Physicians for
Human Rights

520 8th Avenue Suite 2301,
23rd Floor
New York, NY
10018

+1.646.564.3720
phr.org

Call for Input: Health and Care Workers as Key Protectors of the Right to Health

Submission to the UN Special Rapporteur on the Right to Health

January 2025

Introduction

Physicians for Human Rights (PHR) is a global human rights organization that works at the intersection of science, medicine, and the law to document mass atrocities and human rights violations, and advocate for justice and accountability. PHR recognizes that health professionals, with their specialized skills, ethical duties, and credible voices, are uniquely positioned to address human rights violations. Yet, all too often, health care workers are criminalized, attacked and punished for providing medical care in support of their patients' right to health.

PHR provides this submission to respond to questions 6, 7, and 8 in the Special Rapporteur's call for inputs and recommend States parties to:

a. Condemn State policies and practices that lead to "dual loyalty" situations, including criminalization of health care and state action resulting in the denial of health care for detainees; and

b. Ensure accountability for attacks on health care as a violation of the right to health.

Limits on Health Workers Fulfilling the Right to Health: Examples from the United States

The right to health requires that health workers are able to provide medical care in line with their ethical obligations and medical standards of care, without risk of criminalization or other penalty.[1] Further, health workers must not be called upon to participate in the design and implementation of policies and practices that violate the right to health or constitute other violations of human rights.[2] Such situations of "dual loyalty," where obligations to an employer or State prevent health workers from upholding their ethical and professional duties, must be condemned clearly as violations of the right to health.[3] Where dual loyalty situations occur, States parties must act to allow clinicians to provide care ethically and in line with medical standards of care. Individuals who speak out against such violations must be protected against reprisals.

In the United States, PHR has documented numerous situations of dual loyalty leading to violations of the right to health. As this section discusses, State entities are imposing policies and practices that impede basic health care delivery and cause severe physical and mental health harm.

A. Criminalization of Care

Laws that mandate denial of health care and impose criminal or civil restrictions impede clinicians from upholding the right to health. For example, following the overturning of the federal protection of the right to abortion in the United States, PHR documented how criminal and civil abortion bans in four states led to delays and denials of reproductive health care, harming patients and health care workers alike.[4] U.S. states typically have bans with exceptions in certain circumstances, such as medical emergencies. However, PHR's interviews with more than 60 clinicians reveal the unworkability of this "exceptions-based" approach due to the climate of fear caused by criminalization. Clinicians reported patients being forced to wait until their health deteriorated before being given care, airlifted across state lines while facing emergency medical conditions, and unable to access care entirely due to administrative hurdles, and unnecessary referrals to avoid legal risk. The criminalization of care – even with exceptions – has led to delays and denials of abortion information and care, including in medical emergencies, prenatal care, miscarriage management, and even cancer [5]

Clinicians who provide abortion have faced disciplinary action, including by medical licensing boards.[6] A Georgia maternal mortality review committee was dissolved following reports of maternal deaths arising from the state's abortion ban.[7] Clinicians are leaving states with bans, deepening maternity care deserts that further endanger the right to health, particularly for marginalized communities.[8]

The United States experience affirms that the decriminalization of abortion – and not merely an exceptions-based approach – is necessary to ensure clinicians can defend the right to health and avoid situations of dual loyalty.

B. Policies Leading to Violations of the Right to Health in Detention

Federal policies that impede health workers from providing care in U.S. detention facilities, such as in Guantánamo Bay and immigration detention also create dual loyalty crises. Such policies have jeopardized detainees' health and safety. In certain facilities, health care professionals working for the United States were complicit in violations.

In the Guantánamo detention center, PHR research shows medical facilities are unequipped to provide the types of complex care needed by detainees, and that U.S. laws and policies consistently bar detainees from leaving facilities for specialized or complex care. Detainees were often denied access to their medical records. Even when this was made available, their information was frequently devoid of information about physical and psychological trauma histories.[9]

Other patterns of medical neglect and complicity in torture were found in U.S. immigration detention facilities. PHR documented that private prison medical staff employed by Immigration and Customs Enforcement (ICE) participated in involuntary medical procedures by force-feeding detained hunger strikers. ICE failed to adhere to international medical ethics standards, which forbid force-feeding as a form of torture.[10]

While ICE has internal medical oversight standards, these rules are often ignored, or health professionals are not given sufficient resources to ensure quality care. The 2013 "Segregation Directive" by ICE, for instance, mandates that its facilities must not place vulnerable populations in solitary confinement unless as a "last resort." Data obtained from ICE records, however, reveals that by 2023, 56 percent of detainees with mental health conditions were placed in solitary confinement, posing risks of exacerbating their conditions.[11] Independent medical experts also found that 95 percent of the 52 deaths in immigration detention between 2017 and 2021 were preventable or possibly preventable if ICE had provided clinically appropriate medical care.[12]

C. Recommendations

Safeguarding the right to health requires states to end practices of coercion and criminalization of care that compel clinicians to withhold services and become complicit in human rights violations. To that end, PHR recommends this thematic report:

- Call for the full decriminalization of abortion to ensure access to safe abortion and post-abortion care services.

