Blocking Humanitarian Assistance: A Crime Against Humanity?

John D Kraemer, Georgetown University
Dhrubajyoti Bhattacharya
Lawrence O Gostin

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In May, Cyclone Nargis left nearly 140 000 people dead or missing in Burma, while the Government severely restricted international assistance. More recently, Zimbabwean President Robert Mugabe cut off international assistance, apparently to manipulate an election but leaving millions without food aid or medical care. The global community has a long and sad history of exalting human rights in the abstract but failing to protect them in practice. When political leaders wilfully block vital humanitarian aid to their people, they violate international human rights and potentially commit a crime against humanity. Such violations give the international community a legal right of intervention, with force if necessary. While intervention is best pursuant to authorisation from the UN Security Council, without such authorisation regional organisations or individual nations should prioritise the survival of large populations over the sovereignty claims of despotic leaders.

Can a right to health overcome barriers of national sovereignty? Human rights prevent states from claiming that systematic maltreatment of their nationals is exclusively a domestic concern. International law holds the state accountable for safeguarding the human rights of its people, and legitimises the actions of the international community to monitor and redress violations. This view was affirmed in the UN Charter, which proclaimed the UN’s mission as solving international humanitarian concerns through international cooperation.

The International Covenant on Civil and Political Rights guarantees the right to life, and the International Covenant on Economic, Social, and Cultural Rights codifies the right to health. Neither has been signed by Burma, although Zimbabwe has signed both but respected neither. Nonetheless, the rights to life and health are so widely accepted that they are part of international customary law. WHO’s Constitution also requires nations to seek to attain the highest possible level of health for all peoples. But it stops short of mandating countries to accept international aid during crises.

The right to health requires states to respect, protect, and fulfil basic health needs. This demands, at the least, the bare minimums to ensure survival, including medical aid and supplies, potable water, and food for the most vulnerable populations. During crises, countries have limited capacity to secure these public goods, but international law requires cooperation with the international community to meet these obligations. Additionally, the right to life is a non-derogable right, and even the most hardened isolationist regimes must respect it.

Even governments as repressive as Burma and Zimbabwe have ratified the Convention on the Rights of the Child (CRC), which recognises the rights to health and life, and demands international cooperation. The CRC requires states to ensure to the maximum extent possible children’s survival and development, including access to basic determinants of health. Moreover, signatories must “promote and encourage international cooperation with a view to achieving progressively the full realization of the right”. Consequently, they cannot invoke sovereignty to belie obligations to secure the health and wellbeing of their children. Humanity knows no borders and, though imperfect, human-rights laws should be applied vigorously to secure health and life during intentionally exacerbated public-health emergencies.

International crimes—which include genocide, war crimes, and crimes against humanity—are breaches of international norms that result in individual liability. The primary purpose of international criminal law is to bring the perpetrators of international crimes to justice. But when officials commit atrocities, the international community should not remain idle. If leaders act, or

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fail to act, in ways that will lead to widespread death—and then block those who seek to prevent it—they commit a crime against humanity and intervention is appropriate.

Assessing a county’s response to crises under a lens of preventing potential crimes against humanity proffers a useful and pragmatic standard. Generally, crimes against humanity are particularly serious attacks on human dignity. A finding of such crimes rests solely on the widespread or systematic practice of atrocities. Unlike war crimes, crimes against humanity may be committed during times of peace. And unlike genocide, crimes against humanity do not require a special intent to kill on account of group status. Perpetrators need only act with the wilful intent to inflict widespread or systematic harm on their victims—a bar that is readily met when officials block assistance to large populations with vital need.

Crimes against humanity require the infliction of “great suffering, or serious injury to body or to mental or physical health”—or extermination. Both acts that directly inflict injury and refusals to act can constitute a crime. In 2003, the International Criminal Tribunal for the Former Yugoslavia found a physician guilty of extermination for the treatment of prisoners during the 1990s’ Bosnian–Serb conflict, including for “conditions imposed on a [prisoner] whose health was fragile, [which] alone would inevitably cause his death”. The Court held that it was not only the resultant deaths but also the creation of conditions leading to a large number of deaths that justified a conviction. Accordingly, where governments block food, medical supplies, and health care to meet basic survival needs, preventing atrocities is consonant with securing the right to health.

Does international law permit humanitarian intervention? During humanitarian crises, the desire for assistance by the affected country almost invariably exceeds its available resources. Thus the normal crisis model is to request assistance from donor countries. However, when official conduct constitutes a crime against humanity, either by refusing aid to those in need (as in Burma) or actively creating a humanitarian emergency (Zimbabwe), ameliorating the emergency may require foreign intervention without host-country consent.

