The Geneva Conventions and medical personnel in the field *

by Médecin Général Inspecteur J. Miné

To speak of the Geneva Conventions and medical personnel in the field is truly to return to the very source of international humanitarian law, for the event which led to the birth of that body of law was the tragedy suffered at the battle of Solferino in 1859 by the wretched masses of wounded soldiers on both sides who received no care whatever.

But, while in no way detracting from Henry Dunant's achievements, it should be remembered that there were individuals in the medical services who, along with many others, greatly contributed to the development of humanitarian concepts before they were enshrined in the first Geneva Convention of 1864.

It is not my intention to draw up an exhaustive list, I would like to begin by recalling what was written by Ambroise Paré about the siege of the city of Metz in 1552: "Likewise, the enemy left in the abbey of Saint-Arnould many of their wounded soldiers whom they were unable to carry off... My Lord de Guize sent them their fill of food and commanded me and the other surgeons to go and bind their wounds and administer medicine, which we willingly did".

We have also had handed down to us the French code of military medicine as established by Jean Colombani, inspector of hospitals, in 1772, which requires wounded prisoners to be respected. In 1789, Claude Pierson, chief administrator of French military hospitals, sent out similar guidelines. In 1800, Baron Percy championed the idea of having field hospitals declared immune from attack. Hippolyte Larrey in 1861 publicized the memorandum sent to him by the pharmacist Philippe Arnoult regarding the protection of wounded persons. Another example is the publication, in 1863, of the code for French army medical officers. It prohibits the abandonment of wounded soldiers during a retreat.

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Finally, Baudens, in his memoirs published posthumously in 1865, advocated an agreement between nations for bringing aid to the wounded and the adoption of a sign recognized by all to be used by doctors and medical personnel in wartime.

Since then, many other military medical officers have worked for the development and dissemination of a body of humanitarian law. I will mention one only, the chief medical officer Lambert des Cilleuls, who was also a great military historian of the French medical corps.

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This article may be considered as a study of the individual and collective behaviour of medical personnel in the field *vis-à-vis* their responsibilities under the Conventions. This will be done on the basis of the most recent Conventions, those of 1949. They have the force of law because France has ratified them, just as in 1984 it ratified one of the two Additional Protocols of 1977—Protocol II relating to non-international conflicts.

In practice, the provisions of the Geneva Conventions which apply to medical personnel take the form of a series of rights and duties, the main points of which I would now like to describe to you.

The *rights* may be summarized as follows:

— Medical personnel must be afforded respect and protection. This applies to permanent personnel, but also to temporary personnel (auxiliary nurses or stretcher bearers) provided they are officially attached to the medical service of the armed forces and used in that capacity. All possess identity cards confirming that they belong to the Service, and they are armed.
— This protection also covers establishments, units, equipment and vehicles. The same is true for medical aircraft and hospital ships. It is prohibited to attack them or impair their capacity to function, even at times when they contain neither wounded nor sick persons. It should be noted that hospital ships may under no circumstances be captured.
— Another form of protection is protection from captivity. Military medical personnel who fall into the hands of the enemy may not be considered as prisoners of war.
— Finally, these provisions apply to National Red Cross and Red Crescent Societies and sometimes to other voluntary aid soci-

eties which officially take part in transporting and treating the sick and wounded.

— These rights arise indirectly from the duties; the two are greatly dependent on each other.

There are three points that I would like to make at this juncture:

— First, it is important to appreciate what such protection means. It is not accorded to medical personnel for their benefit but because they care for the victims of conflict, and it is a way of helping them to perform their duties better. It is not the medical personnel but the wounded persons in their care who are to be favoured. This indicates the limits of the protection and requires all members of the medical service to adhere scrupulously to their mission of assistance. Otherwise, they may forfeit the protection they enjoy.

