- Araştırma Makalesi -

[H] MEDICAL ETHICS IN INTERNATIONAL HUMANITARIAN LAW[*]

(ULUSLARARASI İNSANCIL HUKUKTA TIBBİ ETİK)

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ABSTRACT

Protecting human life is the common goal of Medical Ethics and International Humanitarian Law (IHL). Within the framework of International Humanitarian Law (IHL), Medical ethics plays an important role in protecting the wounded and sick affected by armed conflicts and providing health services without discrimination. In this study, the obligation to provide health services in armed conflict zones impartially and without discrimination, the prohibition of attacks on patients, wounded and healthcare personnel, the protection of healthcare facilities and the prevention of misuse of healthcare tools by the parties to the conflict, the ethical responsibilities of state and non-state actors in the conflict zone and the problems that arise in practice in conflict zones are discussed.

The problem in today's armed conflicts is not the legal and principled problems in IHL rules and medical ethics, but the problems in their implementation. In fact, it is possible to reduce the problems by providing training to healthcare personnel and parties to the conflict in the conflict zone and by introducing some local regulations regarding their behavior.

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ÖZ

İnsan hayatını korumak, Tıbbi Etik ve Uluslararası İnsancıl Hukuk'un (IHL) ortak amacıdır. Uluslararası İnsancıl Hukuk (IHL) çerçevesinde, tıbbi etik, silahlı çatışmalardan etkilenen yaralı ve hasta bireyleri korumada ve sağlık hizmetlerini ayrımcılık yapmadan sunmada önemli bir rol oynamaktadır. Bu çalışmada, silahlı çatışma bölgelerinde sağlık hizmetlerinin tarafsız ve ayrımcılık yapmadan sağlanması zorunluluğu, hasta, yaralı ve sağlık personeline yönelik saldırıların yasaklanması, sağlık tesislerinin korunması ve sağlık araçlarının çatışma taraflarınca kötüye kullanılmasının engellenmesi, çatışma bölgesindeki devlet ve devlet dışı aktörlerin etik sorumlulukları ve çatışma bölgelerinde uygulamada karşılaşılan sorunlar tartışılmaktadır.

Günümüz silahlı çatışmalarındaki problem, IHL kuralları ve tıbbi etik alanındaki hukuki ve ilkesel sorunlar değil, bunların uygulanmasındaki sorunlardır. Aslında, çatışma bölgesindeki sağlık personeline ve çatışma taraflarına eğitim verilerek ve davranışlarına yönelik bazı yerel düzenlemeler getirilerek bu sorunlar azaltılabilir.

Anahtar Kelimeler: *Cenevre Sözleşmeleri, Sağlık Hizmetleri, Tıbbi Etik, Uluslararası Çatışmalar, Uluslararası İnsancıl Hukuk, Uluslararası İnsan Hakları Hukuku.*

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INTRODUCTION

When the International Red Cross and Red Crescent Movement was founded approximately 150 years ago, its foundation was to provide and maintain adequate health services and to respect and protect the wounded, sick and medical personnel, health facilities and means of transport in armed conflicts, and to address concerns in this regard. The four Geneva Conventions of 1949 and their Additional Protocols of 1977

played an important role in addressing these concerns and in the development of international humanitarian law (IHL).[1]

IHL comes into question during conflict and related situations. Medical ethics is completely different in conflict situations than in peacetime situations. However, healthcare personnel must comply with medical ethics rules in all kinds of medical interventions. The main purpose of IHL is to protect civilians, prisoners of war, wounded and other patients in conflict zones and to provide humanitarian and medical care when needed and to alleviate their suffering. Regardless of the side of the conflict, healthcare personnel must provide care and treatment in accordance with medical ethics and ethics rules.

Health personnel in conflict zones face ethical challenges while performing their duties within the scope of the principle of neutrality. The affiliation of healthcare personnel to any political or military group will make it difficult to fulfill the principle of neutrality.