- Condemn State policies and practices that lead to the denial of health care in detention settings and call upon health workers to refrain from participating in the design and execution of practices that violate the right to health or constitute torture or ill-treatment.

- Recognize medical professional organizations' power and influence in countering dual loyalty pressures and championing the right to health. Efforts by medical associations to defend the right to abortion in the United States through amicus briefs, as well as to institute bans on military psychologists complicit in torture in the Guantánamo Bay detention facility, offer strong examples of how medical associations can protect the right to health.

I. Acts Inhibiting Health Workers in Defending the Right to Health in Conflict Settings

Attacks against health care infrastructure in conflict areas around the globe present clear challenges to securing the right to health. Under international humanitarian law (IHL), medical personnel, ambulances, and hospitals are afforded a heightened level of protection at all times in conflict and only lose their special protection if they commit, or are being used to commit, acts

harmful to the enemy outside their humanitarian function.[13] In the rare instances when medical personnel, ambulances, and hospitals can be considered military objectives and lose their special protection, any attack must still comply with the principles of distinction, proportionality, and precaution.[14] All feasible precautions must be taken to minimize incidental loss of civilian life, injury to civilians, and damage to civilian objects including in the selection of targets. Attacks on hospitals implicate several human rights, including the rights to the highest standards of health, food, water, and life.[15]

UN Security Council Resolution 2286 creates complementary obligations for Member States to hold perpetrators of attacks accountable and provide victims with reparations. Nonetheless, the international community has made little progress to ensure compliance with the resolution and end impunity.[16] As a result, attacks against health facilities remain widespread, creating immediate and long-term health harms for civilian populations. In 2023, 480 health care workers were killed during armed conflict, nearly double the previous year.[17] PHR welcomes the statement by the Special Rapporteur on Health in May 2024 calling for an end to impunity for attacks on health and urges the reiteration of those recommendations in the thematic report.

A. Scope and Nature of Attacks on Health in Conflict

Military policy to target hospitals and medical personnel has the immediate impact of impairing access to qualified medical care. This occurs through physical attacks such as the killing of health workers,[18] attacks on health infrastructure,[19] or attacks on other civilian infrastructure such as energy infrastructure that incapacitates the health sector.[20]

Beyond physical attacks, PHR also documented the impacts of policies that undermine health care. For example, Russia's policy of "passportization" forces Ukrainian doctors in occupied territories to deny care to civilians without a Russian passport as a method to coerce changes of nationality. Doctors who refused to change their passports were dismissed, forced to undergo retraining in Russia, or detained.[21]

B. Gaps in Legal Determinations Concerning Attacks on Health During Conflict

International humanitarian law (IHL) is itself under threat as States promote interpretations that dilute their obligations to provide medical care to the wounded and sick regardless of affiliation, take all feasible precautions to minimize harm to civilians when attacking military targets, and to ensure proportionality where harm to civilians is anticipated in an attack on a military object.[22] For example, Israel claimed that the duty to take all feasible precautions to avoid or at least minimize civilian harm is met by warnings to evacuate alone. Israel also argued the proportionality requirement can be met by the existential threat the enemy poses, such that countering the threat always outweighs the harm of death, injury, and destruction.[23] The international community must strongly reject these efforts to undermine the protection of health care.

Armed forces often justify attacks on health care in the context of armed conflicts by claiming militarization and the immediate military needs of attacking forces and the commensurate harm to civilians. In practice, such analyses fail to consider the longer-term and cumulative impact of

attacks against health infrastructure and thus violate the IHL principles of precaution and proportionality.[24] These analyses also ignore the impact of attacks on health care on the civilian population's right to health, which explicitly remains in force even during conflict.[25]

Evidence collected by PHR affirms that attacks against health infrastructure create reverberating impacts on the health of civilian populations. For example, on average between 2017 and 2019, a health facility attack in Syria saw a 51 percent reduction in outpatient consultations and a 38 percent reduction in trauma consultations the day after an attack, with statistically significant reductions continuing for 37 and 20 days, respectively.[26] These attacks were further associated with an average 23 percent reduction in obstetric deliveries starting the second day after an attack, with significant reductions observed for 42 days. The sharp decline in consultations caused by attacks on hospitals represents thousands of patients unable to receive critical diagnoses, medications, procedures, or treatments. Frequent attacks against health facilities in Ethiopia also impeded care for survivors of sexual violence. Much of the suffering caused by the destruction of health care in conflict is foreseeable. In some settings, attacks on health may be part of a widespread and systematic pattern or a plan to deprive a group of the means of survival.

