The medical profession and international humanitarian law [1]

by Jean Pictet

1. INTRODUCTION

International humanitarian law, whose purpose is to attenuate the evils of war, has been intimately bound from its earliest days to doctors and all others whose mission in life is to heal—the noblest of all professions. The fact is that this law originated from the need to make up for the deficiencies of military medical services and protect those wounded in war. Since then, the law has gone far beyond that framerwork and has extended its protection and solicitude to many other victims of conflicts and also, in peacetime, to victims of day-to-day life—sick people. An essentially medical element was the basis of the law, and continues to be a major element, referred to by some as "medical law".

The initiator of humanitarian law was the International Committee of the Red Cross (ICRC), which is closely associated with medicine, since the Red Cross and doctors have the same aim: to fight against suffering and death. Co-operation between them can never be too close.

The role of the doctor in time of conflict, like that of the Red Cross delegate, is becoming more and more difficult. It is my duty to call attention to this, for our epoch is marked by a hardening of hearts and a weakening of international morality. Nowadays, nations go to war with intensified passion, and the infliction of

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suffering has come to be a political weapon. Accordingly, we must recognize that the relief mission demands ever-increasing courage from those who serve this cause. In a maddened world, fidelity to our duty may demand that we risk our lives. The doctor, more than ever, must therefore be ready to accept such risks. His job also demands a deeper inward preparation—and it is for this reason that knowledge of the texts and principles of international humanitarian law is indispensible.

Let us begin with a glance at the past.

The roots of humanitarian law are embedded in prehistory. What is described as the law of the jungle prevailed in primitive societies, but we know that even then there were attempts made to attenuate unnecessary suffering. We know for example that the wounded in Neolithic battles were treated, for many skeletons show evidence of the reduction of fractures and even of trephination.

In antiquity, examples of humanity shown by kings were isolated gleams of light in the prevailing darkness, but, very slowly, these examples became the rudiments of custom. For instance, Cyrus gave the same care to wounded Chaldeans as to his own soldiers. In India, the emperor Asoka ordered his troops to respect the enemy wounded and the religious sisters who cared from them. Much later, during the Crusades, Saladin allowed European doctors to come and treat their wounded compatriots and then to return freely to their own side. He even sent his own doctor to the bedside of Richard the Lion Hearted. These are just a few of the precursors of the law.

In the Middle Ages, only a handful of military chiefs could bring their own doctors with them, and it is painful to think of how the troops were exploited by quacks and other fakers. The wounded were left in their agony and those of the enemy were commonly finished off.

Only with the dawn of modern times did the practice arise of sparing and treating the enemy wounded, along with the development of medical services in the armies. From the 16th century onward, respect for the wounded was the result of "cartels", the name then given to agreements between opposing commanders. This practice reached its peak in the 18th century. At that time the rules were roughly as follows: hospitals were immune from attack and were marked with special flags; wounded and sick enemy soldiers were treated in the same way as those in the army which captured them, and were sent back after they recovered; doctors and their assistants, and chaplains as well, were not taken prisoner

but sent back to their own lines. Thus, after the battle of Fontenoy in 1747, more than 6000 wounded, on both sides, were evacuated to well organized hospitals and treated by qualified personnel, so that only 583 of them died.

The 19th century however saw a return to the use of mass armies and a collapse of medical services. The battle of Austerlitz was described by Dr André Soubiran as a "medical Waterloo".[1] In the campaigns of Napoleon III, sixty per cent of the wounded died.

This was the background for the appeal by Henry Dunant, witness to the tragic consequences of the battle of Solferino. As a result of that appeal, the Red Cross was founded in Geneva in 1863. In the following year, its international committee succeeded in gaining the adoption of a treaty, valid at all times and in all places: the first Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, the corner-stone of humanitarian law. This confirmed the neutral status of doctors and nurses, who were to be protected on the battlefield and returned to their own armies if they should be captured. Wherever the Convention was in force, mortality among the wounded decreased dramatically.