International Humanitarian Law, including the Conventions (1949) and Additional Protocols (1977), provides comprehensive protections for healthcare personnel and facilities to effectively carry out their duties in conflict zones. In this context, healthcare personnel are immune from attack and healthcare facilities must be respected and protected by all parties to the conflict. These protections are vital for healthcare personnel to be able to carry out their duties without any sense of threat or fear. However, despite these legal protections, healthcare personnel must act within the framework of the principles of non-discrimination, benevolence, impartiality and humanity, observing medical ethical rules. In practice, however, it is observed that these medical ethical rules are restricted by the parties to the conflict.

This study seeks to answer questions such as which medical ethical rules should healthcare personnel follow in conflict zones? What difficulties are encountered when implementing medical ethical rules and what are their solutions? What are the intersections between international humanitarian law and medical ethics?

This article is divided into two sections addressing medical ethics in international humanitarian law (IHL). The first section, Theoretical

[1] Alexander Breitegger, 'The Legal Framework Applicable to Insecurity and Violence Affecting the Delivery of Health Care in Armed Caonflicts and Other Emergencies' (2013) 95(889) International Review of the Red Cross 83-127, 84.

and Legal Foundations of Medical Ethics in IHL, explores key ethical principles like humanity, neutrality, beneficence, non-maleficence, confidentiality, and truth-telling in conflict zones. It also discusses the legal frameworks governing medical ethics, such as the Geneva Conventions and customary IHL principles. The second section, Practical and Contemporary Challenges in Conflict Zones, examines the ethical violations faced in conflict areas, including attacks on medical personnel, denial of care, and breaches of confidentiality, while analyzing the dilemmas medical professionals confront in such settings.

I. THEORETICAL AND LEGAL FOUNDATIONS OF MEDICAL ETHICS IN IHL

A. Principles of Medical Ethics in Armed Conflict

The primary duty of healthcare personnel, in all cases, in war and peace, is to protect and improve the physical and mental health of those who need them. In fulfilling this duty, they must take into account ethical principles such as humanity, impartiality, not harming the patient and telling the truth. These medical ethical principles will be discussed in detail below.

1. Humanity and Neutrality in Medical Practice

Health personnel must display an approach befitting human dignity and free from discrimination while performing their duties; this principle also applies in war and conflict situations. No matter who the patient or injured person is, inhuman, degrading or cruel treatment should not be performed. Behaviors should be carried out within the framework of the principle of humanity.

Humanity is the primary driver of all efforts to prevent and alleviate suffering, wherever it occurs. Its aim is to protect human life and health and to show respect for all. It promotes mutual understanding, friendship, cooperation and lasting peace among all peoples. Humanitarian aid is generally referred to as assistance essential to the survival of civilian populations, including food, shelter, water, medical aid, power/energy and sanitation.[2]

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[2] World Health Organization, A Guidance Document for Medical Teams Responding to Health Emergencies in Armed Conflicts and Other Insecure Environments (World Health Organization 2021) 31 https://www.jstor.org/stable/resrep40717.12 accessed 20 November 2024.

Medical personnel should approach with Medical Neutrality as required by humanitarian and medical ethics. Medical neutrality refers to the principle of non-interference with medical services during conflicts and other humanitarian crises. The concept of medical neutrality is based on legal regulations in international humanitarian law and international human rights law, as well as being influenced by ethical codes such as the Hippocratic Oath.[3] Medical neutrality requires the following three aspects: (1) protection of and non-interference with the operations of medical facilities, medical transport vehicles, and medical personnel; (2) provision of the best possible medical care to all those in need of medical care, including combatants and non-combatants, regardless of political affiliation or conflict party and political participation; and (3) an order for warring parties to both protect and refrain from targeting civilians during conflicts. Numerous non-governmental aid and human rights organizations, United Nations agencies, and states that are signatories to international laws and treaties support and, to varying degrees, implement the principle of medical neutrality. For example, the International Committee of the Red Cross (ICRC) as well as Physicians for Human Rights have made many attempts to define and implement medical neutrality.[4]

