Gunshot Wound Reporting Legislation in the Asia-Pacific Region: A Need to Ensure Better Consistency with IHL

Kelisiana Thynne and Sahar Haroon[*]

ABSTRACT

This article builds upon a report compiled by the Swiss Institute of Comparative Law entitled, "Legal Opinion on the Obligation of Healthcare Professionals to Report Gunshot Wounds" covering 22 countries. The report drew three main conclusions: (1) that there is a universal obligation of doctor-patient confidentiality; (2) that most countries either incorporate a duty of healthcare professionals to report gunshot wounds or have more general reporting obligations that might include the reporting of gunshot wounds; and (3) that very few States have specific legislation protecting healthcare professionals and access to healthcare. Should mandatory gunshot wound reporting legislation require reporting prior to treatment it could impede access to healthcare for gunshot wound victims and lead to unnecessary suffering or death. This article shows that under IHL information sharing is indeed not prohibited and, in many cases, may be necessary. It argues therefore that while legislation affecting doctor-patient confidentiality is not consistent with medical ethics and arguably contrary to IHL in many cases it would be compatible with IHL to have appropriately nuanced reporting legislation that also protects confidentiality. Furthermore, this article draws some conclusions as to how legislation can operate to not impede access to healthcare. This article considers three States in the Asia Pacific region, Pakistan, Papua New Guinea and the Philippines and assesses how their laws on medical ethics and gunshot wound reporting have been or should be adapted to adequately reflect these IHL principles. Broadly speaking, States should revisit their reporting laws to ensure consistency with IHL, and while such contextualized legislation should be adopted by all States, it should ensure patient confidentiality and afford better clarity to healthcare professionals on when and how they are required to report.

Keywords: Asia-Pacific, international humanitarian law, gunshot wound reporting.

* Legal advisers, International Committee of the Red Cross (ICRC). The views expressed in this article do not necessarily reflect the position of the ICRC.

Gunshot wounds have been part of modern conflict and peacetime injuries for several hundred years. Eleven years before Henry Dunant wrote his treatise, A Memory of Solferino, which instigated the development of modern international humanitarian law (IHL), in 1848, The Lancet had already published clinical notes on gunshot wounds and how to treat them.[1] Indeed, the first Geneva Convention of 1864 is dedicated to the protection of those injured as a result of war and those who treat them. Studies have found that while explosive weapons cause the most damage in modern conflicts, in the early stages of conflict, gunshot wounds are most prevalent.[2]

Given the number of gunshot wounds around the world, it is perhaps not surprising that governments would like to document and monitor such occurrences as part of gun violence prevention programs. Gunshot wounds can also be indicative of criminal or conflict activity, and it is necessary for governments to be able to deal with such problems. Under IHL, sick or wounded persons should receive healthcare, healthcare professionals[3] should be protected when giving that care, and patient confidentiality should be respected. Reporting of wounds may be done but only after treatment has been given, and consistently with IHL and medical ethics. Mandatory gunshot wound reporting legislation could otherwise impede access to healthcare for gunshot wound victims and lead to unnecessary suffering or death.[4] Mandatory reporting legislation,

---

1 "Clinical Lectures on Gunshot Wounds", *The Lancet,* Vol. 52, No. 1308, 23 September 1848, available at: https://doi.org/10.1016/S0140-6736(02)70840-4 (all internet sources accessed 9 July 2020).

2 IJ Lewin, "Contingency: the likely spectrum of injuries based upon a review of 3 recent undeveloped theatres of operations; the Falklands," *Journal of the Royal Naval Medical Services,* Vol. 100, No. 1, 2014; Jowan G. Penn-Barwell, Kate V. Brown and C. Anton Fries, "High velocity gunshot injuries to the extremities: management on and off the battlefield," *Current Reviews in Musculoskeletal Medicine*, Vol. 8(3), 2015. A global study estimated that 251,000 people died globally from firearm injuries in 2016: Mohsen Naghavi et al., "Global Mortality From Firearms, 1990-2016", *Journal of the American Medical Association*, Vol. 320, No. 8, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6143020/.

3 The term encompasses "not only … doctors, but also … any other persons professionally carrying out medical activities, such as nurses, midwives, pharmacists and medical students who have not yet qualified." Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949*, ICRC, Geneva, 1987, para. 4686.