In the ensuing century, humanitarian law was extended to cover other victims of armed conflicts. There are now four Geneva Conventions, dating from 1949, which were supplemented in 1977 by two additional Protocols. It is in these fundamental texts that we can discern the features of a Charter for Military Medecine, which I propose to outline.

2. GENERAL PRINCIPLES

The foundation of humanitarian law is the principle of *humanity,* which demands respect for the human person. In contrast to this is war, which is a resort to violence. The latter, however, must not run counter to the imprescriptible rights of the individual.

It follows from this that belligerents must not inflict on their adversaries harm out of proportion with the object of warfare, which is to destroy or weaken the military strength of the enemy.

War is a means, the ultimate one, for a State to bend another to its will. It consists in employing the necessary constraint in order to

[1] Dr André Soubiran: *Napoléon et un million de morts,* Paris, 1969.

obtain this result. All violence which is not indispensable for achieving this object is therefore without purpose. It then becomes merely cruel and stupid.

To achieve its object, which is to conquer, a State engaged in a conflict will seek to destroy or weaken the enemy's war potential at the cost of the least loss to itself. This potential consists of two resources: manpower and material.

To wear out human potential, by which we mean individuals contributing directly to the war effort, there are three means: to kill, to wound or to capture them. There is no difference between these three methods with respect to military efficacy. To be cynical about it, all three are equally capable of destroying the enemy's vital capacities.

Humanitarian reasoning is different, for humanity requires that capture be preferred to wounding; that wounding be preferred to death; that non-combatants be spared; that wounds be no more serious than necessary, so that the victim may be operated upon and healed; that they cause the least possible pain; that captivity be made as bearable as possible.

Military commanders can understand this language, and they have often understood it, since they are not asked to renounce their duty as soldiers and patriots and can attain the same results while causing less suffering. To prolong, by neglect or mistreatment, the suffering of an enemy who has been put *hors-de-combat* is, even from the most realistic point of view, pointless.

It is on the basis of this principle that the Geneva Conventions require that persons who are *hors-de-combat* and those who do not participate directly in hostilities must be respected, protected and humanely treated.

Against the most formidable array of force in the world, that is against war, the Red Cross has erected barriers; barriers which are still fragile for they are constructed of words, under the name of humanitarian law.

The principle of Geneva specifies three duties towards the victims of war—to respect them, to protect them and to treat them humanely, three complementary concepts. It would be dangerous to offer a detailed definition of humane treatment, because one could never catch up with the imaginations of scoundrels. To decide what is humane is a matter of common sense and good faith. Let us limit ourselves at this point to defining it as the minimum treatment which must be accorded to the individual to enable him to lead an acceptable life.

The principle of *inviolability,* according to which the individual has a right to the respect of his life and his physical and moral integrity, requires that no person who suffers should be abandoned but must be given the care required by his condition.

It was in obedience to that imperative that the First Geneva Convention was concluded in 1864. All the other obligations in the Convention derive from it. It is not enough only to respect the wounded and sick, they must also be treated, otherwise they may die. When we speak of suffering, this does not refer only to pain but also to all impairment of health, even if it is not felt.

Although it was conceived for soldiers in wartime, the principle of humanity is all the more valid for civilians in peacetime. In the latter case, it assumes the more positive form of maintaining health and preventing disease.

International medical circles have proposed a rule that all persons who are wounded or sick have the right to be cared for. No principle of this kind has yet been included in the Universal Declaration of Human Rights, in view of the embryonic state of medical assistance in so many of the developing countries.

Another fundamental idea for our present purposes is that of *neutrality,* which implies that medical and rescue services are never to be construed as interference in the conflict; they stand above the fighting.

The concept which is the basis of the First Geneva Convention is that relief given even to adversaries is always legitimate, that it never constitutes a hostile act and is never a violation of neutrality.

The First Convention of 1949, on the subject of assistance which may be given to a party to a conflict by an aid society from a neutral country, specifies that "in no circumstances shall this assistance be considered as interference in the conflict" (Article 27). Even more indicative is Article 70 of the additional Protocol I of 1977, which states that offers of humanitarian and impartial relief "shall not be regarded as interference in the armed conflict or as unfriendly acts".

