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INTERNATIONAL COMMITTEE OF MILITARY MEDICINE
Reference Centre of Education of International
Humanitarian Law and Ethics

Directorate

CONFERENCE PROGRAMME

19 April 2012 to 21 April 2012
Forum Lilienberg, Ermatingen

2nd ICMM Workshop on Military Medical Ethical Dilemmas in Disaster Relief, Humanitarian Missions and Conflict

Patronage

Major General Andreas Stettbacher, MD
Prof. Dr. phil. Peter Schaber
Brigadier General Erwin Dahinden, Dr. iur.

Scientific Coordination

COL Hans Ulrich Baer, Professor MD
Dr. phil. Daniel Messelken

Course Organisation

COL Martin Bächtold

Thursday 19 April 2012

Plenary Session I Law, Ethics, and War

	Chairpersons	**Prof. P. Schaber / MG A. Stettbacher**	**CHE/ ICMM**
0900 – 0905	Welcome Address	MG (ret) R. van Hoof, Secretary General	ICMM
0905 – 0915	Introduction to workshop	Col H.U. Baer	ICMM
0915 – 1000	Ethical origins of the Law of Armed Conflict	Dr. Bill Boothby	UK
1000 – 1045	Legal Aspects of Physicians' Involvement in Armed Conflicts	Sigrid Mehring, LL.M.	DEU
1045 – 1100	*Coffee Break*		
1100 – 1200	Case Discussion in Groups	Cases 1a and 1b (Dr. B. Boothby/ S. Mehring LL.M.)	
1200 – 1300	*Lunch*		

Plenary Session II Decision Making in Medical Ethics

	Chairpersons	**MG M. Merlin / LTC R. Allani**	**ICMM/ TUN**
1330 – 1335	Introduction	Col H.U. Baer	ICMM
1335 – 1415	Military Medical Ethics for the 21st Century	D. Carrick	UK
1415 – 1500	Case Discussion in Groups	Cases 2a/b (MG. M. Merlin / LTC R. Allani)	
1500 – 1530	*Coffee Break*		
1530 – 1600	Introduction to Medical Ethics	Col H.U. Baer	ICMM
1600 – 1700	Role Play in Ethical Decision Making	Col H.U. Baer/ Dr. phil. D. Messelken Cases 2c/d	ICMM/ DEU
1830 – 1930	Dinner		
Afterwards	Gathering & Drinks		

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Friday 20 April 2012

0700 – 0800	*Breakfast*		

Plenary Session III — Military Medical Ethics (1)

Level of Care for the Local Population

	Chairpersons	**BG M.K. Chebbi / C. Clarinval**	**TUN/ CHE**
0800 – 0805	Introduction	COL H.U. Baer	ICMM
0805 – 0905	The duty to provide care to the wounded or sick enemy: grounds, scope and limitations	Dr. P. Bouvier	ICRC
0905 – 1015	Case Discussion in Groups	Case 3a/3b (C. Clarinval / Dr. P. Bouvier)	CHE/ ICRC
1015 – 1045	*Coffee Break*		
1045 – 1200	Case Discussion in Groups	Case 3c/3d (BG J. Johari / SCOL Min Yu)	MYS/ CHN
1200 – 1300	*Lunch*		

Plenary Session IV — Military Medical Ethics (2)

Intercultural Ethical Aspects during Deployment

	Chairpersons	**Dr. M. Barilan / AVM M. Reksoprodjo**	**ISR/ IDN**
1330 – 1335	Introduction	COL H.U. Baer	ICMM
1335 – 1420	Intercultural Aspects of Disaster Medicine	Drs. A. Ahmad	UK
1430 – 1530	Case Discussion in Groups	Cases 4a/4b (Prof. F. Wang/ T. Fuchs)	(CHN/ DEU)
1530 – 1600	*Coffee Break*		
1600 – 1700	Round Table Discussion	Chair: COL B. Mattiesen (DEU) Discussants: AFM Maryunani (IDN), COL H.O Khalil (BHR), LTC C. v. Einem (DEU), Prof. J. XU (CHN) Same Dikongue Same Moudoumbou (CAM)	
1815 – 1830	Welcome Address	Lieutenant General Blattmann (Chief Swiss Armed Forces)	
1830 – 1900	*Apéro*		
1900 – 1930	Concert	SWO Wiesli/ Brass Band Bazenheid	(CHE)
1930 – 2030	*Official Workshop Dinner*		
Afterwards	*Gathering & Drinks*		