Violations of medical neutrality occur, for example, when civilians, medical facilities, and medical personnel are deliberately targeted in conflict. In recent years, the armed forces of several countries have repeatedly and deliberately targeted civilian and medical infrastructure, such as hospitals and ambulances, and have strategically obstructed and disrupted the flow of medical supplies.[5] National militaries now undermine the provision of health care to opposition groups, for example by retaliating against health professionals who treat the sick and wounded in Syria. Access to needy populations, medical facilities, and medical supplies

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[3] F Bouchet-Saulnier et al, The Practical Guide to Humanitarian Law (Médecins Sans Frontières, Rowman & Littlefield Publishers 2013).; LF Roberts and MJ VanRooyen, 'Ensuring Public Health Neutrality' (2013) 368 New England Journal of Medicine 1073–1075.

[4] Lauren Carruth, 'Medical Neutrality' in Antonio De Lauri (ed), Humanitarianism (Brill 2020) 128 https://www.jstor.org/stable/10.1163/j.ctv2gjwwnw.65 accessed 15 September 2024.

[5] SF Hamdy and S Bayoumi, 'Egypt's Popular Uprising and the Stakes of Medical Neutrality' (2016) 40(2) Culture, Medicine, and Psychiatry 223–241.

is sometimes controlled by conflict parties, forcing humanitarian organizations and medical providers to partner with them and channel aid through partisan affiliates.[6] While violations of medical neutrality may rise to the level of war crimes, there are few mechanisms to punish or sanction the actors involved. During times of civil unrest, violations of medical neutrality may violate important human rights treaties such as the International Covenant on Civil and Political Rights and the Convention Against Torture, yet there are few mechanisms through which victims can seek justice.[7]

2. Beneficence and Non-Maleficence

The principle of nonmaleficence is the obligation of healthcare personnel not to harm the patient. This simply stated principle supports several moral precepts—do not kill, do not inflict pain or suffering, do not incapacitate, do not offend, and do not deprive others of the blessings of life. The practical application of nonmaleficence is that the physician weighs the benefits against the burdens of all interventions and treatments, rejects those that are unduly burdensome, and selects the best treatment for the patient.[8] This approach applies not only to patients in peacetime situations but also to patients and beneficiaries in conflict.

Healthcare personnel must act with Beneficence when implementing the principle of non-maleficence. Beneficence is the obligation of healthcare personnel to act in the best interest of the patient and includes a series of moral rules to protect and defend the rights of patients, prevent harm, eliminate conditions that will cause harm, help disabled people and rescue people in danger. The principle of beneficence requires not only not to harm patients, but also to benefit patients, make sacrifices

[6] A Sparrow, 'How UN Humanitarian Aid Has Propped Up Assad: Syria Shows the Need for Reform' Foreign Affairs (20 September 2018).

[7] Carruth, p.129

[8] TL Beauchamp and JF Childress, Principles of Biomedical Ethics (Oxford University Press 2009) 162–164; RA Mularski et al, 'Pain Management within the Palliative and End-of-Life Care Experience in the ICU' (2009) 135(5) Chest 1360–1369.

and promote their well-being.[9] In short, this principle requires medical personnel not to harm the sick and injured, whether in peace or war.

3. Confidentiality and Truth-Telling

Telling the truth is a vital component of a physician-patient relationship; without it, the physician loses the patient's trust. An autonomous patient not only has the right to know (disclose) his diagnosis and prognosis, but also the option to waive this disclosure. However, the physician must know which of these two options the patient prefers.[10] However, in some countries, the patient is informed about certain diseases such as cancer and severe war injuries, while in other countries, if the patient requests it, the patient is informed, otherwise the family is informed. In my opinion, since telling the patient about these chronic diseases will demoralize him/her and cause despair, the patient should not be informed, but if possible, the family should be informed.

