The Geneva Convention: Humanitarian law and medicine

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On Dec. 12, 1977 there opened for signature in Geneva two important instruments of international humanitarian law.[1,2] These instruments are protocols additional to the four Geneva conventions of Aug. 12, 1949,[3,4,5,6] and they contain the first major changes to the law of war for nearly 30 years. They are the result of many years of preparatory study, followed by 4 years of negotiation at the diplomatic conference on the reaffirmation and development of international humanitarian law applicable in armed conflicts.

The original Geneva Convention is dated Aug. 22, 1864. By its title it is described as being "For the Amelioration of the Condition of the Wounded and Sick in Armies in the Field". Its 10 articles have since been developed, in 1906, 1929, and 1949, into 429 articles (plus annexes) of the four conventions in force today. The two protocols (less their annexes) will add another 130 articles.

The reason for the creation of two protocols has nothing to do with the number of conventions. Whereas the conventions are concerned each with a different class of person, the protocols apply to two different sets of situations: international and noninternational armed conflicts (the term "war" has been avoided). This is not the place to go into details that are already confusing enough to experts, but it should not go unremarked that "international armed conflicts" now include "armed conflicts in which peoples are fighting against colonial domination and alien occupation and against racist régimes in the exercise of their right of self-determination..." and that the scope of noninternational conflicts is equally confusingly defined. Protocol I, covering the international field, is longer and more precise than Protocol II, which is concerned with noninternational struggles, is very simply worded and has more the character of a code of conduct than a formidable legal instrument.

Protocol I

Although the 1949 conventions were very largely produced as the result of the experiences of World War II, much has happened since then that has made it necessary to bring them up to date. In particular, it has become more obvious than ever that war is not the concern solely of the armed forces of the antagonists, and therefore one of the principal aims of the diplomatic conference was to formulate a more complete and more effective set of rules for the protection of civilians. These rules include a comprehensive set of articles covering civilian wounded, sick and shipwrecked persons, medical personnel and medical units. Some articles run parallel to provisions of the First and Second Conventions of 1949, which apply principally to military personnel; others extend and elaborate certain parts of the Fourth Convention.

Medical transportation

Of interest primarily to the military is a comprehensive and detailed set of rules in articles 21 to 31 of Protocol I under the heading of medical transportation. The use of aircraft has for so long been the preferred method of evacuating the wounded that it may come as a surprise to learn that their only protection under Geneva law is when the aircraft are flying "... at heights, times, and on routes specifically agreed upon by the belligerents concerned." Even as far back as 1929 there were elementary provisions regarding medical aircraft, but 20 years later it had still not been found possible to develop rules that would allow them to operate more widely under the mantle of international law, owing to the technical difficulty of distinguishing between aircraft being used for humanitarian purposes and those with hostile intent. The 1949 diplomatic conference passed a resolution recom-

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mending further study of the subject, and now Annex I to Protocol I contains detailed provisions regarding the identification of medical aircraft by such means as special radio and radar codes and the use of flashing lights.

Protection of prisoners

Although there is much in Protocol I of importance to all medical workers, two articles are of more than usual interest. In the 1929 convention, chapter II article 1 provided that "Officers and soldiers and other persons officially attached to armed forces who are wounded or sick shall be respected and protected in all circumstances; they shall be treated with humanity . . . etc." As a result of the experiences of World War II, these provisions were greatly strengthened in the 1949 conventions. Article 12 in both the First and Second Conventions now states that the wounded and sick ". . . shall not be . . . subjected to torture or to biological experiments; they shall not wilfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created." The Third Convention article 13 forbids a prisoner of war's being ". . . subjected to physical mutilation or to medical or scientific experiments of any kind which are not justified by the . . . treatment of the person concerned and carried out in his interest." Finally, in the Fourth Convention, article 32 contains a prohibition against "mutilation and medical or scientific experiments not necessitated by the medical treatment of a protected person . . . ."

