This article is based on the Samuel Gee lecture given at the Royal College of Physicians on 19 May 1994 by The Countess of Limerick, Chairman of the British Red Cross Society, London.

A disaster may be defined as an event which either directly threatens the lives of individuals and/or communities, or so harms economic and social structures that it undermines vulnerable people’s ability to survive. The causes may be man-made such as war, or technological such as industrial accidents, or natural: sudden earthquakes, floods or typhoons, for instance, or slowly developing famine or epidemics.

Doctors play a vital role in treating the injured or sick victims in all such situations, but their contribution is only one part of a wide range of expertise needed to provide clean water, sanitation, shelter, food, transport and communication.

In the early 1990s the geography of disasters changed rapidly, shifting relief spending from Africa and Asia to Eastern Europe and the newly independent states of the former Soviet Union. Disasters have become more complex: all the famines in Africa in the past decade have involved civil wars as well as drought. They have also become more pervasive: in the Horn of Africa and Asia, relief at the height of the famine was delivered to 10% of the population, but in the Caucasus, Albania and former Yugoslavia up to 40% of the population is in need of assistance.

In situations of armed conflict, the victims and medical personnel have protected status under international humanitarian law but there is no equivalent international treaty to protect the victims or those assisting them in natural or technological disasters. Primary responsibility in all disaster situations rests with the government of the affected country, or in cases of civil war, with the competent authorities of the different factions.

In disasters it is economically and socially vulnerable persons who suffer most and take the longest time to recover.

Scale of vulnerability

Since the early 1980s, wars have become not only increasingly frequent and lengthy, but also more cruel and destructive. In consequence, the number of refugees has risen from 2.8 million in 1976 to 17.5 million in 1994, with a further 25 million persons displaced within their own countries. This means that now one in every 130 persons on earth has been forced to flee from home. The euphoria that greeted the end of the Cold War in 1989 has dissipated as the collapse of political and economic structures and the cycle of conflict, ecological destruction, famine, and mass population displacement have increased the global number of people affected by disasters three-fold, from 100 million in 1980 to almost 300 million in the mid 1990s.

The International Red Cross and Red Crescent movement

The International Red Cross and Red Crescent Movement is not only the world’s largest humanitarian non-governmental organisation, but also has the longest and most extensive experience in protecting and assisting the victims of armed conflict and natural disaster. Surgeons, public health physicians and other medical specialists have played a prominent role in its formation and development.

The Movement has three operational components:

- The International Committee of the Red Cross (ICRC) which operates in areas of armed conflict
- Recognised national societies of which there are 162, whose members assist in all kinds of emergency and provide health and social welfare services in their own countries
- The International Federation of Red Cross and Red Crescent Societies whose secretariat coordinates international relief following disasters in non-conflict zones and assists national societies with their development.

These components are united by the Movement’s humanitarian mission to protect life and health, uphold human dignity and alleviate suffering; although they have separate functions they cooperate closely with each other. Their actions are guided by the same fundamental principles:

- neutrality—not taking sides or engaging in political, religious or ideological controversy
- impartiality—helping all in need without discrimination
- independence—each component retaining autonomy of action.
National societies support both the ICRC and the Federation with funds, personnel and supplies, and there is a formal agreement between the two defining their respective operational spheres, allowing them to mount joint relief operations.

Cooperation in Rwanda

Red Cross response to the atrocities being perpetrated in Rwanda illustrates how cooperation works. The ICRC has been working with the Rwandan Red Cross for three years, caring for up to 900,000 displaced persons arising from the conflict between the Tutsis and Hutus which broke out in 1990. When tribal slaughter erupted with terrible ferocity in April 1994 and all other aid agencies were forced to leave, the Red Cross in Kigali put two hospitals under protection of the red cross emblem. Two French Médecins Sans Frontières doctors, for security reasons, joined the ICRC team which has increased to over 40, with surgeons, nurses and anaesthetists and convoyers from the British and other Red Cross societies, who are now treating the victims of both tribes in five centres. Medical supplies were brought in immediately from surrounding countries, and food from the World Food Programme.