— Second, the wording of Article 8 of Additional Protocol I defines "medical personnel" as "those persons assigned, by a Party to the conflict, exclusively to... medical purposes".[1]

This wording might give rise to confusion in that it would seem to imply that administrative staff of the medical service would not be protected. This is not, in fact, the case. Nothing justifies the restrictive interpretation which some have wanted to give to it. Be that as it may, one should be guided by Article 24 of the First

[1] Article 8 of Protocol I stipulates, *inter alia*, that

"(c) "medical personnel" means those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under sub-paragraph (e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary. The term includes:

(i) medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organizations;

(ii) medical personnel of National Red Cross (Red Crescent, Red Lion and Sun) Societies and other national voluntary aid societies duly recognized and authorized by a Party to the conflict;

(iii) medical personnel of medical units or medical transports described in Article 9, paragraph 2;

(e) "medical units" means establishments and other units, whether military or civilian, organized for medical purposes, namely the search for, collection, transportation, diagnosis or treatment—including first-aid treatment—of the wounded, sick and shipwrecked, or for the prevention of disease. The term includes, for example, hospitals and other similar units, blood transfusion centres, preventive medicine centres and institutes, medical depots and the medical and pharmaceutical stores of such units. Medical units may be fixed or mobile, permanent or temporary;..."

Convention of 1949, which is perfectly clear on this point, especially as France has not ratified Additional Protocol I.

— Third, the present medical service in France is anxious to be able to use the veterinary corps to fill out its medical units in the field, assigning them, alongside the traditional medical and paramedical personnel, to the tasks of evacuating and assisting the wounded. In their normal role, veterinarians are not counted among those personnel entitled to protection.

Curiously enough, Article 22 of the First Geneva Convention states that where personnel and material of the veterinary service are found in a medical unit or establishment, without forming an integral part thereof, they may not be deprived of protection.[2] The problem, if a problem exists, does not seem difficult to solve. It suffices to ensure that veterinary personnel who are put to such use officially belong to the medical service and are able to provide proof of this.

An examination of the *obligations* reveals two different types. One could be described as military and the other as technical.

Military obligations tend to affirm and justify the principle of protection, that is, the medical service must identify its personnel, establishments and vehicles by marking them with the emblem specified in the Conventions and undertake to use them solely to carry out its offical mission and not commit what the Conventions call acts harmful to the enemy.

The technical obligations entail the following:

— humanitarian assistance, that is, rescuing sick, wounded and shipwrecked persons and affording them respect, protection and the best possible care;

— impartiality, that is, making no distinction between victims on any but medical grounds, especially between wounded comrades and enemies;

[2] Article 22 — The following conditions shall not be considered as depriving a medical unit or establishment of the protection guaranteed by Article 19:

(1) That the personnel of the unit or establishment are armed, and that they use the arms in their own defence, or in that of the wounded and sick in their charge.

(2) That in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort.

(3) That small arms and ammunition taken from the wounded and sick and not yet handed to the proper service, are found in the unit or establishment.

(4) That personnel and material of the veterinary service are found in the unit or establishment, without forming an integral part thereof.

(5) That the humanitarian activities of medical units and establishments or of their personnel extend to the care of civilian wounded or sick.

— setting of priorities for treatment based solely on the degree of medical urgency;
— solidarity, the duty not to abandon wounded or sick persons who have fallen into the hands of the adversary.

It should be pointed out—and everything which follows will confirm this—that respect for the Geneva Conventions conforms fully to the French army's code of military discipline and to the professional code of ethics which applies to its doctors and pharmacists. These roles were set out in the decree of 16 January 1981, Article 50 of which states: "in time of war, they must use the technical means at their disposal in their field to assist their fellow soldiers in a spirit of absolute solidarity and self-denial and in accordance with international humanitarian conventions".

Such a cursory review of these obligations might lead the inattentive observer to conclude that they do not contain much more than conventional medical ethics, which are as old as they are familiar to physicians and, when all is said and done, relatively easy to obey.

The reality is quite different. Respecting these rules means facing many factors associated with war and capable of causing obstacles which the medical service is duty-bound to overcome.

The main factor is the appearance of radical psychological and social changes which affect any individual or group of individuals involved in war, implying the influence of a war mentality characterized by the disappearance of prohibitions prevailing in peacetime, passive submission to the group and to authority. It follows that there is an increase in violence and acts of vengeance, and a decrease in the perceived value of the lives of others. All these things, of course, are contrary to the spirit and letter of the Geneva Conventions.