Article 11 of Protocol I greatly extends the protection given by the 1949 conventions. To begin with, it covers a wider range of people: "Persons who are in the power of the adverse Party or who are interned, detained or otherwise deprived of liberty as a result of . . . (the war)." It states that their "physical or mental health and integrity . . . shall not be endangered by any unjustified act or omission . . ." and prohibits their being submitted to ". . . any medical procedure which is not indicated by (their) state of health . . . and which is not consistent with generally accepted medical standards which would be applied under similar medical circumstances to persons who are nationals of the Party conducting the procedure and who are in no way deprived of liberty." Passing to the particular, paragraph 2 prohibits physical mutilations, medical or scientific experiments and removal of tissue or organs for transplantation, except where medically justified under the general rule above. Because the word "tissue" is used in paragraph 2, the following paragraph makes exceptions in the case of blood for transfusion and of skin for grafting, but even these exceptions are surrounded by safeguards, owing to abuses which are said to have occurred in recent years.

Woe betide any person who violates these provisions! Violations having serious consequences for the victim are "grave breaches", and "Each High Contracting Party shall be under the obligation to search for persons alleged to have committed, or to have ordered to be committed, such grave breaches, and shall bring such persons, regardless of nationality, before its own courts."[7] Or subject to certain conditions, it may, if it prefers, hand them over for trial to another high contracting party. Readers are invited to write their own scenarios.

There is more to article 11, but of lesser import. Thinking back to the late winter of 1975, when the six now rather complicated paragraphs of this article grew out of the two fairly short paragraphs of the original working draft, one can remember how almost every word and phrase was debated, polished, refined, rearranged, redrafted and finally made to agree in English, French, Russian and Spanish. It is a pleasure to relive those days of working so harmoniously with physicians, jurists, diplomats, Red Cross officials and others from so many parts of the world, differing often in their political

Clearing battlefield casualties, Vimy Ridge, April 1917

beliefs but united in their efforts to write better international standards of behaviour in time of war.

Protection of medical workers

The same dedication went into the creation of article 16, which bears the rather dry title of "General protection of medical duties" ("la mission médicale" in French). It deserves discussion paragraph by paragraph.

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

So reads paragraph 1. This rule is the corollary of the principle enunciated in the conventions and the protocols that the wounded and sick shall be respected and protected, and that they shall receive the care required by their condition. This care cannot be given unless medical personnel are allowed the freedom to give it. The rule applies to any person carrying out medical activities, whether or not a trained health worker and no matter how elementary the activity.

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 rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or carrying out work required by those rules and provisions.

Paragraph 2 is the natural corollary of paragraph 1. Whereas paragraph 1 allows the unimpeded performance of medical activities compatible with medical ethics, this paragraph protects the health worker from being compelled beyond ethical bounds. The commentary on the draft prepared by the International Committee of the Red Cross[8] pointed out that medical workers could not be obliged to conduct pseudo-medical research or to take part in the manufacture of weapons or other means of destruction. Nor can they be compelled to administer drugs to prisoners for the purpose of eliciting information. This provision has obvious implications in military law, as it prevents persons from being compulsorily assigned to work on wound ballistics in connection with the development of projectiles or on research to develop poisonous gases, for example. Indeed, such activities do not fall within the scope of "medical purposes" as defined in article 8(e), and persons carrying them out would not be entitled to protection as medical personnel.

Paragraph 3 is concerned with non-denunciation. Although legally it only applies in international wars, it carries an obvious moral lesson, which one can only hope will not be lost on some of the less tolerant régimes in today's world.

Conventions impose obligations toward civil population

No person engaged in medical activities shall be compelled to give to anyone belonging either to an adverse Party or to his own Party except as required by the law of the latter Party, any information concerning the wounded and sick who are, or who have been, under his care, if such information would, in his opinion, prove harmful to the patients concerned or to their families. Regulations for the compulsory notification of communicable disease shall, however, be respected.

