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When caregivers become victims: Towards recognizing psychological harm under the obligation to respect and protect medical personnel in armed conflict

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Abstract

Medical personnel operate on the front lines of armed conflict, addressing its profound physical and psychological impact by providing care to the wounded and sick. At the same time, they themselves experience psychological harm, whether directly from acts of violence or indirectly from the demands of their work during armed conflict. In recognition of their vital role, international humanitarian law (IHL) grants them special protection, requiring that they be respected and protected in all circumstances. This article advances, de lege ferenda*, that the obligation to respect and protect medical personnel should be interpreted to encompass protection against both direct and incidental psychological harm. Such an interpretation is warranted on several grounds: first, it reflects the growing recognition in IHL of the "person" in a broader sense; second, it follows from the broad formulation of the obligation to respect and protect; and finally, it aligns with IHL's object and purpose of alleviating suffering in armed conflict.*

Keywords: medical personnel, obligation to respect and protect, direct and incidental psychological harm, non/international armed conflict.

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Introduction

Armed conflicts expose populations to prolonged and repeated violence, leaving deep and lasting psychological wounds that may even continue into future generations.[1] Medical personnel play a vital role in alleviating this suffering by providing care and treatment to wounded soldiers and affected populations,[2] but they often face significant mental health challenges themselves while performing their duties in conflict settings.[3] The psychological well-being of medical personnel is fundamental for delivering high-quality care, especially during protracted armed conflicts.

In recognition of their essential role in the care and treatment of the wounded and sick, medical personnel are granted special protection under

1 Statistics from the World Health Organization (WHO) show that 22% of individuals who have experienced armed conflict in the previous ten years suffer from depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder or schizophrenia. WHO, "Mental Health in Emergencies", 6 May 2025, available at: www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies (all internet references were accessed in May 2026); Delan Devakumar, Marion Birch, David Osrin, Egbert Sondorp and Jonathan C. K. Wells, "The Intergenerational Effects of War on the Health of Children", *BMC Medicine*, Vol. 12, No. 57, 2014, p. 8; Jaime Moreno-Chaparro *et al.*, "Mental Health Consequences of Armed Conflicts in Adults: An Overview", *Actas Espanolas de Psiquiatria*, Vol. 50, No. 2, 2022, p. 81.

2 Yash Sailesh Kumar and Jasmine Shanti Kamath, "Healthcare Workers on the Frontlines of War: Essential Roles and Responsibilities", *American Journal of Medicine Open*, Vol. 11, 2024, p. 1.

3 33rd International Conference of the Red Cross and Red Crescent (International Conference), *Addressing Mental Health and Psychosocial Needs of People Affected by Armed Conflicts, Natural Disasters and Other Emergencies: Background Document*, 33IC/19/12.2, Geneva, June 2019, p. 6.

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international humanitarian law (IHL);[4] in particular, they are to be respected and protected from attack and violence in all circumstances.[5] Despite this protection, armed conflicts have witnessed a rise in attacks on health care and medical personnel.[6] In recent decades, numerous initiatives have been undertaken to document attacks on health care and raise awareness about their consequences:[7] in 2016, for example, the United Nations (UN) Security Council adopted Resolution 2286 on the protection of health care in situations of armed conflict, condemning the growing violence, attacks and threats against medical personnel and recognizing the long-term consequences that such acts can have on the civilian population and the health-care systems of the countries concerned.[8] Such initiatives, however, have not stopped the attacks on health care that continue to dominate contemporary armed conflicts. In 2024 alone, more than 900 attacks on health-care facilities were documented across multiple conflict-affected countries, resulting in over 870 deaths and more than 770 persons injured among health-care workers.[9]

Beyond this physical harm, medical personnel in armed conflict are often subjected to intense psychological strain, which can even outweigh the physical.[10]

4 For the purposes of this article, the term "medical personnel" is understood in accordance with Article 8(c) of Additional Protocol I (AP I) because these persons are subject to the special protection regime reflected in the obligation to respect and protect. Article 8(c) of AP I defines medical personnel as

> 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 [Geneva] 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.

Health-care personnel who are not assigned by a party to the conflict exclusively to medical duties – if they are civilians – continue to enjoy protection as civilians. Protocol Additional (I) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1979) (AP I).

5 Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1: *Rules*, Cambridge University Press, Cambridge, 2005 (ICRC Customary Law Study), Rule 25, available at: https://ihl-databases.icrc.org/en/customary-ihl/rules.

6 British Medical Association, *Medicine Under Attack: The Increasing Assault on Healthcare in Conflict Zones*, London, 22 July 2025; 33rd International Conference, Res. 33IC/19/R2, "Resolution Addressing Mental Health and Psychosocial Needs of People Affected by Armed Conflicts, Natural Disasters and Other Emergencies", 9–12 December 2019.

7 International Committee of the Red Cross (ICRC), *Health Care in Danger: Making the Case*, 2026, available at: www.icrc.org/en/publication/4072-health-care-danger-making-case; Insecurity Insight, "Attacks on Health Care", available at: https://insecurityinsight.org/projects/healthcare; Médecins Sans Frontières, "Medical Care Under Fire", 21 May 2013, available at: www.msf.org/medical-care-under-fire; WHO, "Stopping Attacks on Health Care", available at: www.who.int/activities/stopping-attacks-on-health-care.

8 UNSC Res. 2286, 3 May 2016, para. 1.

9 *Report of the Secretary-General on the Protection of Civilians in Armed Conflict*, UN Doc. S/2025/271, 15 May 2025, para. 19. The report relies on figures from Insecurity Insight covering twenty conflict-affected countries, including Lebanon, the Occupied Palestinian Territory, Ukraine, Sudan, the Democratic Republic of the Congo, the Syrian Arab Republic and Yemen. Insecurity Insight, above note 7.

10 Aula Abbara *et al.*, "'Actually, the Psychological Wounds Are More Difficult than Physical Injuries': A Qualitative Analysis of the Impacts of Attacks on Health on the Personal and Professional Lives of Health Workers in the Syrian Conflict", *Conflict and Health*, Vol. 17, 2023, p. 5.

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They work continuously under highly stressful and dangerous conditions and are regularly exposed to traumatic events while providing life-saving care to affected patients, often amid shortages of trained personnel and inadequate resources.[11] Their psychological distress is further compounded by the direct violence to which they are subjected, the proximity of attacks and the suffering they witness among patients, colleagues and the broader community.

The potential legal protection offered by IHL against these psychological health consequences for medical personnel remains largely unexplored in legal scholarship. Instead, existing analyses focus on the physical consequences of attacks on health-care facilities and medical personnel.[12] By contrast, the extent to which medical personnel are protected against direct psychological harm – such as that resulting from violence and threats – and incidental psychological harm – arising from the conditions in which medical personnel operate – has received only limited attention.[13] This article addresses this gap by examining whether IHL's special protection regime, which obliges conflict parties to "respect and protect" medical personnel, could provide protection against both direct and indirect forms of psychological harm.

For the purposes of this article, "direct psychological harm" refers to psychological harm resulting from intentional acts such as violence, threats or intimidation specifically directed at medical personnel. "Incidental psychological harm" refers to psychological harm caused without any prior intention to target the individual, including so-called "vicarious trauma", which arises from exposure to the traumatic experiences of others or from the inherent stresses of performing duties in armed conflict.[14]

11 33rd International Conference, above note 3, p. 6.

12 See e.g. Anna-Christina Schmidl and Eitan Diamond, "The Systematic Destruction of Healthcare in Gaza", *Opinio Juris*, 11 July 2025, available at: https://opiniojuris.org/2025/07/11/the-systematic-destruction-of-healthcare-in-gaza/; Emma J. Breeze, "Healthcare in Conflict: Legally Protected, Physically at Risk", in John Tingle, Caterina Milo, Gladys Msiska and Ross Millar (eds), *Research Handbook on Patient Safety and the Law*, Edgar Elgar, Cheltenham, 2023; Laurent Gisel, "Can the Incidental Killing of Military Doctors Never Be Excessive?", *International Review of the Red Cross*, Vol. 95, No. 889, 2013.

13 See Alexander Breitegger, "The Legal Framework Applicable to Insecurity and Violence Affecting the Delivery of Health Care in Armed Conflicts and Other Emergencies", *International Review of the Red Cross*, Vol. 95, No. 889, 2013, giving a broad overview of the legal protection of health-care personnel during armed conflict, but not specifically discussing their protection against psychological harm. See also Amrei Müller, "States' Obligations to Mitigate the Direct and Indirect Health Consequences of Non-International Armed Conflicts: Complementarity of IHL and the Right to Health", *International Review of the Red Cross*, Vol. 95, No. 889, 2013, focusing on the IHL legal framework regarding the indirect consequences of armed conflict on health care, but leaving out any discussion on indirect "psychological" harm. At the same time, the psychological effects of armed conflict on medical personnel are well established in the social sciences literature, but this scholarship does not engage with the applicable IHL framework. See, for instance, A. Abbara *et al.*, above note 10; Natalya Kostandova *et al.*, "'It's Normal to Be Afraid': Attacks on Healthcare in Ouaka, Haute-Kotto and Vakaga Prefectures of the Central African Republic, 2016–2020", *Conflict and Health*, Vol. 18, 2024; Shatha Elnakib *et al.*, "Providing Care Under Extreme Adversity: The Impact of the Yemen Conflict on the Personal and Professional Lives of Health Workers", *Social Science and Medicine*, Vol. 272, 2021.

14 See, for instance, Dan Even, Gregory H. Cohen, Ruochen Wang and Sandro Galea, "The Cumulative Contribution of Direct and Indirect Traumas to the Production of PTSD", *PLoS One*, Vol. 19, No. 8, 2024, p. 2.

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The article advances, as a *de lege ferenda* proposal, that the obligation to respect and protect medical personnel should be interpreted to encompass protection against both direct and incidental psychological harm. This interpretation is supported on several grounds. First, it reflects IHL's growing recognition of the "person" in a broader sense, a development that has also gradually found its way into the legal framework applicable to medical personnel. Second, it follows from the broad formulation of the obligation to respect and protect. Finally, it aligns with IHL's object and purpose of alleviating suffering in armed conflict.