4 *See* e.g., *ibid*. para. 4683.

where it is inconsistent with medical ethics (whether treatment is given first before reporting or not), may be similarly inconsistent with existing domestic implementation of the IHL obligations that all governments have.[5] However, as this article will show, under IHL, information sharing is indeed not prohibited and in many cases may be necessary. It argues therefore that while some mandatory reporting legislation is not consistent with medical ethics and arguably contrary to IHL, in many cases it would be consistent with IHL to have appropriately nuanced reporting legislation.

In 2018, the International Committee of the Red Cross (ICRC) commissioned the Swiss Institute of Comparative Law (mandated by the Government of Switzerland) to draft a report on the obligation of healthcare professionals to report gunshot wounds (the report).[6] Finalized in 2019, the report did not focus solely on situations of conflict or on IHL obligations which is the ICRC's usual remit, but rather presented a global overview of domestic laws in regard to when and where healthcare professionals have to report gunshot wound victims to government authorities. The report also considers what medical ethical responsibilities affect adherence to such laws, and how they modify such laws.

The report is excellent and deserves greater study by all those interested in how legislation is formulated on reporting, medical ethics and protection of healthcare under IHL. However, the report does not answer some key questions which require further reflection, particularly in relation to IHL. One of the purposes of this article is to highlight the relevance of this Report for the Asia-Pacific region, while attempting to highlight contextual issues that require further deliberation.

Between the years 2006 and 2010, States in Asia and Oceania were reported to be the largest importers of major conventional weapons.[7] As many as 610,000 unregistered or "loose" firearms are said to be in

---

[5] The Geneva Conventions have been universally ratified.

[6] Swiss Institute of Comparative Law, *Legal Opinion on the Obligation of Healthcare Professionals to Report Gunshot Wounds covering Australia, China, Colombia, Egypt, El Salvador, France, Lebanon, Mexico, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Philippines, Russia, South Africa, South Sudan, Spain, Tunisia, Ukraine, United Kingdom*, 30 June 2019, available at: https://www.isdc.ch/media/1834/17-120-final-nov19.pdf (hereinafter "The Report").

[7] Melissa Gillis, *Disarmament: A Basic Guide*, 3rd ed., United Nations, New York, 2012, p. 58.

private hands in the Philippines.[8] The estimated total number of guns (both licit and illicit) held by civilians in Papua New Guinea in 2017 was 79,000.[9] In Pakistan in 2017, the number is 43,917,000.[10] The United Nations (UN) Register on Conventional Weapons recorded that Pakistan had imported 10,103 revolvers and self-loading pistols in 2017.[11] Papua New Guinea imported 103 assault rifles for the same year.[12] In 2018, the Philippines imported 85,126 revolvers and self-loading pistols.[13] Pakistan, the Philippines and Papua New Guinea are three States in the Asia-Pacific region which the Report presented.

All three States either suffer from armed conflict and/or situations of violence where gunshot wounds are prevalent. The article highlights the IHL implementation of each of these States as well as their legislative frameworks, and gives recommendations for further study and proposals for new laws in line with IHL. The article spends the most time on Pakistan and then presents Papua New Guinea and the Philippines as comparative examples. The reason for this is that Pakistan, as a federal system, is the most complex State legally speaking and has done the most work (than almost all other States) to amend its laws on mandatory reporting of gunshot wounds.

As the example of Pakistan shows, States in the Asia-Pacific region are considering amending their laws on healthcare protection, specifically as regards access to healthcare and gunshot wound reporting. With sophisticated laws now in place in Pakistan, States in the region may turn to this country for guidance. This article demonstrates some additional considerations that can guide Asia-Pacific States in the legislative process. It draws some conclusions as to how legislation can

---

[8] Matt Schroeder, "Illicit Small Arms and Light Weapons in the Philippines" in The Graduate Institute of International and Development Studies, *Small Arms Survey 2013: Everyday Dangers*, Cambridge University Press and the Small Arms Survey, Cambridge, 2013, p. 302.

[9] Aaron Karp, "Civilian Firearms Holdings, 2017: Estimating Global Civilian-Held Firearms Numbers," Small Arms Survey and the Graduate Institute of International and Development Studies, Geneva, 2018.