Furthermore, the medical service in the field does not exist in isolation from the rest of the military structure: it is part of it and necessarily supportive of one side in the conflict. This means that the medical personnel more or less share the risks, the passion, the fury and the distress—all factors which put them under pressure, bring them into contact with the fighting and draw them into inevitable, indeed essential loyalty to their own side. But that loyalty requires the medical personnel to take care lest it deflect them from their primary calling and, by influencing or dictating their choices, set them at odds with their humanitarian obligations.

There is a third factor which makes their task no easier: the increasingly deadly nature of modern combat. This is due to the growing potency of weapons, their massive and indiscriminate use, the fact that fighting continues without respite, day and night, and that protected zones no longer exist. How then are medical personnel to perform their duty of giving assistance and the best possible treatment to all and abandoning no one?

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To see how the medical service carries out its humanitarian mission in practice in the field, it is necessary to examine its conduct in the different areas of responsibility, that is, collecting, triage, evacuating und treating the wounded. To be sure, rights and duties are involved at each stage, but they take on a specific aspect each time.

As soon as it is deployed, the medical service must, before anything else, take measures for the protection of its personnel and establishments. It must therefore ensure that the prescribed armlets are worn and that its first-aid posts and ambulances are easily identifiable through red crosses on a white background. It is simple to imagine the difficulties, the resistance and even hostility which the medical service may encounter on its own side. It may be accused of ignoring military realities in the face of the more or less valid necessity of using camouflage and the argument that the enemy could use the visibility of medical facilities to calculate their adversary's strength.

To what extent, in real terms, is this protection effective? It is often quite illusory, because the medical personnel are very close to the fighting, weapons are indiscriminate and medical personnel are not always recognized as such. Inevitably, they must take risks.

Indeed, the danger may be so great as to make impossible any exposure to it. Imagine the choice faced by a commander who must choose either to risk the lives of his doctors and stretcher-bearers or deliberately to abandon the casualties which the Conventions and his sense of professional ethics require him to assist. The trenches of World War I rang too often and too long with the cries for help and the agony of those whom no rescuer could ever reach. That is perhaps what made Doctor Soubiran write: "A doctor who goes to fetch the wounded and dead in battle is just doing his job. A doctor who gets killed out there is incompetent". No doubt. But does that

term apply to a doctor who is killed by a wounded enemy soldier whom he was about to assist? Who can say where, for the rescuer, is the demarcation line between courageous performance of a duty and foolhardy or useless heroism?

Thus, protection is often illusory at this stage of the operation and the risks are very great indeed. There are also practical difficulties, because the number of wounded and the severity of their wounds are growing relentlessly and the needs are seldom met by the resources.

Collecting all the wounded then becomes impossible: some are forgotten in places not searched, others receive assistance too late while still others, for lack of resources, do not receive the necessary care.

Further difficulties arise because it is here, at the front, that combatants and rescuers are in the thick of battle. The choices which the rescuers must make will inevitably, and very understandably, be the object of partisan pressure applied by the combatants. The doctor in such a situation will require great authority to be able to impose decisions such as whether the wounded compatriot or wounded enemy soldier will be given the last bandage, the last splint or the last team of stretcher-bearers.

In the heat of battle, more than elsewhere, situations may arise in which the medical service is hard put to observe the Conventions' rules in the face of reprehensible attitudes, and it may sometimes be necessary to take a stand.

One such attitude would be that medical establishments or vehicles should be used, for example, to transport weapons or to shelter able-bodied combatants, or that a first-aid post be used as an observation post. The medical service's credibility would thus be damaged and one can easily imagine the disastrous consequences.

The same would be true of any member of the medical service who was tempted to identify himself with the combatants and "do a John Wayne". Even if he were to remove all identifying badges etc., this is not his role and he is needed elsewhere to perform the tasks for which he has been trained. Apart from the fact that he would rarely be appreciated in such a role, he would be in total breach of the spirit, if not the letter, of the Conventions.