This is a remarkable paragraph. Because the definition of "medical personnel" includes not only people employed in direct medical duties, but also those engaged in the administration of medical units, it protects any hospital worker who might have knowledge of a patient. Because of the words "any information", medical records clerks cannot be compelled to give out such basic information as to whether so-and-so had been a patient, or what was his date of discharge. The protection against the occupying power is absolute; the protection against the police of one's own country depends on the nature of the national law prevailing at the time, but it was pointed out during the course of debate that many countries had, for instance, laws requiring the police to be notified by a physician who had treated gunshot or knife wounds, or traffic injuries. This reference to national law weakens the protection of medical personnel to some extent, but could not be avoided. In view of the reference to "the law of the latter Party", the last sentence of the paragraph might seem to be redundant, but it appeared in the original draft; in any event it is not unreasonable that the occupying power should be able to impose requirements regarding communicable disease control in order to enable it to fulfil its obligations under article 65 of the Fourth Convention with regard to the health of the population in occupied territories.

Protocol II

Protocol II, which, as we have said, relates to the protection of victims of noninternational armed conflicts, is an attempt to apply the principles of humane conduct to conflicts occurring within a state. It is a development of article 3 common to the four conventions of 1949, which contains a few simple and very basic provisions, which apply to any "armed conflict occurring in the territory of one of the High Contracting Parties." Protocol II attempts to tread the fine line of distinction between all-out civil war, which nowadays inevitably becomes international in character, and minor, relatively unorganized uprisings. Throughout the debates on Protocol II the sensitivity of states to infringements on their sovereignty was apparent, and this often made it both a delicate and a difficult task to find acceptable wording. Thus, the humane treatment of individuals under repressive régimes cannot yet be made the subject of international law until a rebellion has reached such a degree of intensity as

to fall within the scope of Protocol II, and this is only a short step away from a Protocol I situation.

The preamble to the protocol emphasizes the need to ensure better protection for victims of the armed conflict in question and lays stress upon the respect and protection of the human person. Indeed, protection of the individual is the theme throughout the conventions and the protocols.

Of the 15 operative articles of the protocol, 6 are in Part III — wounded, sick and shipwrecked. They are short, they are basic and they contain elements both from the conventions and from Protocol I. The parallel to article 11 of Protocol I (protection of persons) is found in a subparagraph of article 5 (persons whose liberty has been restricted). The parallel to article 16 of Protocol I (protection of medical duties) is article 10, which is the longest of the articles in Part III. In view of the brevity of Protocol II it is surprising that the article referring to the freedom of medical personnel has remained so lengthy, especially when one considers the way in which the whole protocol was brought to birth, and it is, perhaps, worth digressing for a moment to have a look at a small fragment of modern history — at least in so far as the development of international law is concerned.

The novelty of the concept of an international legal instrument dealing with the internal affairs of a state was such that there emerged four different points of view regarding the draft as a whole:

- That there should be no protocol, on the grounds that it would be an unwarranted interference with national sovereignty.
- That there was no need for the protocol, because everything to do with it could and should be incorporated into a single instrument covering all types of conflict.
- That the proposed draft was about right.
- That even the proposed draft was too long and complicated, and that it should be a much shorter and simpler document, capable of being easily understood without the need for interpretation by lawyers. This viewpoint was consistently and persistently advocated by Canada, at times alone.

During the four sessions of the conference, Protocol II grew and grew. Not so much as some would have liked, but still it grew. Some of this growth was undoubtedly due to the fact that the main committees of the conference adopted the principle of tackling the protocols in parallel, subject by subject, first in Protocol I and then in Protocol II, so that much of the wording, and of the detail, of the former inevitably was transferred to the latter. Eventually, the 47 comparatively simple articles of the working draft became 47 much longer and more complicated articles, and these were to be placed before the plenary meetings of the conference for adoption.

It is now necessary to go back to the second session of the conference, held in 1975. During the 11 weeks of the session, Canada had been quietly, but insistently, lobbying for a short and simple protocol for which we had developed a draft which achieved a limited private circulation. This draft began to find favour, and eventually arrangements were made for it to be circulated as a conference document. CDDH/212, as it became, carried a note explaining the reasoning and philosophy prompting the development of the draft now offered.