Physicians are required not to disclose confidential information provided by a patient to another party without the patient's permission. One clear exception (with the patient's implied permission) is the sharing of medical information necessary for the patient's care from the primary physician to consultants and other health care teams. There are some notable exceptions to patient confidentiality. These include, among others, the legally mandated reporting of gunshot wounds and sexually transmitted infections, and exceptional circumstances that could result in significant harm to another (e.g., infectious disease outbreaks, partner notification of HIV infection, relative notification of certain genetic risks, etc.).[11] However, especially in conflict areas, sharing confidential information about patients and caregivers can lead to serious security problems.

[9] Basil Varkey, 'Principles of Clinical Ethics and Their Application to Practice' (2021) 30 Medical Principles and Practice 17-28, 18 https://pmc.ncbi.nlm.nih.gov/articles/PMC7923912/pdf/mpp-0030-0017.pdf accessed 05 September 2024.

[10] Ibid, p.20.

[11] Ibid.

B. Legal Frameworks Guiding Medical Ethics

The Geneva Conventions and their Additional Protocols are the leading documents that form the legal basis of armed conflicts today. These conventions provide the legal basis for the protection of civilians, medical personnel, health infrastructure and other facilities during armed conflicts. Although customary international humanitarian law has a longer history than the conventions in question, it still maintains its widespread influence today. These two issues will be discussed separately below.

1. Geneva Conventions and Protocols

The international legal framework on armed conflict is often expressed in terms that reflect state's efforts to balance military necessity with humanitarian concerns.[12] Initially, international humanitarian law encompassed the obligations of one state to another. In this context, nationality largely determined whether a person was considered friend, enemy or neutral.[13]

However, the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, 1864 (GC 1864) is one of the first modern international documents on medical care for enemy soldiers.[14] The states that gathered in Geneva under the leadership of the ICRC came together in part out of their own self-interest: they wanted their wounded or sick soldiers to be treated humanely. As a condition for taking the radical step of providing medical care to the enemy, states wanted to maintain control over the terms and conditions of such care.[15]

[12] Michael N Schmitt, 'Military Necessity and Humanity in International Humanitarian Law: Preserving the Delicate Balance' (2010) 50 Virginia Journal of International Law 795.

[13] Dustin A Lewis, Naz K Modirzadeh and Gabriella Blum, Medical Care in Armed Conflict: International Humanitarian Law and State Responses to Terrorism (Harvard Law School Program on International Law and Armed Conflict (HLS PILAC), September 2015) 38.

[14] Convention for the Amelioration of the Wounded in Armies in the Field, 22 August 1864, 22 Stat 940 (GC1864).

[15] Lewis, Modirzadeh, and Blum, p.39.

33 articles of the *Convention for the Amelioration of the Condition of the Wounded and Sick in Warfare (GC 1906)*, signed at Geneva on 6 July 1906, replaced ten articles of GC 1864 in relations between the parties. GC 1906 extended its scope of application to include, in addition to combatants, persons officially attached to armies who were wounded or sick.[16]

Also in 1929, States adopted two additional conventions concerning medical care in armed conflict: the *Geneva Convention for the Amelioration of the Wounded and Sick in Armies in the Field*, 27 July 1929 (GC W&S1929). The GC W&S 1929 convention recognized the protection of medical aircraft and the use of the red crescent and the red lion and sun emblems. States also signed the *Geneva Convention Relative to the Treatment of Prisoners of War*, 27 July 1929 (GC POW 1929) concerning the treatment of prisoners of war. This convention stipulated that "each camp shall posses an infirmary, where prisoners of war shall receive attention of any kind of which they may be in need".[17]

Finally, after the Second World War, the said agreements were deemed insufficient and four agreements were signed under the title of "The Geneva Conventions of 1949" in 1949. In addition, two Additional Protocol agreements were signed in 1977 and 2005.