The Conventions contain very clear provisions concerning the carrying of weapons. Light individual weapons may be carried for strictly defensive purposes. These may under no circumstances be used in organized fighting or to resist an attack. In such a case, the

unit would have no choice but to surrender. On the other hand, the medical service must play a preventive, police-like role to protect the wounded against pillage and ill-treatment.

Protection at the triage stage is not much better if only because of the proximity of the fighting and the mobility of combat troops. On the other hand, marking and identification are more effective, the pressure of the combat environment is less intense and it is easier for members of the two sides to co-exist.

The interesting question here is whether triage, with all its tragic implications when there is a massive influx of wounded, is legitimate. Triage is a voluntary act of discrimination which takes into account the seriousness of the injuries and the available resources. In triage, the most severely wounded are passed over in favour of those who have a chance of survival if adequate care is administered immediately.

The Geneva Conventions implicitly confirm the lawfulness and even the necessity of such a practice. They refer to treatment "without any adverse distinction". But Article 12 of the First Convention of 1949 stipulates that such a distinction between the wounded and the sick must be based exclusively on medical considerations.[3]

Primary and secondary evacuations must theoretically be accorded total protection provided, once again, that those carrying them out identify themselves clearly and that the evacuations serve no purpose other than assistance to the wounded and sick. Such exclusiveness becomes important when scarce but very effective modes of transport, such as helicopters, are used. Under the Conventions, such scarcity could not be used to legitimize, for example, a helicopter flying a mission which was purely medical on the outbound trip but of a military nature on the return leg. The Falklands/Malvinas conflict provides a good example of this problem.

[3] Article 12 — Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances.
They shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinons, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected to torture or to biological experiments; they shall not willfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.
Only urgent medical reasons will authorize priority in the order of treatment to be administered...

In taking decisions concerning evacuation, the doctor in charge often faces a difficult choice. Should he place the last team of stretcher-bearers in danger to evacuate one emergency case? Up to what point should he press his superiors to obtain authorization for the vital helicopters when the weather or military situation is unfavourable? How, as in the case of the French at the battle of Dien Bien Phu, can he be certain that he has made the best choice of the wounded to be put aboard the last aircraft out? Finally, if there are no more ambulances protected by the red cross, should he refuse to place wounded people on combat vehicles if they are the only means left of evacuating them to a medical establishment or of preventing their capture?

The possibility of capture is amply covered by the Geneva Conventions. They stress above all the absolute solidarity which the *doctor must have with the wounded and sick people in his care. If* they are taken prisoner, he must be prepared to share their fate and continue to assist them. If a medical unit must pull back in order to avoid being captured and is not able to take with them all or part of the people in their care, sufficient personnel and material to meet the needs of those people must be left with them.

Within certain limits, the personnel left behind will have some prospect of being repatriated, for only those personnel will be retained who are judged indispensable to the medical care of the prisoners of their own party. The doctor must continue to work on their behalf and may not be assigned other tasks.

Respecting the Conventions becomes easier in the actual treatment of the wounded and sick, which takes place at a distance from the battle, with the medical services amply identified and separated from combat units. Decision-making and protection are no longer difficult problems. The personnel can turn their attention exclusively to medical care, the healing process itself which can be no better described than by quoting George Duhamel relating his experiences at the head of a mobile surgical unit during World War I: "A machine, just a machine with no soul but with a good head of steam, set to operate for a long period and plough its way through a lot of work... I was operating better and better and faster and faster on men who remained anonymous to me. I often did not even know their nationality."

There also comes a time when one must be able to defend those who have been placed in one's hands. Let us not forget what Larrey's son said to the people who had come to the Hôpital du Gros Caillou and demanded that the wounded members of the

Royal Guard be handed over to them: "What do you want? My patients? They are mine, get out of here!".

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It is justified to ask whether, in such a situation, the medical service does not in fact become merely a cog in the machinery of war and thus contravene the Conventions by maintaining troop numbers and restoring the morale and fighting spirit of the combatants. Nothing of the sort. It is merely respecting its own code of ethics, Article 15 of which states that "a military doctor must constantly do his utmost to maintain troop numbers".