[10] *Ibid*.

[11] UN Register on Conventional Weapons, available at: http://www.un.org/disarmament/convarms/Register/.

[12] *Ibid*.

[13] *Ibid*.

operate to not impede access to healthcare. The example of the Philippines is useful to demonstrate the high level of IHL adherence and implementation which can be achieved in a country in conflict, in contrast with the few statistics and laws around gunshot wound reporting. Similarly, the Papua New Guinea example demonstrates that while assumptions can be made about gunshot wounds, without relevant laws, statistics cannot be collected, and relevant legal and policy decisions become more complex. It is hoped that the three examples provided also cover a wide range of legal and administrative systems which can be found in the Asia-Pacific region and can therefore be useful for other States seeking to learn from their neighbours' experiences (or the authors' recommendations for those States).

The report has demonstrated that there are a range of legislative, administrative and ethical practices around the world in relation to gunshot wound reporting and the protection of healthcare professionals. Going beyond the report, this article briefly outlines the IHL and international human rights law aspects of reporting, addresses the three State context, considers what the next steps are to ensure better access to healthcare for gunshot victims in these contexts and, by extrapolation, in other contexts around the world, and gives recommendations to ensure that there is more consistency with IHL obligations in relation to disclosure of information and protection of healthcare.

The Obligation to Protect Access to Healthcare and Protect Medical Professionals under International Law

The report looked at situations in armed conflict and outside of armed conflict (peace or situations of violence which have not reached the threshold of an armed conflict). As will be discussed in more detail below, the report did not attempt to distinguish between these different contexts and circumstances in their examination of the law and did not assess the laws in each State against the international legal obligations of the State. However, some gunshot wound reporting legislation (or legislation which affects doctor-patient confidentiality or requires reporting of otherwise criminal activity) might be in contradiction to the IHL and international human rights obligations of the relevant State if not appropriately nuanced, as will be explained below.

If the gunshot wound occurs in a context that has not reached the threshold of an armed conflict, the legal framework will be quite different; a law enforcement paradigm, not an IHL/conflict paradigm, will apply on the understanding that "human rights law regulates the resort to force by State authorities in order to maintain or restore public security, law and order."[14] Moreover, the State will have greater power to enforce its own laws in which ethical considerations may play a role depending on the applicable constitutional and legal framework (as discussed in the examples below). It can be that gunshot wounds occur in a country that is in conflict, but the wound and gun activity is in fact unrelated to the conflict—a law enforcement paradigm will apply here too. This might raise other legal and ethical considerations and concerns. These are the types of situations that our three State case studies face in gunshot wound reporting.

Armed Conflict and Protection of Healthcare and Access to Healthcare: IHL

An armed conflict exists where "there is a resort to armed force between States or protracted armed violence between governmental authorities and organised armed groups or between such groups."[15] "A resort to armed force between States" denotes an international armed conflict (also see Article 3 common to the four Geneva Conventions of 1949).[16] "[P]rotracted armed violence between governmental authorities and organised armed groups or between such groups" denotes a non-

---

[14] Gloria Gaggioli (ed.), "Expert Meeting Report: The Use of Force in Armed Conflicts Interplay between the Conduct of Hostilities and Law Enforcement Paradigms," ICRC, Geneva, 2013, p. 7, available at: https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4171.pdf.

[15] International Criminal Tribunal for the former Yugoslavia (ICTY), *Prosecutor v. Tadic*, Case No. IT-94-1 (Appeals Chamber), Decision on the Defence Motion for Interlocutory Appeal on Jurisdiction, 2 October 1995, para. 70.

[16] Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950); Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950); Geneva Convention (III) Relative to the Treatment of Prisoners of War of 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950); Geneva Convention (IV) Relative to the Protection of Civilian Persons in Times of War of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) (Geneva Conventions or GC I, GC II, GC III, GC IV).

international armed conflict where there must be organized armed groups and a certain intensity to the fighting. The Philippines for example has a number of non-international armed conflicts in its territory.