3. PROTECTION OF THE WOUNDED AND SICK

The First Geneva Convention of 1949, a revised version of the Convention of 1864, provides that the military wounded and sick,

who are thus defenceless, shall be safeguarded in all circumstances. They on their part must give up fighting.

In 1864, there were references to the "neutrality" of the wounded. Since that time, the references have been to "respect and protection", respect being a negative idea—do not shoot the wounded soldier—and protection a positive idea—defend him, relieve him and help him. The keystone in the situation is this: one may kill only a soldier who is himself capable of killing. The abandonment of agressivity should suspend all aggression.

Protocol I of 1977 provided useful clarification concerning the safeguard of enemies *hors de combat*. In addition to those who surrender, any person who "has been rendered unconscious or is otherwise incapacitated by wounds or sickness, and therefore is incapable of defending himself", is deemed *hors de combat* (Article 41, par. 2 c).

The Convention protects the wounded person before his capture, when he is still with his own army or in no-man's-land, and also afterwards, when he is a prisoner. The wounded soldier who has fallen into the hands of the adversary, is simultaneously both the wounded person who must be treated as if he were not an enemy, and the captured combatant, who becomes a prisoner of war. He is therefore protected, until his recovery, by two Conventions at the same time, the First and the Third, with primacy given to the First if they overlap. After he has recovered, his treatment is governed by the Third Convention, which offers equivalent guarantees with respect to medical care.

An army which must leave behind its wounded as it retreats should leave with them, as far as possible, medical personnel and material to provide for their care. This was one of the great innovations made in 1864—made possible by the neutralizing of medical personnel, with provisions for their return to their own units.

The wounded must be searched for and collected, as must the dead. The dead must not be buried until after a medical examination and identification. Local armistices may be concluded and special arrangements made to evacuate the wounded from an encircled zone.

Enemy soldiers who are *hors de combat* must be treated like those of one's own army. This great principle of *non-discrimination* has been a part of the Geneva Conventions from the beginning. Until 1929, the Convention forbade only distinctions based on nationality. In 1949, other distinctions were forbidden, "founded on sex, race, nationality, religion, political opinions or any other

similar criteria". The last five words quoted clearly show that all kinds of discrimination are forbidden, and that those enumerated in the text are cited only as examples. It is quite apparent that they were implicitly forbidden earlier—but the tragic events of the Second World War made it advisable to list them explicitly.

Non-discrimination is an indissociable aspect of Red Cross action and has long been a principle of medical ethics. It is a relatively modern humanitarian achievement, however, since it was not a part of the original Hippocratic oath.

In exceptional circumstances, however, it may be necessary to make a distinction, when, for example, a doctor or nurse, lacking sufficient medicaments, can save only some of the sick who need them. This can be a tragic situation, comparable to that on a life raft, which will sink with its human load if other shipwrecked people try to climb onto it. Can we take an oar and smash the hands of human beings, children perhaps, who arrive too late?

I have known cases in which doctors have treated only the wounded, sick or starving people who still had a chance to survive, leaving the others to die. These are what we call cases of conscience, because the choice must be made by the person responsible, who has to decide, with his own mind and heart, the chances of those in front of him. Who can claim to determine the standards of absolute justice in such cases?

In the light of these considerations, we can see that the principle of non-discrimination cannot be construed in absolute terms, but needs to be qualified. Thus, the current Geneva Conventions forbid only "adverse" distinctions. This is not a very happy choice of words, for it is clear that we would be doing a disservice to all those to whom we do not accord the benefits given to others. But, even if the language is awkward, the idea it seeks to express is right: there are indeed legitimate and even obligatory distinctions.

When misfortune has destroyed equality among human beings, the application of humanitarian principles tends to restore the balance. To restore everyone to the same level implies giving the first and most effective attention to those in the greatest need. This is only common sense. We cannot remedy an inequality except by another inequality. There are therefore distinctions we are obliged to make: those which are based on degrees of suffering, distress or weakness—but only these.