The UN Charter prohibits countries from intervening “in matters which are essentially within the domestic jurisdiction” of another state. However, under modern conceptions, sovereignty inheres in the people, not the government, so a government’s sovereign authority is conditional on refraining from grievous violations of human dignity. Thus sovereignty yields to human rights when a government has wilfully taken steps to cause death or widespread suffering.

Non-consensual intervention to relieve grave humanitarian need would likely require military force or its threat if relief efforts were resisted or endangered. This point subjects humanitarian intervention to the body of use-of-force law that prohibits the use or threat of force “against the territorial integrity or political independence of any state, or in any other manner inconsistent with the purposes of the United Nations.”

Intervention sanctioned by the UN Security Council to ameliorate a crime against humanity would be legal. The Charter permits the Council to authorise intervention if a crisis poses a “threat to the peace, breach of the peace, or act of aggression”. Threats to the peace extend beyond armed attack and include widespread suffering and crimes against humanity. This was the basis of the Council’s determination in 1992 that the “human tragedy” of famine in Somalia, exacerbated by deteriorations in that country’s stability, posed a “threat to international peace and security” even though the effects of the crisis were not significantly felt outside of Somalia. Upon a subsequent finding that non-forcible measures were unlikely to succeed, the Council authorised an American-led contingent to ensure delivery of humanitarian aid to starving Somalis.

A 2005 resolution of the UN General Assembly reiterated the Council’s power to act when governments “manifestly fail to protect their populations from...crimes against humanity” if peaceful means cannot avert the crisis. This authority would permit limited interventions, such as airdrops, but, if necessary, would permit broader Somalia-style “boots on the ground” interventions.

Unfortunately, the Council is often paralysed by its five permanent members’ ability to veto initiatives, necessitating examination of the legality of unilateral or coalition interventions. Notably, the Charter prohibits force only where “inconsistent” with UN purposes and when used against the “territorial integrity or political independence of any state”. “Territorial integrity” refers to shifting international borders, and “political
independence” to states gaining control of other’s political machinations. Intervention solely to stop a crime against humanity infringes on neither of these, so it does not fall within the Charter’s force prohibition. Furthermore, humanitarian intervention is within the principles of the UN, because the Charter’s dual purposes are preserving peace and promoting human rights.12

Additionally, international law requires the existence of grave violations of human rights, an exhaustion of non-forcible responses, and the unavailability of UN-sanctioned action. The response must be proportionate—no more than necessary to achieve humanitarian ends—and it must not interfere unnecessarily with a country’s self-determination. Finally, the interveners must disengage upon securing fundamental relief workers, civilians, and troops, as well as the danger of complicating future health-promotion activities. Forced intervention is a complex policy question, but blanket rejection may condemn innocent civilians and prevent deterrence of crimes against humanity. Where leaders engage in intentional acts of cruelty toward their populations, wealthy nations should be prepared to intervene beyond their borders to safeguard health and human rights.

John D Kraemer, Dhrubajyoti Bhattacharya, “Lawrence O Gostin

O’Neill Institute for National and Global Health Law, Georgetown University Law Center, Washington, DC 20001, USA gostin@law.georgetown.edu

We declare that we have no conflict of interest.

2 Rotberg RI. Who will have the courage to save Zimbabwe? Boston Globe June 25, 2008: A15.

How doctors feel: affective issues in patients’ safety

Two books have directed attention to the underpinnings of doctors’ thinking.12 Thinking (cognitive) failures abound in clinical decision making, especially in diagnostic formulation, and taxonomies of common cognitive errors have been developed.13 Diagnostic failure has been identified as a major threat to patients’ safety4 and, this year, the American Journal of Medicine published a supplement on the problem5 to coincide with the first symposium on diagnostic error.6 Despite the tardiness of this focus on how doctors think, we welcome the advance in evolution of patients’ care and safety. The more difficult next step is to recognise that how doctors feel would also be a complementary and worthy topic for investigation, especially for any effects on clinical decision making and patients’ safety.

Historically, the prevailing view in medicine is that clinical decisions should be objective and free from contextual affective issues: one could not be objective and rational if emotion entered the reasoning process. Indeed, many of us would consider it a professional virtue to be able to rise above the emotional pull of clinical situations, to deliver cool, clear, analytical judgments. However, despite what we might believe, our feelings (affect) intrude into almost every decision that we make. Our daily interactions with others are influenced by conscious or unconscious social transference phenomena7 which are affectively polarised in ways that range from subtle to substantial. Similarly, specific clinical situations provoke lesser or greater degrees of affective valence. In fact, our first response to anything is an affective one