The Geneva Conventions and Protocols are applicable to armed conflict and deal with respect for the wounded, sick, prisoners of war and civilian victims. The First Convention covers the principle of respect and care for wounded and sick members of the armed forces without discrimination. The same applies to military ambulances, hospitals and all medical personnel displaying the Red Cross or Red Crescent symbol. The Second Convention deals with related matters at sea and the Third Convention defines the status of prisoners of war. The Fourth Convention deals with the protection of civilians in time of war and deals particularly with the status of civilians in the power of a belligerent country, in the territory of an enemy state or in any occupied territory. Since the Fourth Convention deals primarily with war between two or more countries and does not specifically cover internal or intra-national conflicts, two additional protocols, Protocols I and II, were adopted in 1977, which deal with the protection of victims in international and non-international

[16] Ibid, p.40.

[17] Ibid, p.43.

conflicts. It is noteworthy that the preambles to Protocols I and II contain numerous references to the UN Charter and the purposes of the UN.[18]

The First Convention and Protocol I specify that all parties, especially health service personnel, are responsible for the treatment of war victims without discrimination. This responsibility extends to sick and wounded soldiers of all parties and to civilian victims. Parties have special responsibilities towards vulnerable civilians, such as pregnant women, children and the elderly. The only exception to this general rule is made in Article 14, where an occupying power has a limited right to prioritize civilian medical resources for its armed forces. It must then assume responsibility for meeting the medical needs of the civilian population.[19]

2. Customary International Humanitarian Law (IHL)

Customary law includes rules of international law that derive from and reflect a general practice accepted as law.[20] There is no universally accepted quantitative formula or mathematical equation for accepting a rule as customary international law. However, in general, a decision of the International Court of Justice must reflect (1) sufficiently uniform, comprehensive and representative State practice, together with (2) sufficiently substantial evidence that such practice was carried out in accordance with a legitimate belief (so-called opinio juris sive necessitatis or opinio juris) in order to establish a customary rule.[21]

Clarifying the scope of customary IHL may be particularly important for wartime medical care for three reasons. First, in principle, customary IHL can fill gaps in the lex scripta between States parties to the

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[18] Vidar Lehmann, 'United Nations Peacekeeping: Medical Personnel and International Humanitarian Law' (1996) 12(4) Medicine, Conflict and Survival 315-324 (316–317).

[19] Ibid, p. 317.

[20] Michael Wood, Special Rapporteur, 'Second Report on Identification of Customary International Law' (International Law Commission, 66th Session, U.N. doc. A/CN.4/672, 22 May 2014) para 20.

[21] North Sea Continental Shelf (West Germany v Denmark and the Netherlands) (Merits) [1969] ICJ Rep 3, 42–46; Olufemi Elias, 'Persistent Objector' in Max Planck Encyclopedia of Public International Law (online edn, September 2006).

relevant Additional Protocols and non-contracting States. In this way, customary IHL has the potential to help address the lack of universal ratification of AP I and AP II. Second, in principle, customary IHL can help fill gaps in the lex scripta between medical care measures for IAC and medical care measures for NIAC. And third, in principle, customary IHL can bind parties to rules and principles even if States have not codified these protections in treaties. Medical care is one of the most tightly regulated aspects of the lex scripta. However, this does not preclude the possibility that additional binding medical care rules of international law may emerge outside these treaties. This type of traditional IHL construction may be most useful in this context in terms of internationally recognized legal protections for wartime medical care to which states have not (yet) signed up in international agreements.[22]

II. PRACTICAL AND CONTEMPORARY CHALLENGES IN CONFLICT ZONES

A. The Role of Medical Professionals in Conflict Zones

Medical personnel are expected to comply with the rules and use the tools provided for in the Geneva Conventions and Protocols, even if their provisions are not included in the national law of their country. Violations subject medical personnel to criminal sanctions under IHL. A thorough knowledge of IHL is therefore essential. Medical personnel may quite unexpectedly encounter situations where their duties and rights under these laws are questioned. The difficulties most often arise from warring parties, but conflicts can also arise within a UN mission. For example, failure to provide adequate care to a sick or injured person may constitute a violation. Another example is the duty to regularly report on the health status of patients to their relatives and to ensure that information from their relatives is passed on to the patient. Some UN medical personnel are forced to provide emergency intervention and minor daily consultations to UN soldiers, rather than treating serious emergencies among civilians who are victims of armed conflict or suffering due to the collapse of civilian health infrastructure.[23]

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[22] Lewis, Modirzadeh, and Blum, p.58.