The Geneva Conventions of 1949 are not silent on this point, as had been their predecessors. For instance, they specify that women

should be treated with all the regard due to their sex. Likewise, it is normal to give special attention to children and old people.

Together with quantitative inequality of treatment, the Conventions provide even more clearly for inequality in terms of time. It is specified that, "Only urgent medical reasons will authorise priority in the order of treatment to be administered" (Article 12). If, for example, the military medical service in a given case has to deal with a great influx of wounded, the doctors, without any consideration of nationality, will first treat those for whom a delay would be fatal or at least very injurious, before turning to those whose condition does not require immediate action. Likewise, the distribution of food and medicaments should correspond to the relative needs of each person.

4. MILITARY MEDICAL PERSONNEL

Doctors and other medical and religious personnel shall be respected and protected in all circumstances. They shall not be prevented from discharging their duties. For these purposes, they must wear on the left arm an armlet bearing the distinctive emblem of the red cross or, in Moslem countries, red crescent. They must also carry identity cards.

Who is entitled to such protection by the First Convention? First and foremost, the military medical personnel, both those treating the sick and wounded and those with administrative responsibilities; next, those members of the personnel of National Red Cross or Red Crescent Societies who are assisting and are attached to the military medical services and only such persons.

The granting of such extensive privileges to doctors and nurses is not for their personal benefit. It is accorded only because they are caring for the victims. It is through them that the wounded and sick are benefited. The doctors are protected because they are healers—and this is the finest tribute that can be accorded them.

The immunity given to medical establishments and personnel requires that such personnel must absolutely abstain from any direct or indirect interference in the hostilities. Being regarded by the enemy as "neutrals," in the higher interest of the wounded, they are obliged to act as such.

During the Second World War, members of the medical personnel in occupied territories sometimes concealed combattants in

hospitals and helped them carry out military missions, such as intelligence activities and sabotage. By acting in this way, they were certainly serving powerful and highly honourable patriotic purposes—but they were nevertheless violating the rules of humanitarian law and in so doing running the risk of provoking sanctions against a countless number of innocent beings. The adversary might very well be tempted to refuse protection to the whole hospital, and if such abuses were repeated, to the whole medical service.

One cannot serve the medical mission and also fight. The choice must be made. Open or clandestine resistance to the enemy may well be legitimate and heroic. We do not dispute this, but it is incompatible with the relief mission. If in the general interest, humanitarian institutions are to survive and continue their work in occupied countries, their members' conduct must be irreproachable to maintain the full confidence of the authorities. There might be an exception to this principle, if we are dealing with a faithless enemy with no respect for the law, who systematically violates the law and gives no protection to the persons for whom the Conventions require respect.

One of the problems which gave rise to animated discussion in the course of the 1949 revision was the *retention of medical personnel who fall into the hands of the adverse party*. According to the traditional concept, such personnel should be immediately released and sent back to their own side. During the Second World War, however, the belligerents agreed to have a considerable number of their medical personnel remain in POW camps to care for their compatriots. It was the general opinion that prisoners recovered better from their wounds when treated by medical personnel from their own country. The British and United States representatives proposed the complete renunciation of repatriation of doctors and nurses; they would simply be prisoners of war, but would be assigned to medical work.

A compromise was finally reached: medical personnel would not be retained except to the extent that the state of health and the number of prisoners of war made it necessary. They would not become prisoners of war, but would have all the rights of such prisoners. This solution had the disadvantage of all such compromises: it produced confusion. In any case, we recognize that the authors of the Conventions of 1949 wanted on the one hand not to assimilate medical personnel to combatant prisoners of war but instead maintain the special and traditional immunity inherent in

their professional status and position of being separate from the fighting and, on the other hand, to assure for them the benefits of the Third Convention, which they regarded as providing the best protection for persons in the hands of their enemy.