Saturday 21 April 2012

0700 – 0800	*Breakfast*		

Plenary Session V Challenges for the Medical Officer

	Chairpersons	**LTG V. Ramlakan / LTG M.K. Pasha**	**RSA/ BGL**
0800 – 0820	Introduction	COL H.U. Baer	ICMM
0820 – 0900	"Saving lives – changing minds" ethical challenges for a National Red Cross Society	Dr. h.c. A. Huber-Hotz	SRC
0900 – 0945	Discussion in Groups	Case 5a/b (LTG V. Ramlakan/ LTG M.K. Pasha)	
0945 – 1015	*Coffee Break*		
	Chairpersons	**COL P. van der Merwe/ Prof. Z. Wang**	**(ICMM/ CHN)**
1015 – 1100	Ethical reflections on the role of the Medical Officer	Dr. phil. D. Messelken	DEU
1100 – 1130	Plenary Discussion	Cases 5c/d	

Closing Remarks

1130 – 1200	Closing Remarks	MG A. Stettbacher	CHE
1200 – 1300	*Lunch*		
Afterwards	*Check-Out and departure*		

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CHATHAM HOUSE RULE

The world-famous “Chatham House Rule” is invoked at meetings to encourage openness and the sharing of information. The whole workshop shall be held under the “Chatham House Rule”. It reads as follows:

> "When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed".

EXPLANATION OF THE RULE

The Chatham House Rule originated at Chatham House with the aim of providing anonymity to speakers and to encourage openness and the sharing of information. It is now used throughout the world as an aid to free discussion. Meetings do not have to take place at Chatham House, or be organized by Chatham House, to be held under the Rule.

Meetings, events and discussions held at Chatham House are normally conducted 'on the record' with the Rule occasionally invoked at the speaker's request. In cases where the Rule is not considered sufficiently strict, an event may be held 'off the record'.

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Abstracts of the Presentations

Session 1

Dr. B. Boothby - *Ethical origins of the law of armed conflict*
I trace the humanitarian philosophy that gave rise to the early development of the law of armed conflict and trace how the balance between humanitarian concern and military necessity, central to its acceptance, have influenced its subsequent development.

Sigrid Mehring, LL.M. - *Legal Aspects of Physicians' Involvement in Armed Conflicts*
Because the basic duty of 'respect and protect' in international humanitarian law is well-known, I would like to outline some less known provisions of IHL that complete the legal framework for the work of physicians, whether military or civilian, in armed conflicts. The legal boundaries for physicians' involvement are especially interesting and I will dedicate some time to medical war crimes as defined in international humanitarian and criminal law.

Session 2

Don Carrick – *Military Medical Ethics for the 21st Century*
In 2003 the Borden Institute of America, at the instance of the Office of the Surgeon General, U.S. Army, published its ground-breaking two-volume collection of papers on Military Medical Ethics. At the time of publication one of the editors of the collection, Thomas M. Beam, said 'Our unifying theme is straightforward: There is a tension within the individual military physician between the profession of medicine and the profession of arms, and that tension is good'. The general theme of my presentation will be on much the same lines as that one, but set against a background of nearly ten years of subsequent further analysis of the issues highlighted in the Borden collection, and of the accumulated practical experience of military-medical professionals in engaging with those issues on and off the battlefield. In the presentation I shall outline and draw on the work of the twenty-or-so contributors to a forthcoming two-volume collection of papers by acknowledged experts in the theory and practice of military medical ethics, edited by Michael Gross and myself, which we hope will become the natural successor to the Borden Institute volumes.

Prof. H.U. Baer – *Introduction to Medical Ethics (followed by role play)*
This introductory lectures presents the current mainstream approach to medical ethics which is the so-called principlism first introduced by Beauchamp and Childress. The four principles and their implications are introduced and a model for ethical decision making based on these principles is developed. The approach takes into account the needs and the context of military physicians who shall be enabled to independently conduct an ethical analysis of critical cases.
A role play that follows the session exemplifies one or two relevant cases and gives the participants the opportunity to practice the model from different points of view.