[23] Lehmann, P.318.

The general rule is that medical personnel serving in armed conflict must comply with the principles of medical ethics, just as in peacetime. Failure to comply with this rule opens the door to a violation of IHL and imposes a heavy burden not only on medical personnel but also on their military commanders. Medical personnel who engage in abuse or who fail to comply with IHL are punished, and States parties to the Geneva Conventions are obliged to put an end to violations. Serious violations, such as participation in cruel acts, torture or the malicious use of the Red Crescent or the Red Crescent emblem, will be considered war crimes and will be treated accordingly. Violations of the Conventions not only endanger the health and lives of war victims, but also jeopardize the entire system of protection provided by IHL. IHL provides a minimum but vital level of protection in which parties must have some confidence.[24]

B.Violations of Medical Ethics in Armed Conflict

1. Attacks on Healthcare Facilities and Personnel

The obligations implied by the duty to respect and protect medical personnel, units and transport vehicles are not expressly enumerated in the lex scripta. However, these obligations have been interpreted to mean, at least, that medical personnel, units and transport vehicles, both in IACs and NIACs, must not be deliberately attacked, fired upon or unnecessarily obstructed in the performance of their duties. In general, these protections do not cease until medical personnel are engaged in acts harmful to the enemy or medical units and transport vehicles are engaged in acts outside their humanitarian mission or duties. Even then, this protection of medical units and transport vehicles does not cease until warning has been given, where appropriate within a reasonable time limit, and that warning has not been heeded.[25]

In conflicts, the protection of health institutions and personnel is one of the top priorities. However, in practice, violence and attacks against health personnel are common in conflicts. Very disturbing incidents such as attacks on hospitals, the killing of vaccination teams or the detonation of an ambulance full of explosives have occurred. In summary,

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[24] Ibid, p. 319.

[25] Lewis, Modirzadeh, and Blum, p.84-85.

attacks against health personnel, vehicles and facilities can be considered the most serious attacks. Examples of such attacks can be seen widely in Afghanistan, Somalia, Syria, Congo and Palestine. Medical ethics and rules in the battlefields have been violated in the conflicts that have been going on for decades in these countries.

The First Congo War (1996–1997), which destroyed Rwandan refugee camps in the Congo, began on October 6 when soldiers entered the Lemara hospital in South Kivu and killed more than 30 patients and hospital staff. In Somalia, the looting of several major aid facilities in 2011 drastically reduced health services during a period of food shortages in the south and central regions, and increased the number of vaccine-preventable diseases that compounded the devastating effects of malnutrition. And in Afghanistan, there have been several instances of treason, including the use of an ambulance in a suicide attack on a police training academy on the outskirts of Kandahar in April 2011. When staff at a hospital in Afghanistan's northern Baghlan Province were ordered not to treat opposition fighters or their families, rebels kidnapped a doctor to treat their wounded.[26]

Additionally, Afghan health workers seen as collaborating with foreign troops or the government have been threatened or punished. Local medical personnel have refused to help the U.S. Marines restore health services to the region, saying it involves too many risks. "To get here I was stopped three times by the Taliban who asked me where I was going, if I was working for the Americans. It's too dangerous"[27] one doctor said.

In Congo in October 2009, government forces attacked seven vaccination points in the Masisi district, where families of rebel fighters from the Forces démocratiques de libération du Rwanda (Democratic Forces for the Liberation of Rwanda) were queuing for measles vaccinations. Members of the Médecins sans Frontières (Doctors Without Bor-

[26] Fiona Terry, 'Violence against Health Care: Insights from Afghanistan, Somalia, and the Democratic Republic of the Congo' (2013) 95(889) International Review of the Red Cross 23-39 (28–29).