The article first examines the manifestations of psychological harm and the circumstances in which such harm arises among medical personnel in armed conflict. It then discusses the special protection regime applicable to medical personnel. The article subsequently considers the evolving interpretation within IHL of the "person" in a broader sense, before analyzing the extent to which the obligation to respect and protect may encompass protection against both direct and incidental psychological harm.

Psychological harm experienced by medical personnel in armed conflict: Lessons from practice

Attacks on health care have a profound impact on the personal and professional lives of medical personnel, the communities they serve and even the country as a whole.[15] Health systems are weakened or disrupted, infectious diseases may re-emerge, and public trust in health care can decline, affecting individuals' willingness to seek medical attention.[16] In 2025, the World Health Organization (WHO) documented over 1,300 attacks on health care, with more than 600 of them having specifically impacted medical personnel.[17] Such attacks have consequences that go beyond physical damage and loss of life, causing medical personnel to suffer psychological harm.

In particular, medical personnel frequently suffer from post-traumatic stress disorder (PTSD), with some continuing to exhibit symptoms several years

15 "Attacks on health care" should be understood in accordance with the definition provided by WHO, namely "any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative or preventive health services during emergencies": WHO, above note 7. This definition is thus broader than the notion of "attack" under Article 49(1) of AP I.

16 Mohamad Katoud, "From Syria to Gaza: The Dangerous Normalisation of Attacks on Healthcare", *Global Responsibility to Protect*, Vol. 17, No. 2–3, 2025, p. 247.

17 WHO, "Surveillance System for Attacks on Health Care (SSA)", 2017, available at: https://extranet.who.int/ssa/LeftMenu/Index.aspx. See also World Health Assembly, Res. 65.20, 26 May 2012, on WHO's response and role as the health cluster lead in meeting the growing demands of health in humanitarian emergencies, giving WHO the mandate to collect and disseminate information on attacks on health care. The system makes a distinction between different types of attacks that can specifically affect personnel, including "psychological violence/threat of violence/intimidation", "sexual assault", "criminalization of health care", "obstruction of health care delivery", "armed or violent search of health care personnel", "violence with heavy weapons", "violence with individual weapons", "assault without weapons" and "setting fire".

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later.[18] In addition, exposure to violence has been shown to significantly increase the likelihood of anxiety and depression.[19] A scientific study examining the impact of the 2023 civil war on medical personnel in Sudan found that over half of such personnel exhibited symptoms of anxiety, while 33% experienced depression.[20] Similarly, between 2023 and 2025, alarmingly high levels of psychological health consequences were reported among medical personnel in Gaza, with 84.6% experiencing moderate to severe anxiety, 76.8% reporting stress and 73.3% suffering from depression.[21] These mental health effects have important implications for health-care delivery, as they may impair clinical performance and increase the risk of medical errors.[22]

Mental health consequences are further intensified by the stigma surrounding psychological harm. For instance, medical personnel in Syria reported feeling hesitant or embarrassed in disclosing symptoms of psychological distress and seeking psychological support.[23] Such reluctance often occurs alongside a shortage of available psychological support services, further restricting access to adequate care. Having outlined the psychological distress symptoms experienced by medical personnel, the following sections explore the acts and circumstances that give rise to them.

Direct psychological harm resulting from intentional acts

Medical personnel working in armed conflict face heightened risks of deliberate attacks and targeted violence.[24] Their elevated vulnerability stems from the nature of their work. They manage valuable resources, such as medicines and transportation, and are exposed to potential attacks while travelling to deliver supplies or conduct outreach activities. In some cases, medical personnel are killed as a direct result of air strikes on hospitals while treating patients, or they are deliberately targeted

18 Mohamed Fakhry Hussein *et al.*, "Assessment of Post-Traumatic Stress Disorder and Well-Being among Sudanese during Ongoing War: A Cross-Sectional Study", *BMC Psychology*, Vol. 13, No. 181, 2025, p. 10; Nasser Ibrahim Abu-El-Noor *et al.*, "Post-Traumatic Stress Disorder among Health Care Providers Two Years Following the Israeli Attacks against Gaza Strip in August 2014: Another Call for Policy Intervention", *Archives of Psychiatric Nursing*, Vol. 32, No. 2, 2018, p. 192.

19 Bernardo Carpiniello, "The Mental Health Cost of Armed Conflicts – a Review of Systematic Reviews Conducted on Refugees, Asylum Seekers and People Living in War Zones", *International Journal of Environmental Research and Public Health*, Vol. 20, No. 4, 2023, p. 11.

20 Muhannad Bushra Masaad Ahmed, Ahmed Balla M. Ahmed, Maad Ahmed Mahjoub Nasor and Sohaib Mohammed Mokhtar Ahmed, "Depression, Anxiety, and Coping Mechanisms among Sudanese Healthcare Workers amid the 2023 Sudan Conflict: A Cross-Sectional Study", *BMC Psychology*, Vol. 13, 2025, p. 5.

21 Ahmed Hisham Alhaj, Mohammed Jaser Afana and Hassan M. Abu Rhama, "Psychological Distress among Healthcare Providers during the 2023–2025 Israel Gaza Conflict", *American Journal of Applied Psychology*, Vol. 14, No. 2, 2025, p. 67.

22 *Ibid.*, p. 67; S. Elnakib *et al.*, above note 13, p. 8; Shoaib Naeemi *et al.*, "Psychological Distress among Healthcare Workers in Kabul Following the 2021 Transition", *Conflict and Health*, Vol. 19, No. 59, 2025, p. 2; Stefan De Hert, "Burnout in Healthcare Workers: Prevalence, Impact and Preventative Strategies", *Local and Regional Anesthesia*, Vol. 13, 2020, pp. 171, 179.

23 A. Abbara *et al.*, above note 10, pp. 5, 7.

24 According to reports published by human rights organizations.

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through physical violence, killings, sexual violence and/or torture, resulting in severe psychological harm.[25]

Furthermore, medical personnel report fear of arrest, as the provision of medical care to opponents of the government or certain armed groups is often criminalized.[26] In addition to facing arrest, they risk having their medical licenses revoked or being dismissed from their positions.[27] In some instances, their family members are targeted, kidnapped or arrested in an effort to coerce them into ceasing the treatment of individuals from the opposing side or prioritizing care of their own armed forces.[28] The constant fear of being arrested or detained not only affects their mental well-being but can also influence their decision-making and ability to perform their functions.[29]

In addition, medical personnel are frequently subjected to physical and verbal threats against themselves or their family members, as well as harassment, contributing to high levels of burn-out and emotional exhaustion.[30] For instance, it has been reported that ambulance drivers and physicians conducting home visits are obstructed at checkpoints, preventing them from reaching their patients.[31] In certain cases, harassment even extends to the homes of medical personnel, which are subjected to raids, shelling or gunfire, forcing many to flee temporarily or permanently.[32]

Incidental psychological harm resulting from the broader context of the armed conflict

Medical personnel also suffer from psychological harm as a result of having to perform their duties in armed conflict. For instance, many report fearing for their own lives and those of their family members when missile strikes occur in the vicinity of hospitals or their homes, leading some to live under constant fear, stress and anxiety.[33] In certain situations, medical staff have been forced to abandon health-care

25 Megan Tatum, "Escalating Threats to Health Workers in Myanmar", *The Lancet*, Vol. 399, 2022, p. 619; Rohini J. Haar *et al.*, "'I Will Take Part in the Revolution with Our People': A Qualitative Study of Healthcare Workers' Experiences of Violence and Resistance after the 2021 Myanmar Coup d'État", *Conflict and Health*, Vol. 18, No. 1, 2024, pp. 2, 6.

26 *Assault on Medical Care in Syria: Report of the Independent International Commission on the Syrian Arab Republic*, UN Doc. A/HRC/24/CRP.2, 13 September 2013, para. 21. It can already be mentioned here that criminalizing the provision of medical care to members of a non-State organized armed group contravenes the obligation to respect and protect. The scope of this obligation will be discussed more extensively in the next sections.

27 R. J. Haar *et al.*, above note 25, pp. 2–3.

28 N. Kostandova *et al.*, above note 13, p. 7.

29 Muna Abed Alah, "Echoes of Conflict: the Enduring Mental Health Struggle of Gaza's Healthcare Workers", *Conflict and Health*, Vol. 18, 2024, p. 3.

30 *Ibid.*, p. 3.

31 Ludvig Foghammar *et al.*, "Challenges in Researching Violence Affecting Health Services Delivery in Complex Security Environments", *Social Science and Medicine*, Vol. 162, 2016, p. 219.

32 S. Elnakib *et al.*, above note 13, p. 5.

33 A. Abbara *et al.*, above note 10, pp. 6–8.

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facilities under attack, leaving patients behind to save their own lives; such circumstances can result in profound feelings of guilt. The use of "double-tap attacks", where an initial strike is followed by another minutes or hours later, may further intensify psychological trauma.[34] These tactics subject medical personnel to anticipatory stress, helplessness, and fear of renewed attacks, while they are required to work rapidly to evacuate patients in order to prevent additional casualties.[35] In armed conflicts where chemical weapons are used, stress can be further intensified, as medical personnel must treat patients exposed to chemical agents without adequate protective equipment, increasing both their physical risk and psychological strain.[36]

Moreover, stress symptoms are often exacerbated by the scarcity of medical personnel. While many remain in their posts out of a sense of professionalism, previous research suggests that for some, the psychological burden may become overwhelming, prompting them to resign and seek employment in more stable areas.[37] Those who remain frequently report feelings of helplessness due to the number of patients they are unable to care for.[38] Excessive workloads and resource shortages may contribute to burn-out, anxiety and depression as well as an increased risk of professional errors.[39]

A related aspect is the psychological distress that medical personnel may experience when facing ethical dilemmas. Seizures and destruction of health-care facilities, imposition of blockades and destruction of medical equipment prevent medical personnel from ensuring proper triage and providing adequate care for patients.[40] Moreover, the scarcity of medical equipment forces them to make extremely difficult decisions, providing care only to those most in need, while others must go without.[41] Sometimes, the situation becomes so dire that physicians have to perform life-saving surgeries without anaesthesia, causing them to suffer from feelings of helplessness and secondary traumatic stress.[42] On top of that, medical personnel frequently have to convey bad news to family members, such as informing them of the lack of resources necessary to treat their loved ones, which can be a highly distressing task.