Session 3

Dr. P. Bouvier - *The duty to provide care to the wounded or sick enemy: grounds, scope and implications.*
Introduction: In war and armed conflicts, the parties have a duty to treat humanely the persons who are not taking part in the hostilities or who are *hors-de-combat*, and to collect and provide care to the wounded and sick, without any discrimination. This duty is indeed a core element of International Humanitarian Law and it is deeply grounded in Ethics. It may seem a rare paradox that, in war, you have a duty to provide care to the enemy when he is wounded or sick.
This presentation will briefly consider the history of this duty, the ethics of rescuing persons in distress, and explore the duty to take care of the wounded enemy. Reviewing arguments in recent debates, it will explore how this duty derives from the principle of humanity, and how it closely relates to the medical neutrality and the functional independence of health services in armed conflicts.
The duty to take care of the enemy applies without compromise. What are its practical limits, when resources are limited and security is threatened? The answer in the field is guided by an ethics of responsibility, in light of the context, the dependency of wounded persons and the principles of equivalence of care. Ultimately the best guide might be the golden rule: take care of the wounded enemy as you would like yourself to be treated in similar circumstances.

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Session 4

Drs. A. Ahmad – *Intercultural Aspects of Disaster Medicine*

As eminent medical ethicist, Edmund Pellegrino, states; 'culture and ethics are inextricably bound to each other'. Treating a person ethically in medical practice thus involves recognition and respect of the culture that forms their values and beliefs. This principle is amplified in disaster medicine because the context is often in a different culture, and where resources are limited. To illustrate, I use several case-studies that contain ethical conflicts between cultural values and humanitarian intervention. I conclude by reinforcing the need to maintain awareness of the intercultural aspects disaster medicine in order to recognize, mediate, and resolve such conflicts.

Session 5

Dr. A. Huber-Hotz – *"Saving lives – changing minds". Ethical Challenges* for a National Red Cross Society

The humanitarian activities of ICRC, IFRC and its 187 National Red Cross and Red Crescent Societies are based of the 7 ethical principles of the Movement (Humanity, Impartiality, Neutrality, Independence, Voluntary Service, Unity and Universality). National Societies works in the fields of health, rescue and social welfare for the most vulnerable peoples in their own country as well as in the world.

Swiss Red Cross is faced with ethical questions in its work for the care.

"Health care in danger" - in armed conflicts, natural disasters and other emergencies – is a new, very important project of the Red Cross and the Red Crescent Movement to be presented to the workshop. Ethical guidelines in medicine is also a contentious political issue in Switzerland. Some points out of the ongoing discussion and a personal view will be mentioned in the final remarks.

Dr. D. Messelken – *Ethical reflections on the role of the medical officer.*

Fulfilling the role of a medical officer can lead to a series of ethically problematical situations. During the workshop some exemplary cases have already been discussed. This presentation aims at exploring some of the underlying ethical assumptions and theories, that describe the double role of the medical officer.

Being physician and soldier he is subject to two professional ethics that from case to case may obligate him to different paths of action. Many of the dilemmas a physician-soldier may face can thus be explained by the double role he is fulfilling. Explaining this role from an ethical point of view and showing how to deliberate in conflicting situations is the main topic of this presentation.

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Case Studies

Cases for Session 1

Case 1a. Fictitious: *Physicians' Involvement in Coercive Interrogations*

After a firefight somewhere in an armed conflict, the troops capture an injured combatant of the adversary party. It is not clear whether the person is a prisoners of war, a common civilian, or a civilian actively participating in hostilities. Their military leaders are interested in the information that this person might hold. As the wounded combatant awakes, a physician performs a medical check-up of the now detained person. Subsequently, the detainee is interrogated, possibly with the use of coercion or even torture.

- Should the physician perform a medical check-up knowing that the detainee will subsequently be coercively interrogated and/or tortured? Should a physician 'clear' a detainee for interrogations?
- What information can the physician pass on to the interrogators? Does a detained person have a right to confidentiality of medical information?
- Should a physician be involved in interrogations, for example to monitor the health of the detainee during interrogation?
- The detainee returns from the interrogation with bruises on his chest and face, and some broken ribs. What should the physician do? Should the physician report this? Should the physician prevent further interrogations?
- The detainee passes away while in detention. The dead body shows signs of torture. What should the physician do?
- Is it desirable that physicians contribute to the development of interrogation techniques?