Geneva Convention I (GC I) (which, like all four Geneva Conventions, is universally ratified) provides for a wide range of protection of healthcare professionals, facilities, transportation and access to healthcare by wounded and sick soldiers in an international armed conflict. Geneva Conventions II-IV (GC II, GC III, GC IV) likewise provide specific protection of access to healthcare in international armed conflict for the wounded, sick and shipwrecked at sea (and hospital ships), detainees and civilians in the hands of the enemy.

In an international armed conflict, under the principle of *lex specialis*, IHL will override human rights law.[17] If the domestic law is in contradiction to IHL and the gunshot wound occurs in relation to hostilities during armed conflict, then depending on the State's international obligations or constitutional law, IHL obligations may override the domestic law. In a non-international armed conflict, there are two legal systems that continue in play—domestic law and IHL—the State is potentially fighting a non-State armed group with conduct of hostilities rules under IHL and yet also enforcing its domestic law against the fighters.[18] Minimum standards of humanity should continue to apply and in particular the treatment of the wounded and sick, including gunshot wound victims.

Protection of the Wounded and Sick: Gunshot Wound Victims

Under Article 12 of GC I, the wounded and sick enjoy a general right to be:

- respected (not to be subject to, for instance, being killed or ill-treated);[19]

---

[17] International Court of Justice (ICJ), *Advisory Opinion Concerning Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, *ICJ Reports 2004*, 9 July 2004, p. 136.

[18] *See* e.g., Jan Roemer, *Killing in a gray area between humanitarian law and human rights: how can the national police of Colombia overcome the uncertainty of which branch of international law to apply?* Springer, Berlin, 2009, p. 37.

[19] ICRC, *Commentary on the First Geneva Convention: Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 2nd ed., 2016, paras. 1353-1359 (hereinafter "2016 Commentary to GCI").

- protected (to be assisted, including protection against third parties);[20] and
- cared for (similarly subject to what is possible in terms of security conditions and capacities, but with the least possible delay).[21]

For each of these categories, States and non-States Parties to the conflict and healthcare personnel have corresponding obligations and responsibilities. Of note is the duty to provide impartial healthcare to all persons based on their injury or illness, not their membership of a particular armed group—the wounded and sick of the adverse party receive the same treatment and care as members of a party's own armed forces.[22]

"Wounded and sick" means persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, need medical assistance or care and who refrain from any act of hostility. These terms also cover other persons who may need immediate medical assistance or care and who do not directly participate in hostilities.[23] There is no threshold of severity of medical condition.[24]

Common Article 3 (CA 3) to the Geneva Conventions and Additional Protocol II (AP II) to the Geneva Conventions of 1977 (where a State has ratified it and the additional classification element of control of territory by a non-State armed group is satisfied) apply to non-international armed conflicts. CA 3 provides for non-discrimination and impartiality in the treatment of the wounded and sick, and this would of course include gunshot wound victims.

Article 7 of AP II provides for applicable standards of care in non-international armed conflicts as in international armed conflicts under Article 12 of GC I. In an armed conflict of an international or non-international character, all gunshot wound victims must be treated with

---

[20] 2016 Commentary to GCI, above note 19, paras. 1360-1362.

[21] 2016 Commentary to GCI, above note 19, para. 1380.

[22] 2016 Commentary to GCI, above note 19, para. 1392.

[23] Geneva Conventions, above note 16, Common Art. 3(1).

[24] Protocol Additional (I) to the Geneva Conventions of 12 August 1949 and Relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978), Art. 8 (hereinafter "API").

respect, protected and provided with care, with no distinction as to how they received the wound and indeed without delay. This is consistent with Article 12(3) which provides that only urgent medical reasons can justify prioritization of care. Reporting obligations before medical treatment are excluded, but not after treatment has been given.[25] Care should be given regardless of the classification of the conflict or the nexus to the conflict—that is, whether the gunshot wound victim received the injury in the armed conflict or outside it, for example, during criminal activity).

Protection of Healthcare Professionals

Healthcare professionals exclusively engaged in the search for, collection, transport, or treatment of the wounded and sick members of the armed forces, prevention of disease, and staff exclusively engaged in the administration of medical units and establishments are entitled to respect and protection under IHL (GC I, Article 24; GC IV, Article 20; Additional Protocol I [AP I], Article 15). Reprisals against healthcare workers for any acts they undertake in their duties are prohibited (AP I, Article 20). States should ensure that healthcare professionals are protected under the law and respected for decisions they make in their professional duties. Such decisions should include whether to treat patients before reporting, and to abide by medical ethics (in so doing they would likewise be acting consistently with IHL) as well as whether to report details of the wounds to authorities as required under legislation.