Well before the 47 articles of Protocol II had been debated it was becoming obvious that the document as a whole was not going to be acceptable to many states, including quite a number of those to whom it might well one day apply. In the closing weeks of the conference, therefore, an initiative was undertaken by Pakistan, in consultation with certain other states, including Canada, to reduce the protocol to a simplified form of the kind that we had been advocating for so long. The Pakistani draft was accompanied by an explanatory note that was almost word for word that which Canada had included in CDDH/212!

This brings us back to article 10. During all the hacking and pruning that was necessary to reduce protocol II to acceptable size, article 10 remained intact. Paragraph 1 is the same as its counterpart in Protocol I. Paragraph 2 had to be changed to take into account the different context of application, but there is no essential change in substance. Paragraphs 3 and 4 are where we ran into trouble. The original proposal had been for a paragraph identical to that in Protocol I, but debate over sovereignty and the applicability of national law made agreement very difficult indeed. It took the equivalent of nearly 2 full days of debate in committee, interspersed with the convening and reconvening of a working group, before agreement was reached. Drafting difficulties made it necessary in the end to divide the paragraph into two, and they read as follows:

> 3. The professional obligations of persons engaged in medical activities regarding information which they acquire regarding the wounded and sick under their care shall, subject to national law, be respected.
> 4. Subject to national law, no person engaged in medical activities may be penalised in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care.

The wording is by no means as tight as that of Protocol I, and the words "subject to national law" were by no means to everybody's taste. The text is the best compromise that could be achieved but, to quote a friend in the United States delegation, "a compromise always leaves everybody slightly unhappy."

Conclusion

It is not much of an exaggeration to say that the very existence of the Geneva Conventions is not widely known, and certainly knowledge of their contents is deplorably limited. Perhaps this state of affairs is destined to change. Although the 1949 conventions all contain articles in which the signatories have agreed to disseminate knowledge of their contents among the population,[13] progress in this respect has been slow. Protocol I contains stronger language in this respect than is found in the conventions; article 83 requires that "military and civilian authorities who, in time of armed conflict, assume responsibilities in respect

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cian may have properly performed the procedure, contractual liability may attach where, by his statements prior to surgery, he warranted or guaranteed sterilization. This can be avoided by the physician advising his patient that while he anticipates that sterilization will result from the procedure, the success rate is not 100%.

Such patients should also be advised that, following surgery, other contraceptive measures may be necessary until tests indicate that the desired result has been achieved. While an action based in contract could be maintained depending on the nature of the representations made by a physician, any damages awarded would be limited to the pain and suffering of having to undergo a second procedure and would not extend to the pregnancy itself nor to the expenses incurred in raising and caring for the child.

Another important aspect of the voluntary sterilization question is the necessity of obtaining the patient's spouse's consent. There seems to be a great deal of confusion on this issue, with issues of law, tradition, good practice and plain commonsense thoroughly mixed. So let us be clear about this: there is no legal necessity for obtaining the consent or approval of the spouse of a person who is about to undergo a procedure for sterilization.

None the less, many authors advise that an approval be obtained from the spouse; this is really where the commonsense comes in, and there are obviously ethical considerations that are not within the scope of this article.

The position was well expressed in a 1972 resolution of the CMA General Council, which stated, in part:

> Any procedure for the purpose of producing sterilization of either male or female is acceptable ... if performed with the written permission of the patient and after the patient has signed a statement to the effect that he or she understands that the sterility will in all likelihood be permanent: similar approval of the spouse or guardian, if applicable, should be obtained whenever possible.

A further complication is that the rules of many hospitals require that spouses sign a form agreeing to a procedure of the type we are discussing.