Medical personnel are also susceptible to trauma arising from continuous exposure to their patients' suffering. In armed conflict, fear for personal safety

34 *Report of the Independent International Commission Inquiry on the Syrian Arab Republic*, UN Doc. A/HRC/34/64, 2 February 2017, para. 43 fn. 4.

35 A. Abbara *et al.*, above note 10, pp. 6–8.

36 Katerine H. A. Footer, Emily Clouse, Diana Rayes, Zaher Sahloul and Leonard S. Rubenstein, "Qualitative Accounts from Syrian Health Professionals Regarding Violations of the Right to Health, Including the Use of Chemical Weapons, in Opposition-Held Syria", *BMJ Open*, Vol. 8, No. 8, 2018, p. 7.

37 N. Kostandova *et al.*, above note 13, p. 8.

38 K. H. A. Footer *et al.*, above note 36, p. 6.

39 N. Kostandova *et al.*, above note 13, p. 8.

40 R. J. Haar *et al.*, above note 25, pp. 5, 7. "Triage" is defined as the process of determining the order of treatment of patients or casualties.

41 N. Kostandova *et al.*, above note 13, p. 7.

42 M. Abed Alah, above note 29, p. 2.

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leads individuals to delay seeking medical care, allowing easily treatable conditions to develop into complicated or untreatable cases.[43] Furthermore, medical personnel understandably experience immense psychological trauma and grief when witnessing the suffering of their colleagues.[44]

In light of the severity and pervasiveness of the psychological harm experienced by medical personnel, as well as its potential impact on their ability to perform their functions, the question arises as to whether IHL affords protection against such harm. This article argues that it should, and proposes that the special protection regime reflected in the obligation to respect and protect medical personnel provides the appropriate legal framework for achieving such protection.

The special protection of medical personnel under IHL

IHL serves to limit the suffering inherent in armed conflict and to protect those who are not, or are no longer, taking part in hostilities. The protection of the wounded and sick has been one of IHL's core principles since its early development, as first codified in the 1864 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field.[45] This protection was subsequently expanded to also cover the care of the wounded and sick at sea, as well as that of wounded and sick civilians.[46] It is now an established rule of customary international

43 Babiker Rahamtalla *et al.*, "The Impact of Ongoing Armed Conflict on Sudan's Healthcare System: Narrative Review", *Discover Health Systems*, Vol. 4, No. 49, 2025.

44 M. Abed Alah, above note 29, pp. 2–3.

45 This protection dates back to the 1859 Battle of Solferino, where the Swiss businessman Henry Dunant, shocked by the appalling conditions of the wounded on the battlefield, proposed the idea of adopting an international convention to protect the wounded and sick during armed conflict. This resulted in the Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, which was the first convention to incorporate the obligation to care for wounded and sick combatants. In addition to the proposal to adopt an international convention to protect the wounded and sick, Dunant also advocated for the establishment of a relief organization, which materialized in 1863 with the founding of the International Committee for the Relief of the Wounded, the predecessor of the ICRC. See Henry Dunant, *Un Souvenir de Solferino*, 1862; Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, 22 August 1864 (entered into force 22 June 1865) (1864 Geneva Convention), Art. 6.

46 Additional Articles relating to the Condition of the Wounded in War, 20 October 1868, Art. 11; Hague Convention (III) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention of 22 August 1864, 29 July 1899 (entered into force 4 September 1900), Art. 8; Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 6 July 1906 (entered into force 9 August 1907), Art. 1; Hague Convention (X) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention, 18 October 1907 (entered into force 26 January 1910), Art. 11; Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 27 July 1929, Art. 1; Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) (GC I); Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950) (GC II); Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) (GC IV); AP I; Protocol Additional (II) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609, 8 June 1977 (entered into force 7 December 1978) (AP II).

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law that the wounded and sick must be respected and protected in all circumstances;[47] in addition, they must be treated humanely and cared for without any distinction based on sex, race, nationality, religion, political opinions or any other similar criteria.[48]

Importantly, the Geneva Convention of 1864 not only provided for the protection of the wounded and sick but also entrusted their care and treatment to medical personnel, obliging the latter to provide care regardless of the allegiance of the person they are treating. It further recognized ambulances, hospitals and medical staff as neutral and required their respect and protection.[49] Such safeguards are essential, as the protection of the wounded and sick would be diluted if those entrusted with their care were not themselves protected.[50] Consequently, IHL establishes a subsidiary protection regime for medical personnel.[51]

Accordingly, medical personnel are afforded similar special protection to that afforded to the wounded and sick, and must likewise be respected and protected in all circumstances during armed conflict.[52] In the context of an international armed conflict (IAC), this rule is expressly provided for permanent military medical personnel, auxiliary medical personnel, personnel of aid societies, medical personnel at sea and civilian medical personnel.[53] For instance, Article 24 of Geneva Convention I (GC I) with respect to permanent military medical personnel stipulates:

> Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, [and] staff exclusively engaged in the administration of medical units and establishments, … shall be *respected and protected in all circumstances*.[54]

It has been confirmed in the 2025 International Committee of the Red Cross (ICRC) Commentary on Geneva Convention IV (GC IV) that similar protection, in the context of a non-international armed conflict (NIAC), can be derived from the customary international law obligation in Article 3 common to the four Geneva Conventions (common Article 3), which requires that the wounded and sick "shall be collected and cared for".[55] This obligation confirms that the protection of

47 GC I, Art. 12(1); GC II, Art. 12(1); GC IV, Art. 16(1); AP I, Art. 10(1); AP II, Art. 7(1); ICRC Customary Law Study, above note 5, Rules 110 and 111.

48 GC I, Art. 12(2); GC II, Art. 12(2); AP I, Art. 10(2); AP II, Art. 7(2).

49 1864 Geneva Convention, above note 45, Arts 1–2, 7.

50 ICRC, *Commentary on the First Geneva Convention: Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 2nd ed., Geneva, 2016 (2016 Commentary on GC I), para. 1948.

51 Protection is also granted to medical units and medical transports. See GC I, Arts 19, 35; GC II, Arts 22, 38; GC IV, Arts 18, 21; AP I, Arts 12, 21; ICRC Customary Law Study, above note 5, Rules 28–29.

52 ICRC Customary Law Study, above note 5, Rule 25.

53 GC I, Arts 24–26; GC II, Arts 36–37; GC IV, Art. 20(1); AP I, Art. 15(1); AP II, Art. 9(1).

54 GC I, Art. 24 (emphasis added).

55 GC I, Art. 3(2); GC II, Art. 3(2); Geneva Convention (III) relative to the Treatment of Prisoners of War, 75 UNTS 135, 12 August 1949 (entered into force 21 October 1950) (GC III), Art. 3(2); GC IV, Art. 3(2); ICRC, *Commentary on the Fourth Geneva Convention: Convention (IV) relative to the Protection of Civilian*

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medical personnel operates as a subsidiary safeguard, designed to guarantee that the wounded and sick receive the care to which they are entitled. With the adoption of Additional Protocol II to the Geneva Conventions (AP II), the obligation to respect and protect medical personnel was explicitly extended to NIACs.[56] In any case, it is now generally accepted that the overarching rule that "[m]edical personnel exclusively assigned to medical duties must be respected and protected in all circumstances" has crystallized in customary international law, applying to both IACs and NIACs.[57]

The obligation that medical personnel must be respected and protected "in all circumstances" underscores that this protection cannot be overridden for operational reasons or reasons of military necessity.[58] Medical personnel can lose their protection only in very limited circumstances – namely, when they commit acts harmful to the enemy outside their humanitarian duties.[59] This regime is more stringent than the general protection afforded to civilians; unlike civilians, loss of protection for medical personnel occurs only after a due warning has been issued and remains unheeded for a reasonable period.[60] Moreover, a single harmful act results in only temporary loss of protection, meaning that once the act ceases to produce its harmful effects, protection must be restored.[61] These strict rules demonstrate the rationale of the special protection regime, which is to enable medical personnel to perform their duties.

The critical nature of medical personnel's functions is further illustrated when permanent military medical personnel or personnel of aid societies fall into enemy hands.[62] Rather than acquiring prisoner of war status under Geneva Convention III (GC III), these personnel are subject to a special retention regime which allows them to continue performing medical duties for wounded and sick prisoners of war, according to the patients' medical and spiritual needs and their number.[63] This continuation of duties underscores the essential character of medical

Persons in Time of War, 2nd ed., Geneva, 2025 (2025 Commentary on GC IV), para. 859; Stuart Casey-Maslen, "The Status, Rights, and Obligations of Medical and Religious Personnel", in Andrew Clapham, Paola Gaeta and Marco Sassòli (eds), *The 1949 Geneva Conventions: A Commentary*, Oxford University Press, Oxford, 2015, p. 809.

56 AP II, Art. 9(1).

57 ICRC Customary Law Study, above note 5, Rule 25.

58 2016 Commentary on GC I, above note 50, paras 1983, 1996.

59 GC I, Art. 21; 2016 Commentary on GC I, above note 50, para. 1996; Robert Kolb and Fumiko Nakashima, "The Notion of 'Acts Harmful to the Enemy' under International Humanitarian Law", *International Review of the Red Cross*, Vol. 101, No. 912, 2019.

60 GC I, Art. 21.

61 2016 Commentary on GC I, above note 50, para. 2009.