Although they thus legally escape being designated as captives, by the simple fact that they are not prisoners of war, medical personnel do in fact find that their freedom is somewhat limited. This situation inevitably results from the fact that they are of enemy nationality and from the need of the Detaining Power to ensure its military and political security. The Convention also provides that they shall be subject to the internal discipline of the POW camp.

Under Article 28 of the First Convention, medical and religious personnel "shall continue" to carry out their medical and spiritual duties on behalf of the prisoners. These words indicate that even though their capture and retention place medical personnel in a new situation, their special function—caring for wounded and sick soldiers—remains unchanged and they must continue their work, without interference and with unbroken continuity.

This function must henceforth be exercised under the terms of the laws and military regulations of the Detaining Power and under the authority of its appropriate services. The Convention nevertheless specifies an important limitation on this subordination by stating that doctors and other medical personnel shall carry out their duties "in accordance with their professional ethics". Although they are subject administratively to their captors, this subjection is not unlimited. The constraint of the Detaining Power ends where the domain governed by professional requirements and individual conscience begins. One may not, for example, forbid a doctor to treat a patient or compel him to use a treatment which he considers wrong.

Retained medical personnel in prisoner-of-war camps must be granted the privileges necessary for their work; they may not be required to do any work apart from their medical duties; they must be allowed to visit hospitals and labour units.

At least once a month, all prisoners must be given complete medical examinations, with particular regard for their fitness to work.

All measures must be taken to ensure hygiene in POW camps, the prevention of epidemics, the isolation of cases of infectious diseases, transfers of seriously sick prisoners to hospitals or specialized institutions and the supplying of necessary prostheses.

Similar requirements are effective for civilian internees, whose situation under the Fourth Convention is comparable.

Mixed Medical Commissions of three members, including two from neutral countries appointed by the ICRC, shall visit prisoners, with full authority to make decisions concerning those whose state of health justifies the measures provided in the Third Convention for seriously wounded or sick prisoners—either direct repatriation or hospitalization in a neutral country. A model agreement, annexed to the Convention, specifies the disabilities and diseases to be considered and serves as the basis of the work of the Mixed Medical Commissions.

5. THE MEDICAL MISSION

Private doctors, first-aid workers and members of the general public, under certain conditions, may participate in relief activities. As stated in Article 18 of the First Convention: "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." Another provision in the same article authorizes the inhabitants and relief society to collect and care for the wounded spontaneously, without distinction of nationality, even in occupied areas.

Recent developments in methods of warfare, far from making these provisions illusory, have given them new timeliness, due notably to the evolution of resistance movements and the parachuting of troops. There may be isolated wounded persons anywhere in a country, and civilians must be able to come to their assistance without interference.

During the Second World War, occupation authorities ordered inhabitants, including doctors, on pain of the most serious punishments, to report the presence of any suspected enemy and of any partisan. There were very few doctors who obeyed this order, because doing so would have prevented the wounded and sick from coming to a doctor to be cared for.

Representatives of some States in 1949 wanted the Convention to state that the inhabitants were forbidden to remove the wounded and sick from the control of military authorities. Others opposed this, fearing to legitimatize measures which occupying authorities might take to force doctors and the general population to denounce

wounded enemies or members of resistance movements, which they said would violate medical secrecy. Finally, it was decided not to mention the matter at all.

The question was raised again at the Diplomatic Conference in 1974, which met to draft the two Protocols additional to the Geneva Conventions. This time it was spelled out in black and white that no person engaged in medical activities should be compelled to provide information about wounded or sick persons treated if he believed that such information would be harmful to those persons or to their families. This means that health personnel are not obliged to denounce people who come to them for help.

After all the tragedies and all the discussions in medical circles, a solution had finally been arrived at, based on the freedom of the doctor. So far so good.

Unfortunately, in its final session, the Conference qualified its decision and decided to make an exception, so that the doctor would have to provide the information in question if required to do so by the laws of his own country. This modification is regrettable, for it tends to deprive the clause, obtained after so much difficulty, of much of its substance. The clause remains fully effective, however, vis-à-vis the enemy and the Occupying Power.