Despite the massacre of 13 Rwandan Red Cross personnel who were defending orphans, the overwhelming majority of civilians and combatants have respected the Red Cross emblem. However, the Red Cross cannot stop the killing, and their work is but a small pool of humanity in an ocean of bloodshed.

In early April the Federation redeployed its personnel from Rwanda to Tanzania, and together with the Tanzanian Red Cross became the first to assist the influx of over a quarter of a million refugees, the largest refugee camp ever, with a British Red Cross delegate in charge of one large section. Red Cross, the first to send relief, has now been joined by UNHCR and other agencies and they plan and work closely together.

Historical development of the Red Cross and international humanitarian law

The scandalously inadequate medical arrangements made by armies in the 1850s were brought to public attention by the introduction of the war correspondent W H Russell in the Crimean War, in 1854-6, reported the dreadful reality for The Times newspaper, and so evoked public opinion and the well-known response of individuals such as Florence Nightingale and her band of nurses. Furthermore, the invention of new weapons and the use of conscript armies by all major European powers except Britain, led to worse injuries and created nationwide awareness of the horrors of war. Development of the telegraph made the impact more immediate: Reuters reported by telegraph the fall of Sebastopol in 1855 and conveyed the first news of the battle of Solferino in 1859.

The Red Cross owes its foundation in 1863 not only to Henry Dunant, a Swiss businessman, who had organised volunteers to care for the wounded after the battle of Solferino in 1859 in which France defeated Imperial Austria in Northern Italy, but also to a Swiss surgeon, Louis Appia, who later operated on some of the injured.

Dunant successfully appealed to influential opinion throughout Europe with the publication in 1862 of his book A memory of Solferino which contained two major recommendations for improving the condition of those wounded in war. Supported by Appia, another surgeon and two other Swiss citizens, this Committee of Five, which later became the ICRC, convened an international conference in 1863 and adopted Dunant’s proposal that volunteer aid societies should be formed in each country to assist the army medical services, to be identified by a red cross on a white armband to indicate their neutrality.

A red cross on a white ground (the reverse of the Swiss flag) was chosen in 1864 as the ‘protective’ emblem for military medical services; it is used to this day by army, air force and naval medical services, as well as by the ICRC and national society personnel when subject to military authority in wartime. Misuse of the emblem has, sadly, occurred quite frequently. In the 1875 Russo-Turkish war, Turkish soldiers mistakenly perceived the red cross flag as ‘a religious symbol’ and fired on Red Cross medical units. In desperation, the Turkish authorities obtained the acceptance by the ICRC and the Russians to use the red crescent to identify their medical services for that particular conflict. They used it de facto for 50 years until 1929, when the Geneva Conventions were revised and the Red Crescent emblem was given equal status; it is now used in some 25 Islamic countries. One or other emblem is used ‘indicatively’ by each national society with official authority—given to the British Red Cross by the Defence Council—to indicate membership.

In 1864, 12 nations signed the first Geneva Convention for the amelioration of the condition of the wounded in armies in the field, inaugurating what is known as the Humanitarian Law of Armed Conflict, or Geneva Law. It made individual states responsible for observing prearranged, permanent and binding regulations for the care of the wounded and for the protected status of religious and medical personnel, their hospitals and transport, who should be inviolable from attack. Previous arrangements had rested on customary law or only temporary agreements. Conventions were added in 1907 to protect shipwrecked servicemen, in 1929 to protect prisoners of war, and in 1949, when the Geneva Conventions were revised again, a fourth was added to protect civilians in time of war, especially those interned and those in occupied territories.

The first Geneva Convention stimulated the parallel development from 1868 onwards of the laws of war, known as Hague Law following the 1899 Hague peace
conference. These rules govern the conduct of hostilities and are based on a series of declarations or conventions outlawing the use of weapons that cause unnecessary suffering, such as certain explosive projectiles, Dum Dum bullets, poison gas, and bacteriological and chemical weapons.

Two protocols additional to the Geneva Conventions were signed in 1977 to give further protection to civilians. They have not yet been ratified by either the USA or the UK although Britain has announced its intention to do so.