C. Recommendations

The protections under International Human Rights Law (IHRL) and IHL apply concurrently in conflict situations, and their protections are complementary and mutually reinforcing.[27] It is critical to underscore that the obligations to respect and protect the right to health require that the full cumulative and reverberating impacts of attacks on health are assessed in determinations of compliance with the principles of proportionality and precaution – not merely the direct impact of attacks.

II. Conclusion

PHR reiterates our appreciation for the focus on the role of health workers in upholding the right to health. The recommendations above outline critical measures to address widespread and persistent barriers to health workers' ability to defend and promote the right to health.

Endnotes

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[4] "No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-Roe Oklahoma," Physicians for Human Rights, Oklahoma Call for Reproductive Justice, and Center for Reproductive Rights, April 2023, https://phr.org/wp-content/uploads/2023/04/Oklahoma-Abortion-Ban-Report-2023.pdf; "Criminalized Care: How Louisiana's Abortion Bans Endanger Patients and Clinicians," Reproductive Health Impact, Center for Reproductive Rights, Lift Louisiana, and Physicians for Human Rights, March 19, 2024, https://phr.org/our-work/resources/louisiana-abortion-bans/; Whitney Arey, Michele Heisler, and Payal Shah, "Delayed and Denied: How Florida's Six-Week Abortion Ban Criminalizes Medical Care," Physicians for Human Rights, September 17, 2024, https://phr.org/our-work/resources/delayed-and-denied-floridas-six-week-abortion-ban/;
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[6] Sarah McCammon, "Indiana reprimands doctor who spoke publicly about providing 10-year-old's abortion," NPR, May 26, 2023, https://www.npr.org/2023/05/26/1177435278/indiana-reprimands-doctor-who-spoke-publicly-about-providing-10-year-olds-aborti
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[9] Deprivation and Despair," Physicians for Human Rights, June 19, 2019, https://phr.org/our-work/resources/deprivation-and-despair/
[10] Eunice Hyunhye Cho and Joanna Naples-Mitchell, "Behind Closed Doors: Abuse and Retaliation Against Hunger Strikers in U.S. Immigration Detention," Physicians for Human Rights and ACLU National Prison Project, June 23, 2021, https://phr.org/our-work/resources/behind-closed-doors/.
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[12] Eunice Hyunhye Cho and Tessa Wilson, "Deadly Failures: Preventable Deaths in U.S. Immigration Detention," American Civil Liberties Union and Physicians for Human Rights, June 25, 2024.
[13] GC IV, Art. 18-20; ICRC Study, Rules 25, 28 and 29; Additional Protocol I, Art. 13.
[14] GC I, Art. 21; ICRC Study, Rules 1, 7, 8, 14, 15-21, 25; AP I, Art 52(2); AP I, Art. 51(5)(b); API, Art. 57(2).
[15] ICESCR Arts. 11, 12; ICCPR, Art. 6.
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Through evidence, change is possible.

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[22] "International Humanitarian Law and the Challenges of Contemporary Armed Conflicts: Building a Culture of Compliance for IHL to Protect Humanity in Today's and Future Conflicts," International Committee of the Red Cross, September 2024, https://rcrcconference.org/app/uploads/2024/09/34IC_10.6-IHL-Challenges-Report-EN.pdf. ("some states have sought an increasingly expansive vision of what is permissible, and a contracted notion of what is considered prohibited").
[23] Leonard Rubenstein, "Threats to International Humanitarian Law in Ukraine and Gaza," Humanitarian Alternatives 27, November 2024, https://www.alternatives-humanitaires.org/en/2024/11/27/threats-to-international-humanitarian-law-in-ukraine-and-gaza/.
[24] Repercussive effects refer to the impact of an attack on healthcare on the ability of the facility to provide vital care to patients (that is meet the obligation of providing access to healthcare) beyond the immediate harm to the facility, its staff, and its patients. Cumulative effects refer to the spiraling impact of attacks on healthcare, even when an individual attack may not result in significant damage.
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[27] The complementary and mutually reinforcing protection of IHRL and IHL has been expressly recognized by the International Court of Justice, the European Court of Human Rights, and the Inter-American Commission on Human Rights, as well as by UN organs, such as the Human Rights Council, Special Procedures, and treaty bodies, see, for example, UN Office of the High Commissioner for Human Rights (OHCHR), "International Legal Protections of Human Rights in Armed Conflict" (2011), 118, https://www.ohchr.org/Documents/Publications/HR_in_armed_conflict.pdf; U.N. HRC, Resolution 9/9: Protection of the human rights of civilians in armed conflict, U.N. Doc. A/HRC/RES/9/9 (2008).