional Protocol I to the Geneva Conventions, Art. 43 (2)), whereas civilians (which is what criminals and terrorists are), especially at the level of national law, can expect criminal prosecution for their acts of participation if they are directly involved in hostilities.

The soldiers deployed in ISAF were likewise not combatants, even if – owing to the commitment their countries had made – they were required to comply with the principles of IHL in their use of force during the ISAF mission. They were merely helping the national Afghan security forces to fight the insurgency.

Moreover, even the soldiers of the Afghan National Army (ANA) and members of the Afghan National Police (ANP) were and are not combatants. Soldiers in the ANA, however, represent the legitimate military power of the state and are permitted to fight the insurgents using military force.

Hence the call for a new definition of combatants based on the example of Afghanistan is not factually correct. When it comes to the question of adapting or changing this definition according to IHL, one should always ask:

- Is IHL even applicable to the underlying conflict?
- And if so, to what type of conflict is it applicable: international or non-international conflict?

A fine line between assistance and criminal liability?

For medical service personnel, a lack of clarity about definitions under IHL can have serious consequences – so much so, that if the personnel in question make any mistakes, they may run the risk of criminal prosecution slightly below the level of a war crime.

In recent years, particularly among the medical personnel of leading military nations, the belief has developed that medics should be permitted to use heavier weapons offensively, for example to gain access to and rescue the wounded, and even that they should support combat troops in critical battle situations, e.g. by firing at the enemy. This has been triggered by repeated reports of attacks carried out by parties to the conflict – especially obviously targeted attacks – against precisely these military medical personnel and their facilities.

The right to participate directly in hostilities is also called the combatant's privilege. Members of the armed forces of a party to a conflict are combatants and they have the right to participate directly in hostilities, whereas medical personnel and chaplains are excluded (Additional Protocol I to the Geneva Conventions, Art. 43 (2)). Thus persons having combatant status are permitted to fight against legitimate military targets. This means the power to injure or kill enemy combatants or persons who without authorization participate directly in hostilities (Additional Protocol I to the Geneva Conventions, Art. 51 (3)) and to damage, neutralize, or destroy objects which are classified as military objectives (Additional Protocol I to the Geneva Conventions, Art. 52 (2) sentence 2).

So whereas combatants, in accordance with their combatant immunity (Additional Protocol I to the Geneva Conventions, Art. 43 (2)), shall not be punished simply for participating in hostilities, if other persons – and this includes military medical personnel – participate directly in hostilities they can expect criminal prosecution for their acts of participation, e.g. homicide, assault, damage to property. This is especially the case since medical facilities or mobile units of the medical service

Back to Contents

immediately lose their protection under IHL in battle if they are used outside of their humanitarian purpose to attack or otherwise harm enemy troops; and so, with the backing of the law, they become a legitimate military target.

The call for military medics to be allowed to use force to gain access to and rescue the wounded in cases of doubt will also fall foul of IHL. The rules state that whenever circumstances permit, ceasefires or other local arrangements will be agreed to enable a search for the wounded, sick, and dead on the battlefield, as well as their identification, collection, rescue, exchange and evacuation. This might be hard to endure, but it originates in the same interests that may also legitimize collateral damage, namely the interest of nations in a balanced consideration of military necessity and humanitarian protection. The enemy (but also one's own forces) is therefore allowed to keep fighting, despite wounded personnel lying around on the battlefield.

The limits of self-defense

But if the employer issues weapons to medics, what are these weapons for? At any rate not to harm the enemy, e.g. to gain a tactical advantage – such as suppressing enemy fire on a patrol – or to prevent an enemy from carrying out legitimate operations, such as fighting enemy forces. They are to be used for self-defense against unlawful attacks on patients, personnel and material by any persons, regardless of whether they belong to the military or are civilians. The limits of self-defense at this point are an interesting, much discussed and – beyond the topic considered here – explosive subject, but one which is only even rudimentarily taught to an extremely small number of military medical students during their training.

So what is the right way to use these weapons? As we have seen, members of the medical service do not have the right to participate directly in hostilities, but they are permitted according to the right of self-defense to carry and use weapons to defend their own person, their patients, and their materials against attacks that violate international law.