The basic rules of contemporary international humanitarian law require that:

- the wounded, sick and shipwrecked must be cared for regardless of whether they are friend or foe
- prisoners must be treated humanely
- civilians must not be attacked and are entitled to protection from acts of violence
- the Red Cross emblem must be respected and the ICRC allowed to carry out its mandate
- only military targets may be attacked and the use of force must be proportionate
- it is prohibited at any time to commit murder, torture, mutilation or to take hostages.

Misunderstanding of the role of the Red Cross is frequent. It is the responsibility of states to enforce the Geneva Conventions and to punish those who commit grave breaches or war crimes. The contribution of the Red Cross is to protect and assist the victims of war, hence the motto of the ICRC 'inter arma caritas'.

The Geneva Conventions also lay down the duties and rights of medical personnel serving in armed conflicts (see Appendices 1 and 2).

There is an overlap between international humanitarian law and human rights. Human rights apply mainly in peacetime and govern the relationship between a state and its own citizens, whereas international humanitarian law mainly applies in times of armed conflict and governs the relations between states, or between groups of the population at war within a state, and concerns individuals when at the mercy of an opposing power.

**The International Committee of the Red Cross**

The International Committee of the Red Cross (ICRC), founded in 1863, is a private institution with a governing body of Swiss nationals. Its international designation applies to its activities and not its composition. It has a staff of 660 at its headquarters in Geneva and 1,000 expatriate delegates, of whom over 200 are medical, and 5,000 locally recruited staff working in over 60 countries, more than 35 of which are experiencing armed conflict.

The ICRC is mandated by the Geneva Conventions to protect and assist prisoners of war and civilians in international armed conflicts such as the Gulf War. In civil wars, as in Yemen, Rwanda, Afghanistan, it is
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authorised to offer its services to the leaders of opposing armed groups. No party is obliged to accept and sometimes the ICRC has to negotiate repeatedly in order to be allowed to reach the victims on all sides. Other organisations, who assist only one party to a conflict, are usually not able to enter areas controlled by another party, and the ICRC may eventually be the only organisation to reach those civilians.

How does Médecins sans Frontières (MSF) compare? MSF was founded in France in 1971, from where it has spread to other countries, by doctors disillusioned with what they saw as the ICRC’s unwillingness to protest loudly and publicly enough against acts of inhumanity. MSF’s readiness to speak out about one or other side, and to go in without the consent of authorities, gives them in theory a flexibility which the Red Cross lacks. But MSF too has discovered that in practice parties to a conflict look for evidence of neutrality and impartiality in deciding whether to let outsiders minister to victims of that conflict. Unauthorised use of the emblem by organisations which do not adhere to the ICRC and national societies’ strict rules of neutrality dangerously undermines trust in its neutral significance and puts lives at risk. Tragically, five ICRC delegates were killed in 1992; in 1993 the number of Red Cross/Red Crescent personnel killed in the course of duty rose to over 30.

The ICRC is active in the world today on an unprecedented scale. The five areas of activity which it carries out with the help of national societies, relate to protection, medical assistance, relief, tracing and dissemination work. Doctors play an important role in the first two.

For its protective activities, a doctor and tracing delegate are included in ICRC teams who visit prisoners of war and people detained for political reasons, to register their names, ensure that their treatment is humane and give them Red Cross message forms to communicate with their relatives. The doctor checks their health and talks to them in private, takes note of any ill-treatment, and may recommend medical treatment and issue medicaments. The team insists on access to all places of detention and on being permitted to make follow-up visits to avoid the alarming occurrence of ‘disappearances’ and to verify that proposed improvements to living conditions in the prisons have been implemented. In 1993 almost 144,000 detainees were visited by the ICRC in over 2,300 places of detention within 47 different countries. ICRC reports to detaining authorities and to prisoners of wars’ own governments on physical and psychological conditions are confidential, although the ICRC reserves the right to publish a report if a government has issued an inaccurate or partial version.

Amnesty International operates by publicising detainees’ plights and mobilising world opinion, and is therefore seldom able to visit prisoners. The world needs both organisations.