Case 1b. *Role of Physicians in the Development of Weapons*

With their knowledge of the human body, of amongst other areas, neuroscience, physiology, pharmacology, or psychiatry, physicians' input can be instrumental in developing new weapons. Modern weapons do not necessarily have to be lethal as the recent development of non-lethal weapons, such as malodorants, calmatives or eye attack lasers, has shown. In the development of non-lethal weapons physicians may be even more essential as the thin line between lethal and harmful but not lethal has to be found and respected. Despite their misleading name, however, non-lethal weapons may also injure or in worst-case scenarios kill individuals. Most parties to a conflict use both conventional and non-lethal weapons that may maim, injure or kill anyone they target or hit. This includes civilians who are the main victims of modern conflicts.

Article 35 (2) Additional Protocol I second paragraph reads:
"It is prohibited to employ weapons, projectiles and material and methods of warfare of a nature to cause superfluous injury or unnecessary suffering."

- What should a physician's role be in the development of lethal and/or non-lethal weapons and what role does international humanitarian law play in this respect?

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Cases for Session 2

Case 2a. *Non-assistance for security reasons.* (Adopted from literature)
You are a passenger in a convoy that drives past the aftermath of a roadside bomb. Several local nationals are wounded, and clearly in need of emergent care. However, the driver in the lead vehicle of your platoon refuses to stop and allow you to provide aid.

- How should you react?
- Is the decision of the driver ethically defendable?

Case 2b. *Detainee mistreatment by punitive medical examination.* (Adopted from literature)
An enemy combatant is brought to your aid station after capture by intelligence personnel. They want to question him, however he is moaning and complaining of eye pain, and acute loss of vision. He is appears to be malingering, and your colleague performs a 'punitive' exam maneuver (digital rectal exam) to call his bluff. The maneuver works, and the 'patient' can clearly see; however the laughter from the surrounding medics raises questions of detainee mistreatment.

- Should you treat the patient in order to facilitate the interrogation?
- How is the treatment to be evaluated from a military medical ethics perspective?

Case 2c. *A 4 months old boy with severely crushed autolytic legs after an earthquake.* (Real case)
Four days after the devastating earthquake in Haiti, a 4 months old boy is presented to a surgical team supporting the University Hospital in Port-au-Prince. The boy shows severely crushed legs with open wounds and signs of autolysis extending from the feet to both upper legs. He is somnolent and febrile.

- What treatment options could be envisaged?
- Are these treatment options reasonable in the actual disaster situation?
- How should one communicate the situation to the parents of the boy?

Case 2d. *Keep back own strategic emergency reserves.* (Adopted from real case)
During PSO Mission. While convoys operate between Cities A and B to transport personnel and material, a rescue helicopter is based midway at Camp C in order to guarantee efficient medical supply of soldiers in case of incidents. One day, a group of local people show up at the camp with a pregnant woman and ask for help. The physician realizes at once that only the immediate hospitalization of the woman by helicopter can save her life and that of her unborn child.

- Should the physician use the helicopter?

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Cases for Session 3

Case 3a. *Extent of medical care duties*. (Based on a real case reported to the ICRC)
The military forces of country DDD are at war overseas in country UUU. DDD forces have high quality medical services in the field and access to good tertiary care at home. Country UUU is poor, with very limited access and low quality medical services. Following military operations, DDD medical services provide medical care to severely wounded enemy patients from UUU. After emergency care the need arises to provide quality and sophisticated care, not available in UUU country.

- Question of the military physicians from DDD: "What is the extent of our ethical duty? Do we have a duty to transfer patients from UUU to their own country for tertiary care?"

Case 3b. *Lack of trust to the local care system*. (Based on a real case in Libya)
Problem statement: Local care is available but patients still ask to be medically evacuated
Imagine a context where the local health care system provides medical care according to acceptable best practice standards, but due to lack of trust in the health care system patients ask for evacuation to third countries.