62 Under GC I, permanent military medical personnel covered by Article 24 and personnel of aid societies covered by Article 26 fall under the regime provided in Articles 28, 30 and 31, while auxiliary medical personnel covered by Article 25 fall under the regime provided in Article 29. It is important to note that this special retention regime only applies to medical personnel who have been exclusively assigned to medical duties; otherwise, they remain combatants and are thus not covered by the obligation to respect and protect medical personnel. If such persons fall into enemy hands, they become prisoners of war, covered by the detention regime in Article 32 of GC III.

63 GC I, Art. 28(2). The stringent retention regime applies only in the context of an IAC; parties to a NIAC, on the other hand, are under no legal obligation to release captured medical personnel. 2016 Commentary on GC I, above note 50, para. 2155.

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personnel's work – even in captivity, they must provide medical care, including mental health and psychological support.[64]

Before addressing the specific scope and content of the obligation to respect and protect medical personnel, this article traces the increasing recognition within IHL of the "person" in a broader sense, including both physical and mental integrity. Building on this development, it then argues, *de lege ferenda*, that the obligation to respect and protect should be interpreted as including protection against both direct and incidental psychological harm.

IHL and the recognition of the "person" in a broader sense

While, historically, IHL has centred on protecting persons from physical harm arising from armed conflict, its understanding of harm has gradually evolved to include psychological harm. Today, IHL is increasingly regarded as safeguarding the "person" in a broader sense, encompassing both their physical and mental integrity.[65] This interpretation is supported by the 1958 ICRC Commentary on GC IV, which emphasizes that the Geneva Conventions' focus on the protection of persons reflects an understanding of the individual in "its widest sense", referring to "the rights and qualities which are inseparable from the human being by the very fact of his existence and his mental and physical powers; it includes, in particular, the right to physical, moral and intellectual integrity".[66]

This broader understanding of the "person", together with the growing recognition of mental health within IHL, also finds expression in provisions governing medical duties in armed conflict and in rules prohibiting the intentional infliction of severe psychological harm, under which medical personnel are protected as persons not actively participating in hostilities.

64 GC I, Art. 28(2); GC III, Art. 33; ICRC, *Commentary on the Third Geneva Convention: Convention (III) relative to the Treatment of Prisoners of War*, 2nd ed., Geneva, 2020 (2020 Commentary on GC III), paras 1728–1729. For the purposes of these provisions, the notion of "health" follows an inclusive interpretation, encompassing not only treatment of physical injuries but also treatment for mental health conditions and provision of psychological support.

65 See Eliav Lieblich, "Beyond Life and Limb: Exploring Incidental Mental Harm under International Humanitarian Law", in Derek Jinks, Jackson Nyamuya Maogoto and Solon Solomon (eds), *Applying International Humanitarian Law in Judicial and Quasi-Judicial Bodies*, T. M. C. Asser Press, The Hague, 2014, pp. 194–195, discussing several provisions prohibiting the intentional infliction of psychological harm on civilians. See e.g. GC IV, Art. 33; AP I, Arts 51(2), 75. For the purposes of this article, "mental integrity" refers to a person's right to be free from unwanted interference with their mental state, such as coercion or manipulation. "Psychological harm" refers to the adverse effects on a person's mental health, such as psychological distress, anxiety and trauma. A violation of a person's mental integrity may give rise to psychological harm, but such harm can also occur independently of such a violation.

66 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. 4: *Geneva Convention relative to the Protection of Civilian Persons in Time of War*, ICRC, Geneva, 1958 (1958 Commentary on GC IV), p. 201. See also E. Lieblich, above note 65, p. 195; Solon Solomon, "Concretizing Mental Harm: Warfare's Psychological Impact on Civilians and the Return to Domestic Law for Establishing a Standards-Setting Paradigm", *Transnational Law and Contemporary Problems*, Vol. 31, 2022, p. 124.

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Definitions of "wounded and sick" and "medical personnel"

The evolution of IHL towards recognizing mental health is reflected in the scope of medical services delivered by medical personnel in armed conflict. First, mental health conditions are encompassed within the definition of the "wounded" and "sick". As noted in the 2025 ICRC Commentary on GC IV, the IHL definition of "wounded and sick" is broader than the ordinary meaning of these terms, covering a wide range of medical conditions that includes both physical conditions and mental ones such as PTSD.[67] This inclusive interpretation is also reflected in the definition of "wounded" and "sick" in Article 8(a) of Additional Protocol I (AP I).[68]

Interestingly, to fall under the protection afforded to the wounded and sick, it is irrelevant how the mental conditions were caused – the sole criterion is that the person is in need of medical care, irrespective of the origin of their condition.[69] Accordingly, protection extends not only to individuals whose mental conditions result directly from military operations, but also to those whose conditions or treatment are affected indirectly by the armed conflict, for example through the destruction of medical facilities on which their treatment depends or limited access to essential medicines.[70] Mental conditions therefore need not stem from attacks on the battlefield but may arise from indirect consequences of the conflict.

Furthermore, given the role of medical personnel in providing care to the wounded and sick, it is unsurprising that addressing mental health and psychological harm is recognized as part of their responsibilities in armed conflict. Like the notion of "wounded and sick", the term "permanent military medical personnel" in GC I is defined broadly, encompassing various categories of persons within its protective framework.[71] Notably, the first category mentioned includes "medical personnel

67 Based on the ordinary meaning of these words, a person would normally be considered wounded or sick if they were suffering from either a wound or sickness. Nevertheless, the wording is sufficiently open to accommodate a wide range of medical conditions, both physical and mental, the decisive criterion being the need for medical care. 2025 Commentary on GC IV, above note 55, para. 1695.

68 Article 8(a) of AP I stipulates that "'wounded' and 'sick' mean persons, whether military or civilian, who, because of *trauma*, disease or other physical or *mental* disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility" (emphasis added). This definition is also used for non-international armed conflicts. Yves Sandoz, Christophe Swinarski and Bruno Zimmerman, *Commentary on the Additional Protocols*, ICRC, Geneva, 1987 (ICRC Commentary on the APs), para. 4637.

69 2016 Commentary on GC I, above note 50, paras 741, 1343; 2025 Commentary on GC IV, above note 55, para. 1695. The 2016 Commentary on GC I, para. 1343, states: "For the purpose of Article 12 it is irrelevant whether a certain physical or mental condition qualifies as a wound or sickness in the ordinary sense of these terms. For example, trauma is a medical condition that is typically found on the battlefield, but as Article 8(a) of Additional Protocol I indicates, any other 'physical … disorder or disability' suffices as long as there is a need for medical care. Similarly, mental or psychological conditions, including post-traumatic stress disorder, qualify, provided that they require medical care."

70 2025 Commentary on GC IV, above note 55, para. 1698.

71 Article 24 of GC I stipulates: "Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, staff exclusively engaged in the administration of medical units and establishments, as well as chaplains attached to the armed forces, shall be respected and protected in all circumstances."

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engaged in the search, collection, transport or treatment of the wounded of sick, or in the prevention of disease".[72] The 2016 ICRC Commentary on GC I explicitly notes that "treatment" may include psychological treatment and that "prevention of disease" can cover the activities of psychologists involved in preventing trauma, such as combat-related stress and mental disorders.[73] While this provision focuses on the medical service provided to the wounded and sick, it nevertheless acknowledges the importance of treating and preventing psychological harm in the context of armed conflict.

Building on this, the importance of addressing psychological harm may also be reflected within the customary law obligation to provide care to the wounded and sick. The wounded, sick and shipwrecked are entitled to receive adequate medical care required by their medical condition.[74] One author argues, based on the broad definition of "wounded and sick" given in Article 8(a) of AP I, that "adequate care" may include "short- and long-term medical, *mental*, and rehabilitative care for those with conflict-related physical and *psychological health problems*, including victims of sexual violence".[75]

While these references to psychological harm do not establish a prohibition against causing such harm to medical personnel, nor create an explicit obligation to protect them from it, they signal a growing recognition of the importance of psychological health in the special protection regime of medical personnel. They also demonstrate IHL's capacity to address psychological harm, whether inflicted directly or indirectly.

Prohibitions on the intentional infliction of severe psychological harm

IHL's growing recognition of the person in a broader sense, encompassing both physical and mental integrity, is reflected in the prohibitions against the intentional infliction of certain severe forms of psychological harm on protected persons. Even outside the special protection framework, medical personnel are already protected against such severe forms of harm.

In particular, in the context of a NIAC, common Article 3 contains several minimum provisions protecting persons who are taking no active part in the hostilities, including medical personnel, from harm to their mental integrity.[76] Of particular note is the prohibition against exercising violence to the person, which

72 GC I, Art. 24.

73 2016 Commentary on GC I, above note 50, paras 1956, 1958.

74 AP I, Art. 10(2); AP II, Arts 7(2), 8; 2016 Commentary on GC I, above note 50, para. 1383.

75 A. Müller, above note 13, pp. 143–144 (emphasis added).

76 Medical personnel are regarded as "persons taking no active part in the hostilities" in the sense of common Article 3. 2016 Commentary on GC I, above note 50, para. 522; ICRC, *Commentary on the Second Geneva Convention: Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea*, 2nd ed., Geneva, 2017 (2017 Commentary on GC II), para. 544; 2020 Commentary on GC III, above note 64, para. 556; 2025 Commentary on GC IV, above note 55, para. 596. See also AP II, Art. 4.

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interprets "person" broadly to include the protection of both physical and mental integrity.[77] The rationale behind this is that violations of a person's mental well-being would be irreconcilable with the fundamental principle of humane treatment underlying common Article 3.[78] It is widely accepted that the acts specifically mentioned under this provision, such as cruel treatment and torture, encompass conduct detrimental to the mental integrity of persons.[79] For example, the definition of cruel treatment, namely "treatment which causes serious mental or physical suffering or constitutes a serious attack upon human dignity", demonstrates that suffering need not be physical, and that mental suffering in itself can be sufficient to qualify as cruel treatment.[80] Accordingly, subjecting medical personnel to any of the aforementioned acts, which causes them to suffer serious psychological harm, would be prohibited under this minimum standard.