Medical Ethics

Healthcare professionals are also asked not to be compelled to carry out tasks incompatible with their humanitarian mission (AP II, Article 9). Under IHL, healthcare professionals shall not be punished under any circumstances for carrying out medical activities compatible with medical ethics, regardless of the persons benefiting therefrom. They should also not be compelled to carry out activities which are contrary to medical ethics (AP I, Article 16; ICRC Customary law study Rule 26).[26] Key

[25] 2016 Commentary to GCI, above note 19, para. 1425.

[26] Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1, Cambridge University Press, Cambridge, 2005; ICRC's

principles of medical ethics are beneficence, justice and autonomy,[27] which in turn require treatment of all with no discrimination, doing no harm, ensuring that the needs and views of the patient are respected, and requiring due process. For example, as a principle of IHL consistent with the principle of beneficence, they shall specifically not be compelled to give anyone from any belligerent party information concerning the wounded and sick under their care if such information would be harmful to these wounded and sick or their families (AP I, Article 16).

Therefore, during an armed conflict, healthcare professionals should pay particular attention to their medical ethics and not breach patient confidentiality if patients present with gunshot wounds. In particular, they should not give information about such patients if the patients will be subjected to punishment or ill-treatment. In the debates around AP II, and the specific protection of medical ethics, it was noted:

> If there is any doubt regarding a doctor's obligations towards the authorities, many of the wounded would risk suffering and dying, rather than risk being denounced. An obligation to systematically reveal the identity of the wounded and sick would divest the principle of the neutrality of medical activities of all meaning.[28]

Nonetheless, this does not mean that reporting cannot occur. Again, it was felt during the debates on AP II that "[i]n ethical terms, the rule against denunciation does not mean that information may never be given; the doctor has a certain measure of freedom of action to follow his own conscience and judgment."[29] Under the ethical principle of justice, due process is supposed to be followed, meaning that if the law requires reporting, it should be done, as long as it is consistent with the other medical ethical principles, and in the case of an armed conflict, with IHL. Therefore, it was precisely accepted under AP II that healthcare

---

Customary Law Database, available at: https://ihl-databases.icrc.org/customary-ihl/eng/docs/home.

[27] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed., Oxford University Press, Oxford, 1994.

[28] Y. Sandoz, C. Swinarski and B. Zimmermann (eds), above note 3, para. 4700.

[29] Y. Sandoz, C. Swinarski and B. Zimmermann (eds), above note 3, para. 4697.

professionals should inform about certain activities and findings during their work in an armed conflict consistent with medical ethics.

Situations of Violence Below the Threshold of an Armed Conflict and Protection of Healthcare and Access to Healthcare: Human Rights and Law Enforcement

In situations that have not reached the intensity required for a non-international armed conflict and lack circumstances involving organized armed groups, such as riots, internal disturbances and so on (see AP II, Article 1[2]), or without armed confrontation between two or more States resulting in an international armed conflict, IHL does not apply. Thus, the provisions listed above do not apply. Domestic law is applicable as well as human rights law (which is certainly also applicable during times of armed conflict in conjunction with IHL). The report addressed domestic law applicable to the reporting of gunshot wounds in predominantly (but not all) situations of peace or violence that did not amount to an armed conflict. A law enforcement paradigm operates in situations of violence, such as in Pakistan and Papua New Guinea for the most part (as noted above, in the Philippines there are several armed conflicts where IHL would apply, and yet a law enforcement paradigm might also operate in some parts of the Philippines rather than IHL). State authorities and police have their usual power to enforce national laws. The use of force is constrained, but so can human rights be. These laws are discussed briefly below.[30]

International human rights law provides several principles relevant to the protection of gunshot wound victims, the protection of healthcare professionals, and the protection of confidentiality. The International Covenant on Economic, Social and Cultural Rights (ICESCR)[31] in Article 12 provides that States must provide the highest possible attainable level of healthcare in their territory. The UN

---

[30] For an overview of "other situations of violence" in relation to healthcare laws, *see* Eve Massingham and Kelisiana Thynne, "Promoting Access to Healthcare in 'Other Situations of Violence' Time to Reignite the Debate on International Regulation," *Journal of International Humanitarian Legal Studies*, Vol. 5, No. 1, 2014.