- Should the wish to be medically evacuated be respected and are the justified?
- And if so on which ethical grounds can such operations be justified?
- Or should no cases be evacuated to third countries if medical care is locally available and up to standard?
- Is it ethically justified that resources are spent on medical evacuations for treatments that could be locally provided if patients insist on being medically evacuated due to a lack of trust in the local health care system?

Case 3c. *Does a terrorist forfeit his right to medical care?* (Adopted from literature)
AAA was a leading member of a terror organization based country BBB, which has targeted civilian population in the neighbour country ZZZ. AAA organized terror activities in ZZZ, in which 40 citizens were killed and 110 were injured. He had been tracked by the ZZZ military forces, and he eventually sustained an abdominal gunshot wound in a battle. He was transferred to a hospital in his country BBB where he underwent a partial colectomy. Due to his critical condition, the hospital transferred him to a University Hospital in ZZZ where he was admitted to the intensive care unit and his vital signs were stabilized. After 20 days' treatment, he was discharged in a stable clinical condition.

- At what point does the terrorist forfeit his right to medical care?

Case 3d. *Priority of care*. (Adopted from literature)
One soldier from your country and one soldier from the enemy present with gunshot wound to the chest. Both have low O2 saturations. You only have enough lidocaine for local anaesthesia for one patient, and only one chest tube tray. One will get a chest tube with local anaesthesia, and the other will get needle decompression and be monitored by the flight medic.

- Who gets the chest tube and local anaesthesia and why?

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Cases for Session 4

Case 4a. Fictitious: *Disability vs. Reincarnation*
In the context of a predominantly Buddhist community, the medical team in a UNIFIL medical unit wants to fly a 4 year child by helicopter in order to save his life. The child is suffering from meningitis. The parents are local and simple. Nobody they know has neither flown, nor been far away. The local missionary healthcare provider, who is a nurse, has alarmed the parents about the possibility of permanent neurological damage.
The parents refuse the care offered by the UNIFIL team on the basis that reincarnation, as their fate, will be the result of the child's imminent death and is preferable to a life suffering from disabilities of which there are no provisions for. The doctors feel that the child's disabilities are not incompatible with life and it is not futile to continue treatment.

Case 4b. Fictitious: *Pregnant and alone after an earthquake*.
A woman in her early twenties sustained severe injuries in an earthquake. She is Muslim, six months pregnant, and her husband and father are both missing in the aftermath of the earthquake. To save her life, an emergency cesarean is required. However, due to the extent of her injuries, it may be the case that a full hysterectomy will be required. In her society, a woman who fails to have children is ostracized. Furthermore, without the presence of an elder male figure of her family, the woman refuses consent for the surgery, consequently endangering her life. The woman is cared for in a makeshift military medical unit which is overburdened with many needy victims.

Cases for Session 5

Case 5a. *Compulsory extradition of criminal applicants for asylum*.
Switzerland signed an international treaty providing a neutral observation and monitoring of compulsory extradition of criminal applicants for asylum to their home country. The government asked Swiss Red Cross to accept this mandate. The challenging question was, if, from the ethical point of view, an independent humanitarian NGO should accept such a mandate.

Case 5b. *Medical treatment of prisoners in hunger strike.*
The Federal Supreme Court stipulated to the authorities of the penal system the compulsory feeding of a prisoner in huger strike, if this measure is the only way to prevent severe damages or the death of the prisoner. What are the ethical implications of such a compulsory feeding against the prisoners will?

Case 5c. *Triage Priorities*. (Taken from M. Adams: "Triage Priorities and Military Physicians". 2008**)**
1st situation: "[I]magine a battalion (approximately 400 soldiers) is facing an enemy force of about 550 soldiers and that each force is equipped with comparable weaponry. After several hours of fighting, 50 soldiers in the battalion are wounded. Most of these wounds are life-threatening; in fact, imagine that 40 out of the 50 are severely wounded and that the other 10 have only superficial wounds."
2nd Situation: "Now imagine the same scenario, but that instead of 50 being wounded there are 300 wounded and of these only 15 have life-threatening injuries (perhaps some fit into the category of those who will die whether or not they receive treatment and others will die if they do not receive treatment). Also, assume that the battalion will be overrun in the field if the physicians are unable to quickly treat those with superficial injuries."