In addition, certain acts intentionally inflicting severe psychological harm amount to grave breaches of the Geneva Conventions, and are further prohibited as war crimes in IACs.[81] While these prohibitions are not specific to medical personnel, they apply to them for the same reason discussed above with respect to common Article 3: because of their protected status under IHL. A first category of acts prohibited as grave breaches comprises torture and inhuman treatment. The severe pain or suffering which is covered under torture may be either physical or mental,[82]

77 GC I, Art. 3(1)(a); 2016 Commentary on GC I, above note 50, para. 590. See also ICRC Commentary on the APs, above note 68, para. 4532.

78 2016 Commentary on GC I, above note 50, para. 585; 2025 Commentary on GC IV, above note 55, para. 662.

79 2016 Commentary on GC I, above note 50, para. 590. The 2016 Commentary on GC I explicitly mentions that the value protected by this prohibition is the human "person". While the English text of common Article 3 does not indicate whether "person" comprises only the integrity of the physical person or also a person's mental integrity, the authentic French version, containing the specific wording of "atteintes portées à la vie et à l'intégrité corporelle", seems to suggest that a person's mental integrity is excluded from the protection under common Article 3. The fact that Article 4(2) of AP II, which reiterates the essence of common Article 3, explicitly proscribes "violence to the … health and physical or mental well-being of persons" can be read either as a clarification that the notion of violence to person also includes violence to a person's mental integrity, or as an indication that violence to mental integrity was intentionally excluded; the Commentaries leave this question open. Nevertheless, the acts specifically mentioned in this provision, such as torture and cruel treatment, are nowadays widely accepted to include conduct detrimental to the mental integrity of the person.

80 2025 Commentary on GC IV, above note 55, para. 707. See International Criminal Tribunal for the former Yugoslavia (ICTY), *Prosecutor v. Delalić*, Case No. IT-96-21-T, Judgment (Trial Chamber), 16 November 1998, para. 551 for this definition. Examples of mental suffering amounting to cruel treatment include threats to life, threats of torture and witnessing others being ill-treated, raped or executed.

81 GC I, Art. 50; GC II, Art. 51; GC IV, Art. 147; Rome Statute of the International Criminal Court, UN Doc. A/CONF.183/9, 17 July 1998 (entered into force 1 July 2002), Art. 8(2)(a)(ii)–(iii). Medical personnel are considered persons protected under these provisions on grave breaches. 2016 Commentary on GC I, above note 50, para. 2927; 2017 Commentary on GC II, above note 76, para. 3037; 2025 Commentary on GC IV, above note 55, para. 1932. See also AP I, Art. 75, and ICRC Commentary on the APs, above note 68, paras 3041, 3047, providing minimum treatment to individuals in IACs not benefiting from more favourable treatment under the Geneva Conventions or AP I.

82 GC I, Art. 50; GC II, Art. 51; GC IV, Art. 147; 2025 Commentary on GC IV, above note 55, paras 6687, 6708, 6722; ICTY, *Prosecutor v. Furundžija*, Case No. IT-95-17/1-T, Judgment (Trial Chamber), 10 December 1998, para. 162; International Criminal Court (ICC), *Prosecutor v. Ongwen*, Case No. ICC-02/04-01/15, Judgment (Trial Chamber), 4 February 2021, paras 2700–2701; ICC, *Prosecutor v. Al*

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while inhuman treatment similarly covers serious mental or physical harm that falls short of the threshold required for torture.[83] A second category concerns biological experiments on protected persons, where the experiment seriously endangers their physical or mental health or integrity.[84] Finally, it is prohibited to wilfully cause individuals "great suffering or serious injury to [their] body or health".[85] Again, suffering may be physical or mental, and "injury to health" encompasses harm to both aspects of the protected person's well-being.[86] This prohibition thus underscores the obligation to treat protected persons humanely and to safeguard their physical and mental integrity at all times.[87]

While the foregoing prohibitions concern only the most severe forms of intentional psychological harm that persons taking no active part in hostilities, such as medical personnel, may suffer, they nevertheless demonstrate that IHL is capable of addressing some forms of direct psychological harm caused to medical personnel. Moreover, these rules highlight the growing significance of protecting individuals from severe psychological harm, the violation of which can give rise to accountability for the most serious violations of IHL.

The obligation to respect and protect medical personnel: Extending protection to psychological harm?

Building on the previous section, this part of the article argues that IHL's evolving recognition of the "person" in a broader sense informs the regime applicable to medical personnel under IHL. Accordingly, it advances the argument that the obligation to respect and protect should be interpreted as encompassing protection against both direct and incidental psychological harm.

Hassan, Case No. ICC-01/12-01/18, Judgment (Trial Chamber), 20 November 2024, paras 1125–1128. In this regard, the 2025 Commentary on GC IV, above note 55, para. 6695, explicitly states that "[a]n act of torture does not need to cause a permanent injury or a physical injury, as mental harm is a recognized form of torture", and that "[e]vidence of suffering need not be visible after the commission of the crime". It further mentions examples of mental suffering recognized in the case law of international criminal tribunals, such as being forced to watch severe mistreatment inflicted on a relative and threats of death.

83 GC I, Art. 50; GC II, Art. 51; GC IV, Art. 147; 2025 Commentary on GC IV, above note 55, paras 6708–6711; ICTY, *Prosecutor v. Kordić and Čerkez*, Case No. IT-95-14/2-T, Judgment (Trial Chamber), 26 February 2001, para. 265; ICTY, *Prosecutor v. Naletilić*, Case No. IT-98-34-T, Judgment (Trial Chamber), 31 March 2003, para. 246.

84 2025 Commentary on GC IV, above note 55, para. 6722.

85 GC I, Art. 50; GC II, Art. 51; GC IV, Art. 147.

86 2025 Commentary on GC IV, above note 55, paras 6728–6729. "Suffering" could be either physical or mental and "health" includes the mental health of a protected person. 2016 Commentary on GC I, above note 50, paras 2998–3000; ICTY, *Prosecutor v. Blaškić*, Case No. IT-95-14-T, Judgment, 3 March 2000, para. 156; ICTY, *Prosecutor v. Delalić*, Case No. IT-96-21-A, Judgment (Appeals Chamber), 20 February 2001, para. 424. Examples mentioned in the 2025 Commentary on GC IV, above note 55, para. 6732, include mental suffering caused by brutal killings and mutilations committed in front of family members, as well as requiring persons to witness the beatings or killings of others.

87 2025 Commentary on GC IV, above note 55, para. 6727.

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As noted above, medical personnel benefit from a special protection regime which obliges the parties to the conflict to ensure their respect and protection. The Geneva Conventions, however, do not explicitly define the notion of "respect and protect", nor do they provide an exhaustive list of prohibited acts. The notion of "respect" refers primarily to the obligation to refrain from acts of violence; more specifically, it proscribes making medical personnel the object of an attack, whether the attack is deliberate, indiscriminate or in contravention of the principle of proportionality.[88] It is likewise prohibited to kill, injure or otherwise harm them, as well as to kidnap them, physically or sexually assault them or subject them to torture.[89] The duty to "protect", on the other hand, imposes an obligation to take active steps to ensure that others do not impede the work of medical personnel, and to shield them from harm.[90]

This interpretation of the obligation to respect and protect seems to suggest that the obligation primarily covers protection against attacks and physical harm.[91] Neither the Geneva Conventions nor their ICRC Commentaries discuss whether this obligation also encompasses protection against psychological harm;[92] likewise,

88 2016 Commentary on GC I, above note 50, para. 1987; 2017 Commentary on GC II, above note 76, para. 2462; 2025 Commentary on GC IV, above note 55, para. 1893. See also L. Gisel, above note 12.

89 See also S. Casey-Maslen, above note 55, pp. 809–810, arguing that inspiration can be drawn from the protection of the wounded and sick under Article 12 of GC I, thereby prohibiting medical personnel from being subjected to acts of murder, physical violence and/or medical experimentation, as well as conditions that expose them to contagion or infection. This also includes humane treatment at all times, without any distinction based on sex, race, nationality, religion, political opinion or any other grounds.

90 2016 Commentary on GC I, above note 50, paras 1991–1992; 2017 Commentary on GC II, above note 76, paras 2466–2467; 2025 Commentary on GC IV, above note 55, para. 1895.

91 The 1930 ICRC Commentary on the 1929 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, for example, states: "'Respecter' ces unités signifie ne pas tirer sur elles, ne pas les attaquer ni s'en emparer, pas plus que si elles appartenaient à des neutres." See Paul Des Gouttes, *La Convention de Genève du 27 juillet 1929: Commentaire*, ICRC, Geneva, 1930. See also 1958 Commentary on GC IV, above note 66, pp. 134–135: "The word 'respect' ('respecter') means, according to the Dictionary of the French Academy, 'to spare, not to attack' … ('épargner, ne point attaquer')." See also 2016 Commentary on GC I, above note 50, para. 66, and 2017 Commentary on GC II, above note 76, para. 81, which mention that the 1864 Geneva Convention added the stipulation that medical personnel were to be protected against "hostile acts".