The ICRC medical work concentrates on war wounded and war disabled. The ICRC sets up its own surgical hospital or provides expatriate teams to work in existing local facilities. The aim of all such activities is to support local staff with supplies and the necessary training to cope with conflict-related emergencies and organisational shortcomings. In conflicts, the medical division provides expertise and assistance in war surgery and emergency care, first aid training for combatants and civilians, medical repatriation and evacuation, distribution of basic pharmaceutical and medical materials for emergencies, physiotherapy and orthopaedic rehabilitation of people disabled by war, therapeutic feeding, primary health care and sanitation. The repair of water supplies, veterinary care and the issue of tools and seeds are other essential components of rehabilitation provided by the ICRC.

In 1993, nearly 23,000 patients in eight countries were treated surgically, over 9,000 of them by ICRC expatriate staff or local doctors under immediate expatriate supervision. Burundi, Somalia, Afghanistan and Cambodia, and now Angola, Yemen and Rwanda are the chief theatres of surgical activity.

For example, the ICRC/Somali Red Crescent hospital in North Mogadishu, which I visited in 1992 by way of a rice-carrying Hercules aircraft landing between the sand dunes, had a dozen expatriate doctors and nurses supervising many Somali doctors and nurses; the latter continued when security deteriorated after the UN landings to the point that expatriates had to withdraw temporarily. The hospital, which for three years has been the only surgical facility in that part of the capital, received over 3,000 admissions per year. At the same time the ICRC was bringing in sufficient food to feed one and a half million people daily through 900 feeding kitchens, distributing medical supplies to hospitals and clinics in other parts of Somalia and was operating two helicopter mobile surgical teams and an extensive veterinary inoculation programme. Millions of lives have been saved.

The medical division of the ICRC is equally active in education, spreading knowledge of health problems related to armed conflict, including those specific to prisoners and detainees, and organises regular seminars on health in prisons and on war surgery. The latter cover Red Cross classification of war wounds and many important aspects of war surgery, including triage, wound excision and delayed primary closure.

In addition to its practical manual Surgery for victims of war, the ICRC has produced three videos for teaching civilian and military surgeons: ‘Management of war wounded patients’, ‘Anti personnel mine injuries —surgical management’, and ‘A basic introduction to operating theatre techniques’.

Limb wounds account for 70% of all war wounded patients and British surgeon Robin Coupland’s excellent publication, War wounds of limbs—surgical management, adds up-to-date lessons for surgeons, based on the ICRC’s experience over the past 12 years of performing 45,000 operations on war casualties.
Anti-personnel mines

It was ICRC doctors who first drew public attention to the severe mutilation of men, women, children and animals wrought by anti-personnel mines for years or decades, even after hostilities have ceased.

Over 100 million mines lie unmarked in the ground in more than 62 countries. Every month some 800 people are killed worldwide and at least a further 450 injured as they go to cultivate their fields, graze their animals or play on waste ground. Whole villages, fields and forests are turned into 'no-go' areas, preventing food production and many refugees from returning home. It takes a team of four mine clearers one month to clear an area the size of a tennis court. The task will be long, costly and dangerous.

The worst affected countries are Angola, where nine million mines are scattered over one third of the country; Afghanistan where, in one district over a period of two years, one in 50 of the population was killed and one in 30 suffered injury; and Cambodia where land-mines have caused more casualties than any other weapon and where there are over 30,000 amputees arising from mines—one in every 236 persons—it will take 4,000 years to clear the mines at the present rate of progress.

Red Cross surgeons have been sickened by the extent of the injuries as land-mine explosions 'drive dirt, bacteria, clothing and metal and plastic fragments into the tissues causing secondary infections'. Casualties often cannot reach treatment for several days or even weeks. The human cost is enormous as medical facilities are overwhelmed by traumatic amputations, and disabled survivors become a social and economic burden, plunging their whole family into abject poverty.

Tragically, the laws of war have singularly failed to halt the escalation of civilian mine casualties. This dire situation led the ICRC in April 1993 to hold a symposium, and in February 1994 to call for a worldwide ban on anti-personnel mines as the only effective humanitarian solution; meanwhile, as a practical measure their use should be restricted by universal ratification and strengthening of the 1980 UN Weapons Convention.