- Who should be treated and why?

Case 5d. *Priority to comrades?* (Reported during LOAC Course)
The international PSO mission in Blueland at the moment is rather successful and no fighting has taken place lately. When a road accident happens in a village near to Redland's camp, the decision is taken to send the camp's single rescue helicopter to help treating some severely wounded victims. In the moment the helicopter is about to arrive at the accident, a patrol unit of Redland's troops sends a request for medical emergency aid as they have run on a landmine. They are far away from any medical aid and can only be reached in time by the helicopter.

- Should the helicopter turn over in order to help their own troops?

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Speakers

Drs. Ayesha Ahmad

A. Ahmad is a doctoral candidate in philosophy of medicine and ethics at the Peninsula College of Medicine of Dentistry, Universities of Exeter and Plymouth. Her background is Philosophy, Religion, and Psychoanalysis specializing in psychological trauma. She is a tutor at University College London Medical School and Visiting Research Fellow at the University of Durham, U.K. Her main research interests are in Ethics, particularly cultural or religious conflicts in the medical setting – including the emergency medical setting in disaster medicine and humanitarian intervention as well as in hospital practice.

Contact: ayesha00ahmad@yahoo.co.uk

COL Hans U. Baer, Prof. Dr. med.

COL Baer is a professor titularis of surgery of the University of Bern, Switzerland and professor at the Tarumanagara University of Jakarta, Indonesia. He is working in his own centre for abdominal surgery and is the director of the International Committee of Military Medicine reference centre of education for international humanitarian law and ethics, based in Switzerland.

He has also completed a Master in Advanced Studies in Applied Ethics of the Ethics Centre of Zurich University.

Contact: hans.baer@baermed.ch

Dr. Bill Boothby

Bill Boothby joined RAF Legal Branch in September 1981 as a qualified solicitor. During his career as an RAF Legal Officer he has served at JHQ Rheindahlen in Germany (1982 to 1986), at the Ministry of Defence, London (1986 to 1989 and 1991-1992), at HQ British Forces Hong Kong (1989 to 1991), at HQ British Forces Cyprus (1992 to 1996), at NATO Support Command HQ in Zagreb, Croatia (1996 to 1997), and at the HQ of the RAF Legal Branch at Innsworth near Gloucester from 1997 to 1999. He returned to MOD from 1999 to 2002 before being chief legal adviser at the UK Joint Doctrine and Concepts Centre, Shrivenham from 2002 to 2006, dealing with weapons law negotiations, legally reviewing new weapons and legally vetting all doctrine and concepts for future military activities. From 2006 to 2008 he served as a member of the legislation team at the Directorate General of Legal Services at MOD where he drafted secondary legislation to implement the 2006 Armed Forces Act. From 2008 to 2009 he took on the duties of Gp Capt Advisory at HQ Air Command on the staff of DLS(RAF), providing administrative law advice to the command and more widely to the Service.

He was promoted to Air Commodore on 3 April 2009 on appointment as Deputy Director of Legal Services (RAF). He retired from the Royal Air Force in July 2011.

His degrees/qualifications are BA in Economics, 1973 Kent University, Solicitor 1977, PhD in international law at the Europa Universität Viadrina, Frankfurt (Oder), Germany 2009. His book on 'Weapons and the Law of Armed Conflict' was published in 2009 by OUP. With Professor Michael Schmitt he is working on 'The Law of Targeting' to be published by OUP in 2012.

Contact: williamboothby@hotmail.com

Dr. med. Paul Bouvier

Dr. Paul Bouvier, MD, MSc, ICRC Senior medical advisor. Lecturer in public health, Geneva University.

After medical studies in Geneva, Paul Bouvier worked as physician delegate of the ICRC in the early 1980's, in detention and assistance operations in Africa and Central America. Specialization in clinical Paediatrics (Swiss paediatrics board FMH) and in Child Public Health (MSc in Community Paediatrics, London). From 1989 to 1996 he worked with the University of Geneva in research projects in child public health in Africa and in Switzerland. From 1997 to 2007, he directed the Child and Youth Health Services of Geneva, in charge of prevention and health promotion activities in schools. He developed various programmes and research in the field of preventive medicine and child protection, child ill-treatment and abuse, violence prevention, promotion of resilience. Chaired the Ethics committee for epidemiological research for 15 years.