[31] International Covenant on Economic, Social and Cultural Rights, 993 UNTS 3, (entered into force 3 January 1976) (hereinafter "ICESR").

Committee on Economic and Social Rights has said that, read in relation to the principle of non-discrimination:

> The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.[32]

The obligation to respect requires respect for medical ethics in the promotion of health, and the UN Committee has particularly noted that the duty to protect means ensuring that healthcare professionals meet appropriate medical ethical standards.[33] As Peel has said:

> Human rights and medical ethics are parallel mechanisms, the former working at the sociopolitical level and the latter more at the level of the doctor-patient relationship. Human rights place a duty on the state and on healthcare providers to comply with minimum standards. Medical ethics place a duty on individual doctors to comply with parallel standards. Human rights and medical ethics are complementary, and use of the two

[32] Committee on Economic, Social and Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), UN Doc. E/C.12/2000/4, 11 August 2000, para. 33 (hereinafter "General Comment No. 14").

[33] General Comment No. 14, above note 32, para. 35.

> together maximizes the protection available to the vulnerable patient.[34]

Therefore, healthcare professionals should be allowed to treat gunshot wound victims immediately without discrimination and without needing to report beforehand. This would enable them to comply with both the State-enforced human rights standards of respect and protection. The principles under human rights of fulfilling the full standards of health and the medical ethical principle of justice, however, do not mean that healthcare professionals cannot report the nature of the injury to ensure good record keeping and statistics. Indeed, it might be necessary under both systems to do so.

The right to privacy (International Covenant on Civil and Political Rights, Article 17) similarly would prevent release of confidential information, but it is constrained by the wording "[n]o one shall be subjected to arbitrary or unlawful interference with his privacy." It could be argued that reporting of certain information about gunshot wounds would not be arbitrary (certainly it is not unlawful as it mandated under laws that the report had considered). Thus, in times of non-conflict, even when the situation amounts to violence, human rights might and should nuance the application of laws and influence amendments to those laws.

The Report: A Summary

Looking solely from a legal perspective, while slightly touching on some issues of medical ethics, the report addressed the following questions paraphrased below:[35]

1. What is the general framework for confidentiality/ duties of disclosure of healthcare professionals towards State authorities?
2. Is there a duty of healthcare professionals to disclose gunshot wounds of patients to authorities, and if so, under what conditions?

---

[34] Michael Peel, "Human rights and medical ethics", *Journal of the Royal Society of Medicine*, Vol. 98, No. 4, 2005, p. 173.

[35] The Report, above note 6, pp. 8-9.

i. If so, when and how should the reporting take place?
ii. What is the scope of disclosure: what information must be revealed?
iii. For what purpose (criminal prosecution, statistics, etc.) and to whom (police, security forces, administrative bodies, others) must the information be reported?
iv. What are the consequences of non-compliance with duties of disclosure of gunshot wounds?

3. Is there specific legislation protecting the provision of healthcare in line with ethical principles of healthcare? If so, does domestic legislation provide any guidance on how to resolve the potential tension between protecting medical ethics and providing for duties of disclosure of gunshot wounds of patients?

As the authors note, the purpose of the Report's conclusions and analysis:

> is to provide an outline of certain tendencies and types of approach taken to the issues of confidentiality and disclosure, in general, as well as to the conditions and modalities of the duty to report gunshot wounds, in particular, as well as highlighting interesting examples where provided by the authors of the national reports.[36]

The report did not have the capacity to address issues of global legal norms of protection of access to healthcare around the world, addressing as it did only twenty-two States. The States were chosen to cover different continents and legal traditions, as well as representing a standard for other States in their national legislation, or those experiencing armed conflict or situations of violence where ICRC had a particular interest in exploring the effects of national legislation on access to healthcare and on medical ethics.

---

[36] The Report, above note 6, p. 206.