Rehabilitation of war-disabled individuals is another vital ICRC medical activity; in 1993 more than 12,000 amputees were fitted with prostheses and over 3,000 with other orthopaedic appliances in 28 rehabilitation centres in 14 countries. The British Red Cross runs an orthopaedic workshop with the Ugandan Red Cross where there are thousands of persons disabled by 20 years of war under Idi Amin and Obote, and by poliomyelitis following the collapse of any preventive immunisation. It is a joy to witness the patients' thrill at being upright and mobile after years of literally crawling on the ground.

Some issues raised by the conflict in former Yugoslavia

Over three million mines have been laid in former Yugoslavia since 1991, as Red Cross personnel and the United Nations Protection Force know to their tragic cost.

The ICRC is seriously concerned over the use, by other bodies, of armed escorts of the United Nations
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(UN) to protect humanitarian convoys in places like Bosnia, since this leads to politicisation of humanitarian action by making humanitarian assistance, political peace-making and military peace-keeping interdependent. The ICRC's ability to protect and assist all victims rests on its being perceived as a specifically neutral intermediary, therefore in principle it will not use armed escorts except for protection against banditry.

One fifth of all aid going into former Yugoslavia has come from the Red Cross. In 1993 the ICRC visited more than 28,000 prisoners in some 200 different places of detention in Bosnia, and secured the release of more than 2,400 detainees, reunited over 1,000 persons with their families, set up a medical assistance programme of surgical supplies and medicines for 270 hospitals and clinics, delivered food each month to over 600,000 vulnerable persons in institutions and hospitals, provided engineers to repair vital drinking water supplies, and when the UN had to withdraw from Sarajevo, Red Cross personnel remained to continue its daily soup kitchen for 15,000 persons. More than four million Red Cross messages between family members within Bosnia and abroad in 99 different countries were exchanged at the rate of 100,000 per week. Such handwritten notes are the only way prisoners can let their families know they are alive.

The ICRC has 214 expatriate staff in Bosnia, 38 supplied by the British Red Cross, and 760 local employees.

The Federation, supported by many national societies, also has a massive relief programme for 1½ million people in the non-conflict zones of Croatia, Serbia/Montenegro, Macedonia and Slovenia, distributing through the local Red Cross food, hygiene parcels, infant care parcels, medical supplies and a social welfare programme which includes support for psychologically traumatised persons, for refugees and displaced persons in settlements.

The International Federation of Red Cross and Red Crescent Societies

The Federation, called 'the League' until 1991, was founded in 1919 after the First World War following a
medical conference which extended Red Cross societies' actions in peacetime to meet the dire health needs arising from famine in central and eastern Europe, epidemics of typhus, cholera and influenza sweeping across the continent, and countless disabled and sick servicemen and bereaved families needing continuing care.

The Federation's 1994 membership of 162 national societies, with a further 23 in formation, covers 97% of states in the world. The secretariat in Geneva of about 250 professional staff of 30 nationalities coordinates international relief. Its health division gives technical assistance to national societies for health projects, for first aid and hygiene training, and for Red Cross blood programmes, worldwide.

In 1993 the Federation had at any one time over 300 relief and development delegates working in 65 countries, supporting the efforts of national societies, and assisting more than 15 million persons worldwide.

In the same year only 11 appeals were for natural disasters but 22 relief appeals were launched for emergencies relating to population movements arising from conflict.

The Federation's role in natural disasters

Once a week a natural disaster strikes somewhere in the world; one in three is beyond the resources of the affected region and this is when a national society can call on the Federation secretariat for help. The secretariat can assist with immediate assessment and can launch an international appeal to other national societies, coordinating the people, money and materials that are requested and donated.

The success of an appeal depends to a great extent on worldwide media coverage of accessible victims. This has a profound influence on governments, who sometimes seek to gain political kudos from meeting a publicised humanitarian need, and on the public who are moved to help by pictures of suffering but with only a partial understanding of the problems and of the affected region's ability to cope. This has led to a growth both in the number of people wanting to travel to a disaster site, irrespective of local requirement, and of organisations of variable experience competing for publicity to raise money for relief activities. Television stories, to be newsworthy, tend to focus on the immediate response phase and expatriate assistance from the country of broadcast; whereas the immediate response is only one part of a much longer cycle of reconstruction, rehabilitation and disaster prevention and preparedness.