As the ICRC Senior Medical Advisor, since 2007, his responsibility involves advising the ICRC Assembly and Directorate on health and ethical issues, ensuring the relevance and quality of humanitarian interventions in the domains of health and medicine, and ensuring ethics in the operations and in people management. He is the coordinator of the HELP course on the management of humanitarian emergencies, in 10 countries around the world.

Contact: pbouvier@icrc.org

Don Carrick

Don Carrick is currently a researcher in military ethics education in the Department of Defence Studies, King's College London, based at the U.K Defence Academy, Shrivenham, Wiltshire. He teaches political philosophy and jurisprudence at the University of Hull, and medical ethics in the Medical School at the University of Leeds. He has also taught medical ethics at the Hull -York Medical School and (online) at the University of Oxford. He has published on military ethics and military ethics education and co-edited two collections, also on military ethics education, for Ashgate Publishing. He is in process of co-editing with Michael Gross a two-volume collection for Ashgate entitled 'Military Medical Ethics Education for the 21st Century'.

Contact: D.Carrick@hull.ac.uk

Dr. h.c. Annemarie Huber-Hotz

Born in 1948 in Baar/ZG, married and mother of 3 adult children. 1969- 75 studies at the Universities of Berne, Uppsala/Sweden and Geneva in sociology and political science (lic.ès.sc.pol.), 1975-77 postgraduate studies in urban planning at ETHZ, 2004 Honorary doctorate awarded by the Faculty of Law at the University of Berne.

1978-2007 career in the Swiss Parliament and Government (1981- 1991 Secretary of the Council of States, 1992-1999 Secretary-General of Swiss Parliament, 2000-2007 Chancellor of the Swiss Confederation). Since 2008 Swiss Red Cross (2008-2011 as Vice- President, since 2011 as President). Member of the Board of the Lucerne University and of various foundations.

Contact: Annemarie.Huber-Hotz@redcross.ch

Sigrid Mehring, LL.M.

Sigrid Mehring studied international law in Amsterdam. After gaining valuable insights into the practical realities of international law during internships at the International Criminal Tribunal for the former Yugoslavia and at the Dutch Representation at the UN, she joined the Max Planck Institute for Comparative Public Law and International Law as a research fellow concentrating on international humanitarian and criminal law, and was a member of a research group on bioethics and law. In December 2011, she finished her Ph.D. thesis on 'The Role of Physicians in Armed Conflict – The Intersection of Medical Ethics and International Humanitarian Law'.

Contact: mehring@mpil.de

Dr. phil. Daniel Messelken

Daniel Messelken has studied Philosophy and Political Science in Leipzig and Paris (1998-2004). He has written his master thesis in 2004 on „Just Wars Today?". He finished his doctoral thesis on „The Notion of Interpersonal Violence and its Moral Evaluation" in 2010.

From 2004-2009 he worked as an assistant to Prof. G. Meggle at the Institute for Philosophy at the University of Leipzig. Since 2009 he is a Research Assistant on "Military Medical Ethics" at the Ethics Centre of Zurich University (Cooperation with ICMM and Swiss Armed Forces) and Scientific Coordinator at the ICMM Reference Centre of Education of International Humanitarian Law and Ethics.

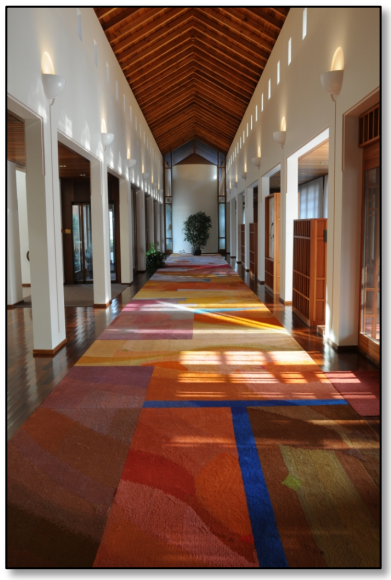
His main research fields include Just War Theory, the Morality of Violence, Military Ethics, Political Philosophy, and Applied Ethics in general.