92 Medical personnel may already be protected against incidental psychological harm resulting from attacks under the proportionality and precautionary principles, when such harm is excessive as compared to the direct military advantage to be gained. These principles regulating the conduct of hostilities protect medical personnel in their capacity as civilians; the discussion on the inclusion of incidental psychological harm in the principles is, however, outside the scope of this article. See 2016 Commentary on GC I, above note 50, para. 1987; 2017 Commentary on GC II, above note 76, para. 2462; 2025 Commentary on GC IV, above note 55, para. 1893; L. Gisel, above note 12, p. 222. See also, in general, Advanced Training Program on Humanitarian Action, "Incidental yet Monumental: Incorporating Mental Health Impacts into IHL Proportionality Assessments", 7 April 2017, available at: https://reliefweb.int/node/1985519; E. Lieblich, above note 65, pp. 194–195, 201; ICRC, *International Humanitarian Law and the Challenges of Contemporary Armed Conflicts: Recommitting to Protection in Armed Conflict on the 70th Anniversary of the Geneva Conventions*, Geneva, 2019, p. 17; Isabel Robinson and Ellen Nohle, "Proportionality and Precautions in Attack: The Reverberating Effects of Using Explosive Weapons in Populated Areas", *International Review of the Red Cross*, Vol. 98, No. 901, 2016, p. 129; Kailash Jeenger, *A Humanitarian Critique of International Humanitarian Law*, Springer, Singapore, 2025, pp. 183–184; Rebecca Sutton and Emanuela-Chiara Gillard, *Beyond Compliance: International Humanitarian Law, Humanitarian Need and Civilian Harm in Armed Conflict*, PeaceRep, Edinburgh, 2022, p. 13; Samantha Holmes, "Beyond

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there is currently no international practice confirming that such harm falls within its scope.[93] Nevertheless, it will be demonstrated in the next sections that extending this protection to include psychological harm would not require legal innovation but would primarily be a matter of interpretation, which should be guided by IHL's object and purpose.

The obligation to respect and protect is formulated in a broad manner

Although there is no specific mention of protection against psychological harm to medical personnel in the Geneva Conventions, the ICRC Commentaries emphasize that the multifaceted nature of the notions of "respect" and "protect" cannot be reduced to a simple checklist of measures. The Commentaries "merely serve to highlight, by way of example" some of the different aspects involved in implementing the obligation.[94] In other words, the examples provided above are illustrative rather than exhaustive.

Moreover, the protection afforded to medical personnel implies that they cannot be harmed *in any way* and that parties to the conflict must take feasible steps to "protect" them from harm.[95] The Geneva Conventions do not specify the types of harm from which they must be protected, but the broad framing of "harm" may leave the door open for an interpretation that extends protection to psychological harm – for instance, *Black's Law Dictionary* defines "harm" as "injury, loss, damage; material or tangible detriment", and explicitly includes mental harm, defined as "any impairment of a person's mind, [especially] when the impairment has resulted from something external, such as injury". *Black's* further notes that harm may be accidental, meaning that it is not caused by a purposeful or tortious act.[96] Importantly, as discussed above, in light of IHL's recognition of the person in a broader sense, which encompasses both physical and mental integrity, the notion of harm should reasonably be understood to include psychological harm.

In this regard, the ICRC Commentaries provide some indications that intentionally causing psychological harm to medical personnel would be prohibited under the obligation to respect and protect; for instance, the obligation to respect prohibits threats and acts of intimidation, indicating protection beyond purely

Compliance Symposium: War is Not Skin Deep – International Humanitarian Law and Mental Health", 15 October 2024, available at: www.armedgroups-internationallaw.org/2024/10/15/beyond-compliance-symposium-war-is-not-skin-deep-international-humanitarian-law-and-mental-health/.

93 This statement is based on a review of the military manuals listed in the ICRC Customary IHL Database, available at: https://ihl-databases.icrc.org/en/customary-ihl/src/iimima. The review did not identify any references indicating that psychological harm is considered to fall within the scope of the obligation to respect and protect.

94 2016 Commentary on GC I, above note 50, para. 1985.

95 The 2016 Commentary on GC I, above note 50, para. 1987 makes specific mention of the prohibition against "harm[ing] [medical personnel] in any way". See also 2025 Commentary on GC IV, above note 55, paras 1893, 1895–1896, 1898.

96 Bryan A. Garner (ed.), *Black's Law Dictionary*, 12th ed., Thomson Reuters, 2024. *Black's* is one of the dictionaries used by the ICRC Commentaries on the Geneva Conventions: see 2016 Commentary on GC I, above note 50, para. 22. See also Vienna Convention on the Law of Treaties, 1155 UNTS 331, 23 May 1969 (entered into force 27 January 1980) (VCLT), Art. 31(1), requiring treaties to be interpreted in accordance with the ordinary meaning of the terms.

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physical harm.[97] This interpretation is reinforced by the case law of international criminal tribunals, which recognizes that threats and intimidation may cause serious psychological harm to victims.[98] Furthermore, guidance may be drawn from the interpretation of Article 12(2) of GC I on the protection of the wounded and sick, which prohibits any form of violence, whether physical or psychological.[99]

In addition, the obligation to respect requires parties to comply with the legal framework governing medical ethics,[100] and to this end, several provisions are designed to eliminate fear or coercion faced by medical personnel in the performance of their duties.[101] For example, it is prohibited to threaten, harass or punish medical personnel for carrying out their functions,[102] and it is also prohibited to compel them either to act contrary to medical ethics or to refrain from acts required by medical ethics, such as providing care to members of the adverse party.[103]

While extending protection to direct psychological harm poses few interpretative difficulties, applying it to incidental psychological harm would present

97 2016 Commentary on GC I, above note 50, para. 1987. See also E. Lieblich, above note 65, p. 195, making a similar argument when discussing the reference to "measures of intimidation and terrorism" in the context of Article 33 of GC IV.

98 In the case law of international criminal tribunals, serious mental harm is defined as "more than minor or temporary impairment of mental faculties such as the infliction of strong fear or terror, intimidation or threat". International Criminal Tribunal for Rwanda, *Prosecutor v. Kajelijeli*, Case No. ICTR-98-44A-T, Judgment and Sentence, 1 December 2003, para. 815; ICTY, *Prosecutor v. Tolimir*, Case No. IT-05-88/2-A, Judgment (Appeals Chamber), 8 April 2015, paras 203, 206.

99 When interpreting the notion of "any attempts upon lives, or violence to their persons", in Article 12(2) of GC I, which deals with specifically prohibited forms of conduct against the wounded and sick, the ICRC Commentary on GC I states that "the word 'any' indicates that these general prohibitions are to be interpreted broadly to cover any form of violence …, physical or *psychological*, against the wounded and sick". 2016 Commentary on GC I, above note 50, para. 1397 (emphasis added).

100 *Ibid.*, para. 1987.

101 ICRC Commentary on the APs, above note 68, para. 640 mentions that "any person able to perform medical activities for the benefit of the wounded should be able to do so *without fear or any coercion*" (emphasis added). Medical ethics refers to the moral duties of medical professionals. The World Medical Association has adopted guidelines on medical ethics, including the International Code of Medical Ethics, the Declaration of Geneva and the Regulations in Times of Armed Conflict. These guidelines constitute an important point of reference: see 2016 Commentary on GC I, above note 50, para. 1385. Medical ethics would, for instance, require medical personnel to use their resources in the best way possible for the benefit of the wounded and sick, to respect the patients' right to confidentiality, and to ensure that their professional judgment is not influenced by personal profit or discriminatory considerations. See World Medical Association, International Code of Medical Ethics, October 1949 (last revised October 2022).

102 Article 18(3) of GC I stipulates: "No one may ever be molested or convicted for having nursed the wounded or sick." See also AP I, Art. 16(1); AP II, Art. 10(1); ICRC Customary Law Study, above note 5, Rule 26. The term "molest" encompasses "any form of annoyance, threat or harassment": ICRC Commentary on the APs, above note 68, para. 650. In contrast to the obligation to respect and protect, this prohibition covers a broader group than solely the specific category of medical personnel who have been assigned by a party to the conflict to exclusively serve medical duties; regular health-care personnel, not so assigned, are also protected under this prohibition. For practice on the punishment of health-care personnel for the sole reason of providing medical care, see Leonard S. Rubenstein, "Punishing Health Care Providers for Treating Terrorists", *Hastings Center Report*, Vol. 45, No. 4, 2015. See also Inter-American Court of Human Rights, *Case of De La Cruz-Flores v. Peru*, Judgment (Merits, Reparations and Costs), Series C, No. 115, 18 November 2004, para. 102; United Nations Human Rights Committee, *Marlem Carranza Alegre v. Peru*, UN Doc. CCPR/C/85/D/1126/2002, 17 November 2005, para. 3.9.

103 AP I, Art. 16(2); AP II, Art. 10(2); ICRC Customary Law Study, above note 5, Rule 26. See also GC I, Art. 12(2); ICRC Customary Law Study, above note 5, Rule 110.

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additional complexities. A central question is whether the duty to protect is capable of addressing psychological harm that occurs indirectly. This question should be answered in the affirmative, drawing on the interpretation of the obligation to protect the wounded and sick.[104] In this regard, it has been suggested that the obligation to protect could cover not only harm posed by other individuals – such as a party's own soldiers, enemy combatants or civilians – but also indirect harm arising in the context of an armed conflict, such as through ongoing hostilities or natural hazards.[105] If the obligation to protect can encompass such indirect forms of harm arising from the broader conflict environment, it could likewise extend to incidental psychological harm suffered as a consequence of those same circumstances.[106]

Moreover, in relation to the wounded and sick, the 2016 Commentary on GC I even notes that the duty to protect "could be interpreted as a requirement to protect them from the dangers arising from their medical condition", which implies the provision of necessary medical treatment.[107] Although this provision concerns the wounded and sick rather than medical personnel, it illustrates that the obligation to protect may also require measures addressing risks arising from the circumstances of armed conflict or from the individual's condition. By analogy, this broader understanding of the duty to protect lends support to the view that the obligation should, in principle, encompass incidental psychological harm affecting medical personnel when such harm results from the conflict environment.

The obligation to protect medical personnel also requires that parties to the conflict take measures to ensure that they can carry out their medical duties.[108] This obligation is articulated in Article 9(1) of AP II, which requires parties to grant medical personnel "all available help for the performance of their duties".[109] Article 15 of AP I affords similar protection to civilian medical personnel in areas "where civilian

104 It follows from Article 31(1) of the VCLT, above note 96, that in order to determine the ordinary meaning to be given to the terms of a treaty, those terms must be placed "in their context". Article 31(2) mentions that the context to be considered for treaty interpretation comprises not only the text of the treaty, but also its preamble and annexes. Specifically for the Geneva Conventions, the ICRC Commentaries state that "[t]he context also comprises the structure of the Conventions, their titles, the chapter headings and the text of the other articles": 2016 Commentary on GC I, above note 50, para. 26.