The experience of the Federation, however, is:

- At the response phase, most lives are saved by local people, local Red Cross or Red Crescent volunteers and local officials and professionals.
- Expatriate search and rescue teams are rarely needed even after sudden onset disasters since experience has shown that they seldom reach the site in time. For example, a study of earthquakes in the 1980s showed that 95% of trapped victims were extricated alive, rescued within 48 hours; therefore to be effective rescue must be within two days, preferably 24 hours. The most important factor determining the survival after entrapment is the length of time and appropriateness of medical care: intravenous fluids, stabilisation of the neck with a cervical collar and maintenance of airway are crucial. Most countries prone to earthquakes are now well identified and many have the necessary doctors and sophisticated equipment available. In major earthquakes, such as those in Turkey in 1992 and India in 1993, local health systems were able to cope with the high number of surgical cases removed from the rubble. Extra supplies, however, were needed and sent.
- In most slow-creeping disasters people face the same health problems as in day-to-day life, and local doctors with knowledge of the indigenous culture diseases and health systems, are better placed than expatriates; although large scale epidemics may require expatriate assistance.
- The nearer the resources, the faster they arrive, therefore local expertise, familiar with the country and language, is utilised to the maximum; where possible, purchase of materials is made locally which not only supplies familiar goods but also boosts the local economy.
- After relief there is the need for continuing support to rebuild the infrastructure when the media have often lost interest. According to the nature and scale of the disaster, the Federation may recruit experts with appropriate specialist skills, such as public health doctors, nurses with expertise in nutrition, water or sanitation engineers or specialist teachers such as speech therapists or teachers of the deaf.
- When the recovery phase of an operation is over, the Federation secretariat and the national society work together on longer term programmes to help the affected people to withstand disasters. The most effective way is to develop basic health and education services and income-generating skills to reduce the vulnerability of the poor, and to train and equip populations at risk in disaster preparedness.

The 1994 Code of conduct relative to humanitarian aid in times of disaster

A voluntary code of conduct exists which embodies the following four key principles:

1. The humanitarian imperative comes first: there is a need for unimpeded access of humanitarian non-governmental organisations and relief should be decided upon in partnership with the affected country.
2. Aid should be given impartially.
3. The culture, customs and structures of assisted communities must be respected.
4. All agencies must respect the dignity of disaster victims in their information, advertising and publicity activities.

Blood transfusion

The National Red Cross and Red Crescent Societies make available in whole or in part two-thirds of the world’s supply of blood.

The history of Red Cross involvement with worldwide blood transfusion activities began in Britain in 1921 with a telephone call from King’s College Hospital to the Camberwell division of the British Red Cross, urgently seeking volunteers to donate blood for a seriously ill patient. Red Cross secretary Percy Lane Oliver, and five others volunteered, only one of whom was the correct blood group. As further requests came, Percy Oliver formed a permanent panel of donors for hospitals in London which grew into the London Blood Transfusion Service and then as affiliated donor panels were added from all over the UK into the British Red Cross Blood Transfusion Service, so that by the early 1940s there were 2,000 donors reaching 6,000 cases a year. The enormous growth of blood transfusion during World War II led to the state taking permanent responsibility, and the British National Blood Transfusion Service was established in 1946, still collecting from volunteer donors.

Worldwide, 23 National Societies are in total charge and 41 societies collect a large part of the blood, and a further 92 participate in the recruitment of voluntary, non-remunerated blood donors. Only 26 societies have no activities in blood programmes.

Through Red Cross involvement in blood transfusion, national societies also are involved with the worldwide effort to eliminate AIDS and other blood transmitted conditions. One hundred national societies have active AIDS programmes ranging from hospital research in Thailand through health education and care of sufferers, to homes for children who are orphaned.

The British Red Cross Society

The British Red Cross is best known for its work overseas in 46 countries which represents half its annual expenditure of about £60 million; of the 83 delegates working in 28 countries, a third are medical, a third logistical and a third financial or administrative. For example, in Hong Kong a British Red Cross medical team has provided primary health care for 7,000 Vietnamese Boat people in High Island camp for three years.