Another related problem, equally painful, remains to be dealt with. In a number of countries, during and after the Second World War, men and women were killed, mistreated or imprisoned because they had given care to resistants or to parachutists. In addition, after the liberation of some countries, doctors and nurses who had worked for the medical services or the Red Cross Society of the occupying power were subject to prosecution under rigid laws which defined as high treason any engagement in the enemy army and treated them on the same basis as those who took up arms against their country. The 1949 Convention states that, "No one may ever be molested or convicted for having nursed the wounded or sick" (Article 18). The 1977 Protocol goes further: "Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom" (Article 16, par. 1). I would like to draw attention to the fact that medical ethics have thus in a sense become a part of international law.[1]

[1] In international terms, we may recall the principles of medical ethics embodied in the Oath of Geneva of 1948, adopted by the World Medical Association, a revised version of the Hippocratic Oath, and the International Code of Medical Ethics, which completed it. A new draft code is currently under consideration by the World

Other provisions in the 1977 Protocols, also requested by medical circles, provide better protection than before for the individual and for the medical mission. One article, for example, forbids subjecting protected persons to any medical procedures not indicated by their state of health and not consistent with generally accepted medical standards. The purpose was to condemn pseudo-medical experiments, of evil memory, and also the removal of organs for transplantation, a relatively new problem. In the same spirit, blood donations are hedged about with precautions. In other words, people in the power of an enemy are not to be treated as experimental guinea pigs nor as sources of biological spare parts. Finally, it is specified that persons engaged in medical activities may not be forced to perform acts contrary to humanitarian law or medical ethics—a very important provision.

It is useful to recall at this point that medical personnel who violate humanitarian law are subject to punishment. What are designated as grave breaches—commonly called war crimes—are accordingly dealt with very severely. These include endangering the physical or mental health or integrity of any person by a wilful act or omission, biological experiments, torture and punitive treatments and the perfidious use of the red cross emblem if this results in death or serious injury to human beings. It is also forbidden to leave persons, wilfully, without access to medical attention and care or to expose them to risks of contagion or infection.

The wishes of patients, even those in captivity, must be respected. Before undertaking an operation or treatment the doctor must try to obtain the patient's consent, in writing if possible, unless the patient is incapable of giving such consent.

Some medical circles have raised the question whether doctors have the right to carry out research in domains threatening the lives or integrity of individuals. Can they do work designed to make weapons more cruel or more deadly? Can they say how far torture may be proceeded with? In the spirit of the law of Geneva, I reply with a categorical no—and I add that from the moment when they engage in such criminal activities they have lost the right to call themselves doctors.

Health Organization. In addition, in 1957, the ICRC, the International Committee of Military Medicine and the WHO drafted "Rules of medical ethics for wartime," and the World Medical Association adopted "Rules to assure relief and services to the wounded and sick in times of armed conflict."

6. HOSPITALS AND MEANS OF TRANSPORT

If we intend to protect the wounded and the persons caring for them, it is obvious that immunity must be given to the buildings sheltering them, the medical units to which they belong, the vehicles which transport them and the medical material used.

Both fixed establishments and mobile medical units must be respected at all times, whether or not they contain wounded or sick persons. If they fall into the hands of the adverse party, their personnel must be allowed to continue their activities so long as the capturing Power has not itself ensured the necessary care of the patients.

The protection accorded to both fixed and mobile elements comes to an end if they are used to commit what the Conventions call "acts harmful to the enemy." Such acts have the aim or effect, by favouring or impeding military operations, of being detrimental to one of the belligerents. They may consist, for example, of hiding able-bodied combatants, concealing weapons or installing a military observation post in a hospital.