[27] Karim Talbi, 'Uphill Task for US Marines on Afghan Healthcare' (AFP, 24 March 2010) https://www.afghanistannewscenter.com/news/2010/march/mar252010.html#23 accessed 06 October 2024.

ders, MSF) team that organised the campaign and received security 'guarantees' from all sides felt they had been used as bait.[28]

In Somalia, health facilities have been misused and destroyed for military purposes. Human Rights Watch (HRW) alleged that during the Ethiopian invasion of Mogadishu in 2007, three hospitals in the city were deliberately damaged, suggesting that this was because the Ethiopians were suspicious of the facilities treating insurgents.[29] As can be seen here, Ethiopian soldiers did not respect these health facilities, which they are obliged to do under IHL, nor did they prevent them from being looted by others.[30]

In all three countries given as examples, healthcare personnel were threatened, subjected to violence, and their duties were obstructed in violation of medical ethics and the provisions of medical ethics while performing their duties, and healthcare facilities were attacked, occupied and turned into shelters.

2. Denial of Access to Medical Aid

The Geneva Conventions and Protocols require all parties to respect medical personnel and ensure that they have free access to places where their services are required. This applies to medical personnel, the delivery of medical supplies and access for medical transport. When medical personnel and their transport vehicles comply with the formal requirements of IHL, including the use of the Red Cross or Red Crescent emblem, it is the duty of parties to the conflict to allow them access to places where their services are required and to provide them with any assistance they may require to carry out their duties. This provision includes the duty of parties to refrain from reprisals against medical personnel. Medical personnel must also refrain from all hostile acts. They must refrain from using weapons other than small arms in self-defense and their patients. This is limited to situations where a hostile party deli-

[28] 'DR Congo: MSF Vaccination Used as Bait in Unacceptable Attack on Civilians' (MSF press release, 6 November 2009) https://www.doctorswithoutborders.org/press/release.cfm?id=4055&cat=pressrelease accessed 01 September 2024.

[29] Human Rights Watch (HRW), Shell-Shocked: Civilians under Siege in Mogadishu (HRW, New York, August 2007) 51–57.

[30] Terry, p.30.

berately seeks to kill the wounded, patients or medical personnel involved.[31]

CONCLUSION

In international armed conflicts, medical law must be followed before international rules on health. In this context, while providing impartial health services, violence must not be resorted to, health facilities must be protected and health personnel must be respected. In addition, both the parties to the conflict and health personnel must fulfill their obligations to provide care and protect the wounded and sick within the scope of the right to health. In accordance with medical ethics and law, the parties to the conflict must take the necessary measures so that health personnel can work safely and without fear. These measures will also provide assurance that health services are not interrupted.

Considering the difficulties in implementing the principles of medical ethics such as humanity, impartiality, benevolence and telling the truth, we see that these principles are not fully implemented in conflict areas. The failure to implement these ethical rules also means that the legal regulations related to the conflict are not complied with. Therefore, medical ethics and international legal regulations are not sufficient and local legislation on conflicts must also be strengthened. In particular, attacks, threats and other violent interventions against health personnel during and in the conflict area should be subject to local penal sanctions. In addition, the obligation of health personnel to report confidential information that would endanger the lives and freedoms of injured and sick people to local authorities should be limited. Necessary measures should be taken to prevent incidents such as the misuse of an ambulance as a means of attack in Afghanistan. In addition, the necessary permission mechanism should be established to prevent the misuse of emblems.

It is also critical that health personnel be impartial and comply with the principles of confidentiality and the protection of personal data, and respect medical ethics. In order to achieve these goals, health personnel should be provided with the necessary training and information on medical ethics and the international legal framework.

[31] Lehmann, p. 318.

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