105 2016 Commentary on GC I, above note 50, para. 1361.

106 See E. Lieblich, above note 65, p. 210 for a similar analysis with respect to incidental psychological harm and the principle of proportionality.

107 2016 Commentary on GC I, above note 50, para. 1361.

108 *Ibid.*, para. 1991. This paragraph also mentions that the overarching objective of the obligation to protect is to ensure that medical personnel can reach those in need, specifically the wounded and sick.

109 AP II, Art. 9(1). See also a number of military manuals relied on by the ICRC Customary Law Study, above note 5, recognizing far-reaching, proactive obligations towards medical personnel in armed conflict: Argentina, *Leyes de Guerra*, PC-08-01, 1989, para. 7.06 ("medical personnel shall be respected, protected and assisted in the performance of their duties"); Canada, *The Law of Armed Conflict at the Operational and Tactical Level*, 1999, p. 17-4, para. 34 (medical personnel shall "receive all available aid to enable them to fulfil their duties"); Netherlands, *Toepassing Humanitair Oorlogsrecht*, Instruction No. 27-412/1, 1993, pp. XI-5–XI-6 (stipulating with respect to NIACs that medical personnel "must receive aid to fulfil their tasks"); New Zealand, *Interim Law of Armed Conflict Manual*, DM 112, 1992, para. 1818(2) ("receiving all available aid to enable them to fulfil their duties"); Spain, *Orientaciones: El Derecho de los Conflictos Armados*, Publication No. OR7-004, Vol. 1, 1996, para. 9.2.a.(2) (medical personnel shall be "defend[ed], assist[ed] and support[ed] when needed"). See also A. Müller, above note 13, pp. 161–162.

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medical services are disrupted by reason of combat activity".[110] The Commentary on AP I clarifies that the object of this provision is to enable civilian medical personnel to fulfil their task, not only by ensuring their respect and protection, but also by providing the necessary assistance.[111] The 2025 Commentary on GC IV illustrates that the obligation to protect includes both passive measures to avoid impeding access to affected areas and active measures to facilitate the performance of medical duties, such as providing shelter and transport to the wounded and sick.[112]

Considering that the obligation to protect requires parties to take active measures to enable medical personnel to carry out their duties, and that similar obligations toward the wounded and sick may be interpreted as encompassing risks arising from their medical condition, it may be argued that the obligation to protect medical personnel could, in some instances, extend to measures supporting their mental health, including the provision of psychological support.

In view of IHL's object and purpose, the obligation to respect and protect should be interpreted to include psychological harm

In any event, protection against both direct and incidental psychological harm should be considered part of the obligation to respect and protect, in view of the object and purpose of the Geneva Conventions. Pursuant to Article 31(1) of the Vienna Convention on the Law of Treaties (VCLT), the Geneva Conventions must be interpreted "in good faith in accordance with the ordinary meaning to be given to the terms of the [Conventions] in their context and in the light of [the Conventions'] object and purpose".[113] The overarching purpose of IHL, as reflected in the Geneva Conventions, is to alleviate the suffering of persons who are not, or are no longer, actively taking part in the hostilities. This is especially evident from the titles of the respective Conventions: while GC I and II focus on the protection of wounded, sick and shipwrecked members of the armed forces, GC IV serves to protect civilians against the consequences of armed conflict.[114]

Moreover, the special protection afforded to medical personnel, as well as to medical units and transports, specifically serves the purpose of alleviating the suffering of one category of persons not actively participating in hostilities, namely the wounded and sick. The significance of this protective framework within IHL should not be under-estimated.

110 AP I, Art. 15(2). The emphasis here is on the disruption of medical services; importantly, the provision also takes into account medical services that are not situated in the combat zone but are still disrupted by it. The Commentary on AP I gives the example of bombing behind the lines and problems in ensuring adequate supplies: ICRC Commentary on the APs, above note 68, para. 611.

111 ICRC Commentary on the APs, above note 68, para. 601.

112 2025 Commentary on GC IV, above note 55, para. 1897. See also ICRC Commentary on the APs, above note 68, para. 613.

113 VCLT, above note 96, Art. 31(1).

114 2016 Commentary on GC I, above note 50, para. 30; 2017 Commentary on GC II, above note 76, para. 30; 2025 Commentary on GC IV, above note 55, para. 112.

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In light of IHL's purpose to alleviate human suffering in armed conflict, the protection granted to medical personnel is of paramount importance. When medical personnel are unable to provide care to the wounded and sick, the consequences can be disastrous for both the affected population and the broader health system.[115] The special protection of medical personnel thus reflects the critical role they play in the challenging context of armed conflict, where the number of casualties and the need for medical care are exceptionally high.[116]

Limiting the obligation to respect and protect medical personnel to physical harm alone does not reflect the contemporary understanding of the suffering caused by armed conflict, which the Geneva Conventions seek to mitigate. Over recent decades, there has been increasing awareness of the impact of armed conflict on individuals' mental health.[117] Importantly, the special protection framework applicable to the wounded and sick recognizes such psychological harm and provides protection against it. Accordingly, medical personnel care not only for patients suffering from mental health conditions caused by direct acts of violence, but also for those affected indirectly by the conflict environment.[118]

Unsurprisingly, medical personnel are not spared from these effects. As noted above, they experience psychological harm as a result of direct violence, exposure to traumatic events and the stressful conditions under which they perform their duties.[119] In some cases, the impact on their mental health may be even more severe than physical injury.[120] When psychological harm impairs medical personnel to such an extent that it affects their ability to perform their medical duties (the possibility of which is shown by the scientific studies mentioned above), IHL's humanitarian purpose of alleviating the suffering caused by armed conflict and protecting the wounded and sick cannot be fulfilled.

Additional support for this interpretation may be drawn from the principle of "good faith". As noted above, under Article 31(1) of the VCLT, the Geneva Conventions must be interpreted in good faith;[121] this means that they must be construed in a way that ensures that the protections they afford to individuals affected by

115 See, for instance, A. Müller, above note 13, p. 156: "Mitigating the direct and indirect health consequences of non-international armed conflicts … is impossible without the presence of skilled medical personnel and functioning medical units (facilities) and transports."

116 *Ibid.*, p. 160.

117 International Human Rights and Conflict Resolution Clinic of Stanford Law School and Global Justice Clinic at NYU School of Law, *Living under Drones: Death, Injury and Trauma to Civilians from US Drone Practices in Pakistan*, September 2012, pp. 80–88; *Report of the United Nations Fact-Finding Mission on the Gaza Conflict*, UN Doc. A/HRC/12/48, 25 September 2009, paras 1653–1658; Shr-Jie Wang *et al.*, "Survivors of the War in the Northern Kosovo: Violence Exposure, Risk Factors and Public Health Effects of an Ethnic Conflict", *Conflict and Health*, Vol. 4, 2010, p. 2.

118 2025 Commentary on GC IV, above note 55, para. 1698.

119 33rd International Conference, above note 6, p. 1.

120 A. Abbara *et al.*, above note 10, p. 5.

121 VCLT, above note 96, Art. 31(1).

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armed conflict are fully effective.[122] In light of this, and given the impact of psychological harm on medical personnel, interpreting the obligation to respect and protect in good faith – which entails ensuring the effective protection of the wounded and sick – supports an interpretation that the obligation should extend to such harm. Indeed, effective care and treatment of the wounded and sick necessarily presupposes that the medical personnel responsible for their care are themselves in a sound state of (mental) health.[123]

Psychological harm under the obligation to respect and protect: Implementation in practice

Without purporting to provide an exhaustive account of parties' obligations in armed conflict, this section offers illustrative examples of what the obligation to respect and protect medical personnel from psychological harm might include. It seeks to invite further reflection on how direct and incidental psychological harm could be more explicitly recognized and addressed within the special protection framework.

The operationalization of the obligation to prevent direct psychological harm to medical personnel follows from the obligation's character as a negative obligation of result.[124] The duty to respect requires parties to refrain from conduct that causes such harm; accordingly, any intentional act directed at medical personnel, whether specifically aimed at affecting their mental well-being (including threats, intimidation, harassment, coercion and psychological torture) or aimed at inflicting physical injury (such as attacks or assault) and thereby also resulting in psychological harm, is absolutely prohibited.

By contrast, the protection against incidental psychological harm raises more complex issues of operationalization. The prevention of such harm requires measures that go beyond prohibiting specific harmful acts and instead address the broader armed conflict environment in which medical personnel deliver medical care. Such measures could, for instance, include integrating awareness of the mental health impacts of armed conflict on medical personnel into military training and ensuring that such considerations are reflected in operational planning.[125] They reflect a due diligence obligation requiring parties to the conflict to take feasible steps to reduce incidental psychological harm in the planning and conduct of military operations affecting medical personnel and the hospitals in which they work.[126] In addition, they may include measures to reduce the inherent psychological strain

122 International Court of Justice, *Case Concerning the Gabčíkovo-Nagymaros Project, ICJ Reports 1997*, 25 September 1997, para. 142; Jean-Marie Henckaerts, "Protecting Civilians in Good Faith: The Updated Commentary on the Fourth Geneva Convention", *Humanitarian Law and Policy Blog*, 21 October 2025, available at: https://blogs.icrc.org/law-and-policy/2025/10/21/protecting-civilians-in-good-faith-the-updated-commentary-on-the-fourth-geneva-convention/.

123 See above note 22.

124 2016 Commentary on GC I, above note 50, para. 1353; 2025 Commentary on GC IV, above note 55, para. 1715.

125 E. Lieblich, above note 65, p. 215.

126 2016 Commentary on GC I, above note 50, para. 1360; 2025 Commentary on GC IV, above note 55, para. 1719.