The Conventions enumerate acts which are not to be considered as harmful. For example, medical personnel may be armed and in case of necessity may use their weapons to defend themselves or the wounded for whom they are responsible. Such arming of medical personnel has often been misunderstood and wilfully misinterpreted. We should stress that only purely defensive weapons are referred to—light arms such as pistols. They are not intended for use in resisting an illegal attack, and in such instances the unit should surrender since its means of defence are insignificant. The weapons are intended only to maintain order and discourage looters. Of course this does not mean that doctors are expected to be totally passive and let their throats be cut by barbarians with no respect for any standards. As we can see, the weapons in questions do not modify in any respect the essentially neutral and peaceful character of a medical unit.

Until 1949, medical material had to be restored to its army of origin. This is no longer the case. The change was due to the modification agreed upon with respect to the possible retention of medical personnel. It may not be confiscated however as long as it is needed for the care of the wounded.

A similar situation prevails for land vehicles. They are protected at the front, but if captured they need not be returned.

Medical aircraft belong in the same category. Before 1949, it was sufficient for their protection that they be painted white and be marked with red crosses. At the 1949 Diplomatic Conference however it was recognized that this was insufficient, since planes were commonly fired at before they could be seen. Accordingly, protection for medical aircraft was made to depend upon an agreement between the belligerents about their flight schedules—the route, time, altitude, speed, etc. Since it is very difficult to reach such agreements in wartime, especially in cases of emergency, this virtually clipped the wings of medical aviation and left it grounded, unless it was possible to provide it with an escort of fighter planes. This was naturally a great misfortune for countries which did not have control of the air, for planes are a wonderful means of quick transport for the wounded. It became the practice to take them by helicopter from the place they fell directly to the hospital, to save them from the long, painful, and often fatal transport by land. During the war in Vietnam, large American transport planes carried the wounded directly to the United States and treated them en route in virtual airborne operating rooms.

The question was considered again in 1974, and science provided the remedy for the evil it had caused. It was recognized that one could easily identify planes in flight before firing at them—since this was already being done in the case of warplanes, which could be instantly recognized as friendly or hostile. Accordingly, a technical annex was joined to Protocol I of 1977 creating a system of three types of signal: a flashing blue light, a radio signal and a secondary radar system, as part of the international communication procedures.

A rebirth of immunized medical aviation has therefore become possible, and let us hope it will soon be a reality.

At sea, it is *hospital ships* which must be considered. These are used in several situations: in maritime warfare, they follow the fleet and collect the shipwrecked and wounded after combat; in intercontinental wars, they are means of evacuation and transport; in amphibious warfare, they serve as floating hospitals, providing complete treatment for soldiers taken aboard.

Providing the adverse party with information about their characteristics and signals confers protection on these hospital ships and makes them immune to capture under all circumstances, whether or not they carry wounded. This protects them in their totality, including their medical personnel, crews and material. This gives them a specially privileged status in warfare, in which ships

are rare and hospital ships even more so. Without their crews, hospital ships would be no more than drifting derelicts. They are therefore protected as total entities.

Even though they belong to navies, hospital ships are not warships. They are separated from the conflict. The adverse party may stop them, order them to follow a particular course, etc. If hospital ships venture into the midst of a naval battle, they do so at their own risk.

Hospital ships, under the penalty of losing their protection, obviously cannot commit acts "harmful to the enemy", such as transporting war material, except for weapons taken from the wounded or shipwrecked, and the weapons of the vessels' personnel, used for their own defence and that of the wounded.

7. CIVILIAN MEDICAL PERSONNEL

The Fourth Geneva Convention dating from 1949 finally accorded to civilians guarantees which had been so tragically lacking during the Second World War. In the domain with which we are now concerned, it extended to wounded and sick civilians the principles originally conceived only for the military wounded, of which I have spoken.

Civilian hospitals are accordingly protected in the same way as military hospitals, on the condition that they correspond to the definition of the Convention and are duly recognized by the State. Civilian hospitals, if authorized by the State, will be identified by the red cross emblem, which had not previously been the case.

The Convention grants to the personnel of civilian hospitals a protection similar to that given to military medical personnel. This is also the case for the transport of civilian patients, which must however be carried out by organized convoys.