Military doctors do have one obligation, however, and it remains in keeping with the Conventions: they must not allow their therapeutic activities to be dictated by immediate military imperatives in such a way that it harms the medical interests of their patients. Meeting this obligation may be particularly perplexing when it comes to removing soldiers from combat because of psychiatric disorders, which can be very severe in today's conditions of combat.

As we have seen, it has not always been easy for the medical service to observe the Geneva Conventions. Looking to the future, we see three important trends:

— ever more sophisticated weapons,
— the spread of new types of warfare,
— the impact of alarming social and cultural phenomena.

Concerning weapons, people will in future do their fighting without seeing each other, on land, at sea and in the air. How then can those entitled to protection identify themselves? By a radio signal reserved for those carrying out medical evacuations? By means of radar transponders? No, because helicopters cannot use these. By prior agreement on a distinctive signal? For the moment, we are only at the discussion stage, though Article 23 of the First Geneva Convention provides for neutral zones, called "hospital zones", to be established.[4]

[4] "In time of peace, the High Contracting Parties and, after the outbreak of hostilities, the Parties to the conflict, may establish in their own territory and, if the need arises, in occupied areas, hospital zones and localities so organized as to protect the wounded and sick from the effects of war, as well as the personnel entrusted with the organization and administration of these zones and localities and with the care of the persons therein assembled."

Even leaving aside the possibility of bacteriological, chemical or nuclear war, we are increasingly faced with new types of warfare such as guerilla war, civil war and so-called small-scale conflicts. It has been our misfortune to have had some experience of these. The French medical service has had to learn to respect the provisions of the Conventions prohibiting it from abandoning its duties on the pretext that the other side has not met its own obligations. The Service has, however, very often been a prime target, not only because it was not protected but because its humanism and impartiality made it an obstacle for the enemy.

The humanitarian missions in which the French medical service takes an increasingly active part have seen it providing equal assistance to combatants from both sides in separate places. A good example of this has been the civil war in Chad, where we have at times had to protect this or that wounded person or post-operative patient against murderous night attacks by the enemy. All we were doing was obeying both our code of ethics and the Conventions.

But new and alarming social and cultural factors are coming into play. We are witnessing a weakening of international moral standards and an unprecedented explosion of radical, totalitarian ideologies which carry the banner of holy war and fanaticism. "War has become an object of passion, and suffering a political tool" and it is sometimes the States themselves which, more or less, sponsor the taking of hostages. This being the case, what is the point of having international humanitarian standards which look more derisory with each passing day?

This is what justified the adoption in 1977 of provisions additional to the Geneva Conventions, including two paragraphs in Article 10 of Protocol II: "Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom". That is a forceful reaffirmation of the general protection for those engaged in a medical mission, regardless of the place, time or circumstances. Article 10 goes on: "No person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care".[5]

[5] Protocol II, Article 10, par. 4.

The memories which we French have of four years of occupation are enough to justify these provisions and, sadly, they remain very necessary.

Given such a gloomy outlook, we may well ask how we can always be prepared to carry out our mission, obeying both our code of ethics and the Conventions.

First, commanders must be made aware of humanitarian requirements (since they, after all, are responsible for their implementation). Next, we must fix clearly in our minds the moral precepts enshrined in the Conventions. To do this, the medical service gives instruction to its doctors and other personnel and verifies through practical training courses, exercises and even examinations whether they have the required understanding and commitment. It maintains close contact with representatives of the Red Cross on an international, national and regional level. Finally, it is happy to co-operate with projects to spread knowledge of humanitarian law.

Thus, the medical service of the French army serves as an example for those around it. It is aware of the responsibilities which, though shared with others, must be shouldered mainly by the service itself. It respects the principles of humanitarian law and is strong enough to denounce violations of that law. The medical service always endeavours to maintain its place in the vanguard of those who are determined that the great hope of 1864 will not, at the end of the 20th century, be but a tragic illusion.

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