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experienced by medical personnel during armed conflict, thereby enabling them to perform their functions effectively, for example by addressing shortages of personnel and medical equipment.[127] Moreover, in certain instances, ensuring that medical personnel can continue to carry out their duties may require psychological support mechanisms, including resilience programmes and appropriate treatment for psychological harm.[128]

Psychological harm under the obligation to respect and protect: Addressing criticisms

Having demonstrated that the obligation to respect and protect medical personnel should be interpreted *de lege ferenda* to include protection against psychological harm, and having discussed how this could be operationalized in practice, this section attempts to briefly address some of the criticisms that may be raised regarding this interpretation.

As with the protection of civilians, extending protection to cover psychological harm to medical personnel may be subject to criticism.[129] A concern frequently raised in discussions of psychological harm to the civilian population is that fear and psychological harm are, to some extent, inherent in armed conflict. In the *Milošević* case, the International Criminal Tribunal for the former Yugoslavia (ICTY) observed that "a certain degree of fear and intimidation among the civilian population is present in nearly every armed conflict";[130] such criticism may be particularly relevant when considering incidental psychological harm experienced by medical personnel. It should be emphasized that, for incidental psychological harm to be covered under the protection framework, it must be serious and cannot be reduced to mere feelings of discomfort.[131] In light of the rationale underlying the obligation to respect and protect, incidental psychological harm should, at a minimum, significantly impair medical personnel's ability to perform their essential duties of providing care and treatment to the wounded and sick. Examples include psychological conditions like PTSD or severe anxiety disorders.[132]

127 2025 Commentary on GC IV, above note 55, para. 1897.

128 33rd International Conference, above note 3, pp. 3, 6.

129 See E. Lieblich, above note 65, for criticism of expanding civilian protection to cover incidental psychological harm from attacks.

130 ICTY, *Prosecutor v. Milošević*, Case No. IT-98-29/1-T, Judgment (Trial Chamber), 12 December 2007, para. 888. Nevertheless, as noted by S. Solomon, above note 66, p. 126, these same tribunals have recognized that when such fear reaches a certain threshold, it may give rise to international criminal responsibility. ICTY, *Prosecutor v. Galić*, Case No. IT-98-29-T, Judgment and Opinion, 5 December 2003, para. 137; ICTY, *Prosecutor v. Strugar*, Case No. IT-01-42-T, Judgment, 31 January 2005, para. 221.

131 See, for instance, Michael N. Schmitt (ed.), *Tallinn Manual 2.0. on the International Law Applicable to Cyber Operations*, 2nd ed., Cambridge University Press, Cambridge, 2017, Rule 100, p. 443, para. 26, and Rule 113, p. 472, para. 5, mentioning that "inconvenience, irritation, stress or fear" do not qualify as incidental psychological harm and that "a decline in civilian morale is not to be considered collateral damage in the context of … the rule of proportionality".

132 Both PTSD and generalized anxiety disorder are long-lasting conditions that can interfere with daily functioning, including the ability to work. National Institute of Mental Health, "Traumatic Events and

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Relatedly, an additional concern regarding the legal recognition of psychological harm is that it may not be sufficiently tangible and foreseeable to be incorporated into the IHL protective framework.[133] This concern arises from the inherently subjective nature of psychological harm, which varies across individuals and may make it difficult to establish predictability and a causal link between a specific event and the resulting psychological harm.[134] The issue is most pronounced for incidental psychological harm, which arises from the broader context of armed conflict rather than from deliberate acts. By contrast, direct psychological harm is more straightforward to address, as its inclusion within the obligation to respect and protect can be achieved by interpreting the notion of "respect" as prohibiting conduct that deliberately causes psychological harm to medical personnel.

Nevertheless, potential criticism that incidental psychological harm would be too intangible or unpredictable to be included under the obligation to protect should be rejected. Consider, for example, a soldier suffering from PTSD. Due to his mental condition, he would be regarded as wounded and sick under the definition found in the Geneva Conventions,[135] and as a result, he would benefit from protection under the obligation to respect and protect, meaning that he should be shielded from further harm.[136] If psychological harm is sufficiently tangible to trigger protection for the wounded and sick, the same reasoning should *a fortiori* extend to medical personnel.

Moreover, it should be borne in mind that the obligation to protect requires parties to take preventive measures to minimize, as far as possible, psychological harm to medical personnel. Scientific studies on trauma prevalence among medical personnel in armed conflict can provide guidance on the likely occurrence and severity of incidental psychological harm in specific circumstances, and established conceptual frameworks for understanding psychological harm, most notably those relating to PTSD, can help identify when such harm reaches a level that impairs medical personnel's ability to provide care.[137] This, in turn, can inform both the

Post-Traumatic Stress Disorder (PTSD)", December 2024, available at: www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd; WHO, "Anxiety Disorders", 8 September 2025, available at: www.who.int/news-room/fact-sheets/detail/anxiety-disorders.

133 Compare with criticism on including incidental psychological harm to civilians in the proportionality analysis: see ICRC, *International Expert Meeting: The Principle of Proportionality in the Rules Governing the Conduct of Hostilities under International Humanitarian Law*, ICRC, Quebec, 22–23 June 2016, pp. 35–36.

134 *Ibid.*, p. 36; Julia L. Perilla, Fran H. Norris and Evelyn A. Lavizzo, "Ethnicity, Culture and Disaster Response: Identifying and Explaining Ethnic Differences in PTSD Six Months after Hurricane Andrew", *Journal of Social and Clinical Psychology*, Vol. 21, No. 1, 2002, p. 27.

135 See above notes 67–68. In addition to being in need of medical assistance – regardless of the origin of the medical condition, whether physical or mental – the soldier must refrain from any act of hostility. The 2016 Commentary on GC I, above note 50, para. 1345 seeks to find a balance between humanitarian considerations and military necessity: "Otherwise every combatant who is in need of medical care would automatically be entitled to be respected and protected and could thus no longer lawfully be attacked. Such far-reaching protection for combatants would be unrealistic and impossible to uphold in the context of an armed conflict."

136 *Ibid.*, para. 1360. It should be emphasized that in the context of hostilities, it must be visible to the opposing combatants that the soldier concerned is being treated for his condition in a medical facility: *ibid.*, paras 1344–1346.

137 E. Lieblich, above note 65, p. 205.

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identification of when preventive measures are necessary and the design of those measures.

Another aspect of criticism could concern the additional burden that conflict parties might face if psychological harm were interpreted as falling within the protection to be accorded to medical personnel. As noted, the duty to refrain from causing direct psychological harm is straightforward to observe, as it merely requires abstaining from conduct that causes such harm. The obligation to protect medical personnel from incidental psychological harm, on the other hand, would require active measures and resources, such as organizing resilience campaigns, providing psychological treatment and establishing mental health centres.

One might argue that imposing additional burdens on parties in the already constrained context of armed conflict could, at first glance, appear to exceed the scope of IHL; however, IHL already anticipates obligations addressing indirect consequences of armed conflict, such as organizing vaccination campaigns.[138] In any event, compliance with the obligation to protect medical personnel from incidental psychological harm should be assessed on a case-by-case basis, taking into account the resources and capacities available to the party concerned. In light of the balance that IHL seeks to strike between military necessity and humanitarian considerations, it would be excessive to require parties to take every technically possible measure to prevent psychological harm among medical personnel.[139] The relevant criterion to be taken into account is feasibility, which depends on factors such as the imminence and severity of the psychological harm, control over territory where the hospital is located, and the State's capacity and resources.[140] At a minimum, parties should aim to raise awareness of the psychological health effects on medical personnel enjoying special protection and take reasonable measures to mitigate them.

Ultimately, although safeguarding medical personnel against psychological harm may impose additional burdens on parties, such measures benefit all sides. Medical personnel are obliged, in accordance with medical ethics, to provide care and treatment to all wounded and sick persons, irrespective of whether those persons belong to their own forces or to those of the adverse party.[141] Protecting such personnel from psychological harm helps to ensure that they can continue performing these duties, which in turn serves the interests of all parties: wounded and sick combatants are more likely to recover and potentially return to the battlefield, while civilian suffering is also mitigated.

Conclusion

Medical personnel face significant psychological harm while performing their duties during armed conflict, whether directly through acts of violence or threats, or

138 See, in this regard, A. Müller, above note 13, pp. 150–151.

139 2016 Commentary on GC I, above note 50, paras 32, 1993.

140 *Ibid.*, para. 1365; 2025 Commentary on GC IV, above note 55, para. 1895.

141 GC I, Art. 12(2)–(3).

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indirectly through the pressures of working under conflict conditions and witnessing the suffering of those affected by the armed conflict. Such harm not only affects their well-being but also undermines their ability to provide care, with consequences for patients, health systems and communities more broadly.

In recognition of their indispensable role in armed conflict, medical personnel are entitled to special protection, reflected in the obligation to respect and protect them at all times. This article has called for an interpretation of this obligation that encompasses protection against both direct and incidental psychological harm. Rather than this being an unduly idealistic proposal, it has been shown that IHL already contains the necessary characteristics to accommodate such protection. First, the inclusion of protection against psychological harm should be understood as a natural consequence of the recognition within IHL of the "person" in a broader sense, safeguarding both their physical and mental integrity. This recognition has also found its way into the protection framework for medical personnel, as evidenced by several provisions referring to the safeguarding of the mental health of protected persons. In addition, the inclusive interpretation proposed by this article is supported by the broad formulation of the obligation to respect and protect, as well as by the object and purpose of the Geneva Conventions; indeed, such an extension is necessary if IHL is to preserve its legitimacy as a body of law aimed at alleviating human suffering.

Incorporating psychological harm under the obligation to respect and protect will not be an easy task, particularly with regard to incidental psychological harm. While protection against direct psychological harm can be accommodated as a prohibition under the obligation to respect, addressing incidental psychological harm requires active measures by conflict parties. Despite remaining uncertainties regarding practical implementation, objections grounded in the alleged intangibility of psychological harm or in the perceived additional burden for conflict parties cannot justify rejecting this interpretation. Recognizing the mental health of medical personnel as an integral aspect of their special protection under IHL ultimately serves the interests of all those in need of medical assistance during armed conflict.

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