In fact, there has never been a single successful action against a physician for failure to gain the consent of a spouse to a sterilization procedure. However, it behooves us to explore the legal literature. In a somewhat ancient, unreported decision of the Ontario Supreme Court, Mr. Justice Kelly held as follows:

> As the relationship between a husband and wife is not only confidential, but is of the most intimate nature, and is attended upon with such far reaching consequences, I am of the opinion that anything that might be done which would interfere with such a sacred relationship and its consequences should be undertaken only with the consent of both parties and after discussion with the parties and advising them upon the consequences .... It, therefore, follows that any operation performed upon a wife which would interfere with that intimate relationship and its responsibilities and consequences should be authorized or consented to by both spouses.

One must assume that the learned judge would at that time have also required the consent of both spouses to the sterilization of the husband.

Grave potentialities

Another case often referred to is a British divorce action in which the majority referred to "the obviously grave potentialities of such an operation for the parties to a marriage". Indeed, in the dissenting judgement, Lord Justice Denning held that the consent of the spouse is absolutely essential, for "if a husband undergoes an operation for sterilization without just cause or excuse, he strikes at the very root of the marriage relationship."

Even the Canadian supplement to the Hospital Law Manual advises that consent to sterilization be obtained from both spouses since each has an interest in the procreative ability of the other.

Thus, although I am unable to construe even a remote possibility of a successful legal action against a physician who performs a sterilization procedure on his patient with that patient's informed consent where the consent of the patient's spouse was not obtained, there is no harm in gaining the agreement of that spouse if convenient. Such agreement need not go into matters concerning the surgery itself but should be restricted to the intended result — sterilization. Where the patient objects to involving his spouse in a consensual capacity, or where it is impractical to follow this course of action, I would advise that the physician may proceed with the surgery without fear of incurring any legal repercussions so long as the operation is not performed negligently and an informed consent is obtained from his patient.

This advice is, of course, subject to legislation to the contrary. For example, in Virginia, specific legislation controls voluntary sterilization for the purpose of contraception. This state requires both the written consent of the adult patient and his spouse to the procedure and a "cooling off" period of 30 days before the surgery can be performed. But I know of no such legislation in any Canadian province.■

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of the applications of the conventions and this protocol shall be fully acquainted with the contents thereof." This applies to health administrations at all levels of government.

It cannot have fallen to the lot of many physicians to have attended a conference such as this. To have been present, from the opening day on Feb. 20, 1974 until the signing of the Final Act June 10, 1977 was an experience that gave me an education in international law and the workings of diplomacy, the friendship of many people I would not otherwise have met and the satisfaction of having been able to contribute to the slow, patient and occasionally successful task of trying to do a little more for the innocent victims of wars.

Surrounded as we were by men and women who were experts in the art of negotiating and making laws and treaties, the small group of physicians at the conference played its own part. As most of us had military backgrounds we were able, from time to time, to interject a note of reality into the debates and to point out where humanitarian "pie in the sky" had to be forgotten and had to give place to reality, so that what we were seeking to achieve could be effective in practice rather than in theory.

It would not be inappropriate to end with a word of thanks to my professional colleagues for the pleasure and the privilege I had of working with them. Thanks most of all, though, must go to my wife for her understanding in putting up with my long absences in Geneva.

References

1. *Protocol additional to the Geneva conventions of Aug. 12, 1949, relating to the protection of victims of international armed conflicts (Protocol I)*
2. *Protocol additional to the Geneva Conventions of Aug. 12, 1949, relating to the protection of victims of non-international armed conflicts (Protocol II)*
3. *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (First Convention)*
4. *Geneva Convention for the Amelioration of the Condition of Wounded Sick and Shipwrecked Members of Armed Forces at Sea (Second Convention)*
5. *Geneva Convention Relative to the Treatment of Prisoners of War (Third Convention)*
6. *Geneva Convention Relative to the Protection of Civilian Persons in Time of War (Fourth Convention)*
7. *First Convention*, art 49; *Second Convention*, art 50; *Third Convention*, art 129; *Fourth Convention*, art 146
8. INTERNATIONAL COMMITTEE OF THE RED CROSS: Draft additional protocols to the Geneva Conventions Aug. 12, 1949. Commentary. Document CDDH/3. Geneva, October 1973
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