Contact: messelken@ethik.uni-zuerich.ch

International Committee of Military Medicine
Reference Centre of Education of International
Humanitarian Law and Ethics
Witellikerstrasse 40, CH-8032 Zurich
Phone +41 44 387 30 92; Fax +41 44 387 30 90
E-Mail: hbaer@cimm-icmm.org – Web: www.reference-centre.ch

Scientific Coordination

COL H.U. Baer hans.baer@baermed.ch
Dr. phil. D. Messelken messelken@ethik.uzh.ch



Course Organisation

COL M. Bächtold martin.baechtold@vtg.admin.ch

Congress Language

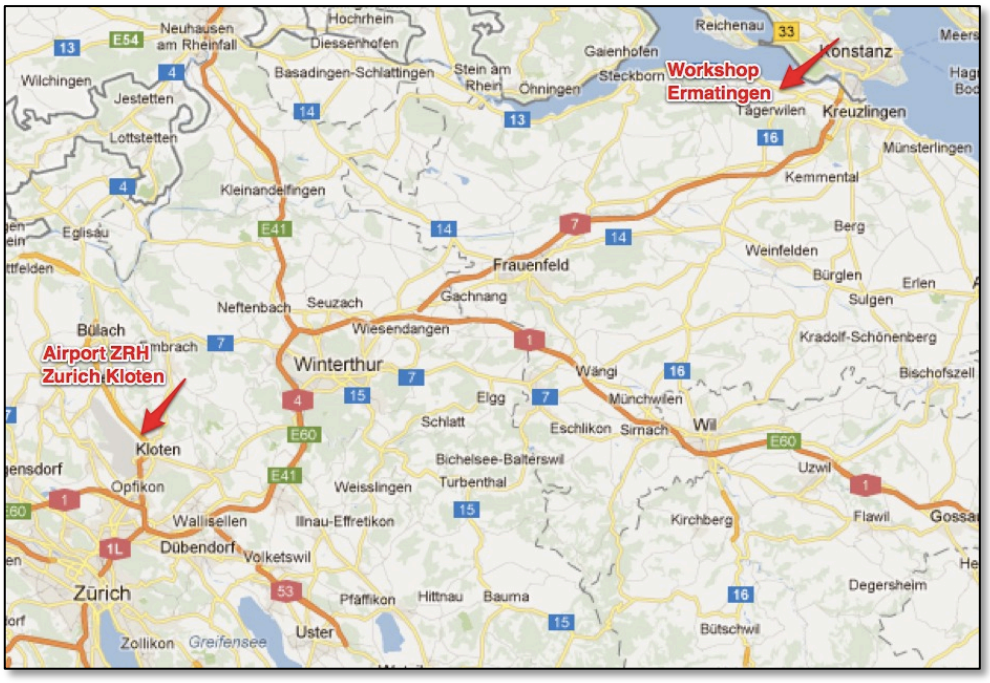
The official language of the workshop is English. No translation is provided during the workshop.

Dress Code

Military	Office Uniform
Civilian	No Code

Arrival to venue: Forum Lilienberg, Switzerland

Address	Blauortstr. 10, CH 8272 Ermatingen, Switzerland http://www.lilienberg.ch/
Airport	Zürich Kloten (ZRH)
Railway Station	Ermatingen
Shuttle	Transport in cars from the Airport to the conference venue will be organised. Please register early.
Workshop Fee	CHF 600



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Venue: Forum Lilienberg, Ermatingen (CH)

Aims of the Foundation

- Advancement of cultural and social activities of all kind
- Preserve liberal business ideas

Venue

- of encounter, discussion
- entrepreneurial education and culture

Forum

- Environment for thoughts
- Platform for discussions
- Forum of liberal spirit, everything may be thought, everything my be voiced, everyone learns form the others

Overview map of the venue

• (1)	Rooms 1-6	"Stiftung Lindeguet"	Guest rooms
• (2)	Rooms 51-52	"Zentrum"	Lectures and group discussions
• (3)	Rooms 40-44	"Forum"	Reception, group discussions, meals
• (4)	Rooms 10-35	"Gästehaus"	Guest rooms

Emergency-Number Lilienberg
+41 71 663 23 23

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Notes

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