The law of war does offer solutions or loopholes – though they are only rarely observed or used – in the event that a party to a conflict wishes to heavily arm medical personnel and let them participate in combat operations. But their "cost" is such that disadvantages are incurred at the same time, which probably accounts for their extremely infrequent use.

The law of war does not automatically force nations to make somebody a medic because of his or her medical training. Medics are protected under the IHL, but they are not given the combatant's privilege. If the administrative act of assigning exclusively medical tasks, the associated marking with the international protection symbol, and hence the claiming of protection under the provisions of IHL are not carried out, then there is nothing to prevent these personnel being heavily armed and participating in combat operations alongside combat troops.

But even though the law of war leaves this option open, this decision is not up to the individual (First Geneva Convention, Art. 7) but only the organs of state or corresponding decision-making levels in the military.

Attacks on medics – which law applies?

There is no way, however, particularly in asymmetrical conflicts, to rule out tactics such as deliberately attacking medical personnel as a way of ultimately eroding the willingness of combat troops to fight and take risks. An infantryman in battle will naturally think twice about taking a risk if he knows that he cannot receive immediate, competent treatment if he gets wounded.

But here too, regarding the question of whether these tactics in asymmetrical conflicts are a

Back to Contents

reason to make changes to IHL, it is first necessary to establish whether IHL is applicable to the underlying conflict in the first place. Conflicts in recent times, in the vast majority of cases, have been non-international in character and did not cross the threshold at which the law of war applies. Ultimately, then, calls to change IHL based on experiences in conflicts which it does not cover are tantamount to comparing apples with oranges. Thus, in cases which are not covered by the law of war, the question of who is allowed to participate actively in combat operations and who is not is a matter of national law or other restrictions outside the boundaries of IHL. At any rate, it would not be justified to change the law of war on this basis.

But let us suppose that IHL is involved. Then it would still be necessary to verify what really caused incidents: Did the enemy specifically intend to hit medical personnel, or was it perhaps the direct proximity of medical personnel and their facilities to combat troops and/or their facilities and equipment, or unfortunate circumstances, or military necessity? Because it may have been abusive or negligent behavior by one's own troops that provoked the attack, e.g. using armed force to rescue the wounded in battle, or military medical personnel participating in patrols or sentry duty at facilities that are not part of the medical service.

There is a long list of potential hazards for medical personnel which may bring them into conflict with IHL and/or national criminal law. It includes such things as participation in "harsh" interrogation methods or overseeing their safety, as well as giving preferential medical treatment to one's own military personnel. The last point in particular is often demanded by militarily superior powers, and especially here, the demand should be met with the response: "Do unto others as you would have them do unto you."

It is often overlooked, as is the case with other points of discussion, that changes to rights and obligations resulting from IHL always work both ways, i.e. against the enemy but also possibly to the detriment of one's own side. If one asks a combatant if he would like to be treated – whether by his own or enemy personnel – according to his nationality or medical necessity, it seems likely that he would prefer the latter. At any rate, no legitimization by "military necessity", which is an argument often raised in this context – exists in IHL. This has its significance in other areas of IHL, but not in the provisions concerning access to medical treatment.

Conclusion

As things currently stand, probably no nation and only a few members of the medical services can claim to be free of deficiencies in training concerning the aspects of IHL which are important for medics. At the same time, these deficiencies go beyond familiarity with laws and quite obviously touch on the ethical roots regarding the role of medics in violent military conflicts – and hence fundamentally affect the self-image of military medical personnel.

In some ways it is hard to escape the impression that the armed forces consciously accept deficiencies, not least for budgetary reasons, particularly since uncertainty makes medics more flexibly deployable in a conflict, and especially when political and budgetary requirements have an impact on operational principles in respect of the allocation of equipment and personnel.

But this is essentially to throw overboard precisely those values of the international community which – at least officially – we aim to defend in many of the conflicts in which we are involved, especially nowadays.

Back to Contents

Hence there is an urgent need, for the sake of upholding humanitarian principles, and not least to protect medical personnel from criminal prosecution, to continue with efforts to enhance and improve training and to preserve knowledge in these areas.

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Back to Contents