The vast majority of our membership of 90,000 volunteers, headquarters staff of 286 and branch staff of 1,200, is engaged in voluntary service to the sick, injured, frail, elderly, disabled persons and refugees within the UK.

It is because of our regular activities in the community, our network of 91 county branches and over 1,000 centres throughout the UK, and the training undertaken by our members, that the society was well placed to fulfil its obligations as a Voluntary Aid Society to give assistant nursing and welfare support to the medical services of the armed forces at the time of the Gulf War (when St John Ambulance worked with us). The Society also offers support to the statutory emergency services, including the NHS, in the event of a major local or national emergency in peacetime.

The Society has recently reviewed its strategy and decided to enhance its emergency capability and to plan its community, training, youth and international services to give time-limited care to the most vulnerable. Hence our mission statement ‘to give skilled and impartial care to people in need and crisis in their own homes and in the community, at home and abroad, in peace and war’.

Many of the 1,000 doctors within our membership are volunteer medical officers, responsible for all medical aspects of each branch’s or centre’s activities, in particular first aid training given to over 150,000 persons each year, and first aid cover at some 37,000 events annually.

The Red Cross has provided first aid, transport, escort, international message and tracing services or comfort for survivors, bereaved relatives and rescuers in all the technological accidents, floods and storms that have occurred in Britain in recent years. Red Cross medical officers are the only persons in rest centres qualified to prescribe medicaments to survivors, evacuees and relatives. The British Red Cross is also the agency designated to distribute EC grants to help disaster victims and their families, and has set up a disaster appeal scheme which can be immediately activated and used by any local authority to appeal for funds.

Reaffirmation of humanitarian values

Despite the endeavours of doctors and the Red Cross, why has humanitarian law been so blatantly flouted and the Red Cross so often frustrated in fulfilling its mandate?

Part of the explanation may be that international humanitarian law cannot work properly unless the parties to a conflict are convinced not only that its rules are important but also that following them is compatible with their military objectives.

But the objectives of some parties to the conflict in many ethnic conflicts are not merely to acquire territory but also to exclude ethnic and religious minorities; and so the civilian population, which is supposed to be spared the effects of armed conflict, becomes the very point of harassment, attack and forcible displacement. The rules of war are important; eventually
opposing leaders will have to negotiate peace arrangements with each other; this will be infinitely harder if atrocities and hatred are out of control.

The prevalence of ethnic conflicts reveals an erosion of fundamental humanitarian values. As Fyodor Dostoevsky reminded mankind: ‘Each one of us is responsible to all others for everything’.

### Appendix 1—Duties of medical personnel in armed conflicts (laid down by the Geneva Conventions)

- To provide humane treatment for the wounded and sick without distinction
- To respect medical ethics
- To abstain from:
  
  a) **all acts of hostility**: only light weapons may be carried which may be used only for self defence or for the defence of the sick and wounded for whom medical personnel are responsible
  
  b) **grave breaches of conduct** (war crimes): which are subject to prosecution at any time and in any place and include
     - wilful killing
     - torture or inhuman treatment
     - wilfully causing great suffering or injury
     - wilful acts or omissions which endanger health or integrity
     - perfidious use of emblem
  
  c) **any procedure not indicated by state of health**: medical, biological or scientific experiments are not permitted (even if consent is given); however, donation of blood for transfusion or skin for grafting, if consent has been given, is permissible
  
  d) **any cooperation in reprisal action**.

### Appendix 2—Rights of medical personnel in armed conflicts

Medical personnel are entitled by right to:

- Respect and protection
- Access to the sick and wounded
- The means and facilities to provide care
- Carry and use light weapons for defence of self and patients

- Exemption, in principle, from capture and retention except to look after prisoners of war from their own forces
- Freedom to act without compulsion, fear of reprisal or punishment

Medical personnel cannot be:

- compelled to act contrary to medical ethics
- compelled to give information (with exceptions)
- punished for discharging medical duty
- subject to reprisal.

The rights of medical personnel are not allowed to be renounced.

(NB some of these are qualified)

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