In 1949, the Diplomatic Conference refused to extend the special protection of the Convention and the use of the red cross emblem to all civilian medical personnel, on the ground that such an extension to poorly defined groups, not officially organized and not under strict control, would increase the danger of abuse of the distinctive sign and thus weaken the protection which all civilians should enjoy.

The Diplomatic Conference of 1974, however, took the great step forward at which its predecessor had balked twenty-five years earlier. It recognized that the 1949 solution was embryonic and very

inadequate. The whole territory of a country is now affected by a conflict and civilians are afflicted just as much as, if not more than, the soldiers. Medical personnel must be free to go everywhere, often into danger zones, and care for the wounded without distinction. Under the additional Protocol of 1977, civilian medical personnel as a whole now benefit from the immunity originally provided in 1864 for the army medical services. Substantial guarantees were provided to prevent the abuses which had been feared earlier. To have the right to the protection and the use of the red cross emblem, civilian military and para-military personnel have to be authorized and controlled by the State.

How was such a considerable extension deemed possible? It is undoubtedly due to the fact that a real civilian medical service has been created in many countries and, even more important, that this civilian service has often become merged with the military medical services, so that in wartime there is only one medical service.

In our time, wartime medical personnel and peacetime medical personnel are recruited from the same sources and are receiving the same training.

We are thus in the presence of an irreversible evolution. We must insist however that government control be exercised with unceasing vigilance, because it is essential at all costs that the authority of the emblem and respect for it be assured. We must never forget that *many human lives depend on this.*

Other special provisions for the benefit of civilians should also be mentioned. In a conquered country, the occupation authorities are responsible for the maintenance of public health. All categories of medical personnel and all relief societies must be allowed to carry on their work.

The Convention also provides for agreement on the creation of hospital and safety zones for the wounded, the sick, certain categories of the civilian population and, of course, the necessary medical personnel.

There has been much talk of such zones, but very few of them have actually been created. If such places of refuge should become widespread, there would be a danger of weakening security in other parts of the national territory. However, it is conceivable that zones of this kind could be established in urgent cases, with very specific boundaries.

The Fourth Convention also provided for various exceptions to blockades, thus directly challenging this powerful form of economic warfare. This proposal encountered strong resistance by some gov-

ernments. It was finally decided that these exceptions would be limited with respect to the nature of the shipments and the categories of recipients. Only shipments of medicaments and medical material are assured for the whole population. Food and clothing are allowed free passage only for children and pregnant women. These exemptions from blockade are subject to conditions and to guarantees of control.

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In what has gone before, I have evoked only the letter of the Geneva Conventions, but the spirit is more important than the letter. The spirit of the Geneva Conventions is the very spirit of the Red Cross itself, which is much older and much broader than the texts. The First Geneva Convention embodied a noble humanitarian idea, going far beyond what it specifically stated, that all the wounded must be cared for without distinction of nationality. It follows from this that relief given even to adversaries is never a hostile act and is never an interference in the fighting.

It is clear that if we look at it from an exclusively egoistic and purely utilitarian point of view, the Geneva Convention may seem to be an aberration. Is not the very essence of war to attack enemy soldiers? If only the most immediate military interests—although they were poorly understood—had prevailed in 1864, it would have been considered that wounded enemies who might recover were still dangerous adversaries. Therefore, the medical service which strengthened the military potential by "recuperating" the combatants would not have been protected.

Accordingly, the Geneva Convention would never have existed, and all those who cared for the enemy wounded would have been traitors. However, this concept did not prevail and the States, in signing the Geneva Conventions, agreed to sacrifice national interest to the demands of conscience. This is indeed the miracle of the Red Cross.

In conclusion. I express a wish: let the white flag with the red cross never be struck, anywhere in the world. If this were done, we should soon see, hoisted in its place, another emblem which is also well known—and respected in its own way—the black flag bearing a skull and crossbones. Let us not forget that the flag with the red cross, which has floated for more than a century over all the battlefields of the world, and everywhere else where there are

suffering people, is not only the banner of those who fight with their bare hands to deprive death of its prey; it is also the emblem of peace itself.

Jean Pictet