Although the report concludes that there are few similarities between the legislation in each country on mandatory reporting,[37] three broad areas of conclusion could be reached in line with the original questions asked. This section addresses the three conclusions of the report and then identifies some further questions and avenues that need exploring beyond the report. The following sections consider how some of these avenues have already been explored particularly in the relevant case studies presented, or what still needs to be done.

Conclusion 1: General Legal Framework on Disclosure by Healthcare Professionals to State Authorities

The one concrete conclusion the report drew was that there is a universal obligation of doctor-patient confidentiality.[38] This duty has existed since the Hippocratic Oath, now contained in the Geneva Declaration.[39] All States covered in the report have such a duty protected in different forms—legislation[40] or ethically,[41] or implicitly in the right to privacy.[42] The principle of confidentiality is not absolute in any situation. However, it can be breached if there is a legal obligation to disclose information[43] or if there is evidence of criminality in some cases.[44] In some States there is an inherent contradiction between a constitutional duty to maintain confidentiality and the legal obligation to report criminal activity, of which gunshot wounds might be evidence. In other cases, there is no contradiction, as the duty to disclose information to State authorities is explicitly excluded from the duty of confidentiality.[45]

---

[37] *Ibid*.

[38] *Ibid*.

[39] World Medical Association, "Declaration of Geneva", 1947, available at: https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/.

[40] For the purposes of this article, this includes the Philippines and Papua New Guinea.

[41] For the purposes of this article, this includes Pakistan.

[42] The Report, above note 6, pp. 207-8. For example, in Papua New Guinea.

[43] This is the case in the Philippines and Pakistan, for example.

[44] The Report, above note 6, p. 207.

[45] The Report, above note 6, p. 208.

Conclusion 2: Duty to Report Gunshot Wounds

The report found that "all but a few countries (i) provide for a duty of healthcare professionals to report gunshot wounds, or (ii) have more general reporting obligations that might include the reporting of gunshot wounds."[46] Papua New Guinea is one of only four States covered where there is no duty on healthcare professionals to report gunshot wounds or any other information more generally, but there are indications that such reporting may happen in practice in any case.[47] Indeed, in Papua New Guinea, healthcare professionals can make an exception to the duty of confidentiality "where non-disclosure may result in a danger to society" under medical guidelines.[48]

More common is the obligation under law to report gunshot wounds to authorities. Although in most cases, there is no explicit reference to gunshot wounds.[49] In many cases the requirement for reporting arises on suspicion that a crime has been committed. As the report authors point out, this is a subjective test requiring that healthcare professionals put themselves in the minds of police and lawyers and make an assumption as to what has happened to incur a gunshot wound. In many cases, it is opined, professionals report out of caution.[50]

How and when healthcare professionals do report differ among States. There are few laws which set deadlines for reporting, meaning that the healthcare professional could treat the patient and then report the injury. No State makes "reporting as a precondition to the emergency treatment of the patient."[51] Pakistan in fact ensures that patients receive treatment before reporting:

> Pakistan has adopted legislation specifically aimed at insuring that the duty of disclosure does not interfere with essential medical treatment. It provides, inter alia that emergency medical treatment has priority over reporting

---

[46] The Report, above note 6, p. 209.
[47] *Ibid*.
[48] *Ibid*.
[49] The Report, above note 6, p. 210.
[50] *Ibid*.
[51] The Report, above note 6, p. 211.

> requirements and that police may not interfere with medical treatment or even approach a gunshot wound victim without the doctor's permission.[52]

Where there is a duty to report, there are different forms and means (e.g., telephone, writing etc.) to report. There are different levels of information that is required to be given to authorities. In most cases, detailed information about the patient and the injuries are to be given. In some cases, the report is anonymized to protect the confidentiality of the patient, and yet ensure adequate data collection—on crime, broadly, to determine patterns, as is the case in the Philippines, to act as a preventive measure or to contribute to criminal prosecutions.[53]

In many cases, healthcare professionals who do not report when they have a legal obligation to do so may be subject to administrative or criminal sanctions themselves under the law (i.e., Philippines).[54]

Conclusion 3: Protection of Healthcare Professionals

Despite the fact that all but five of the twenty-two States studied have ratified or acceded to the two Additional Protocols to the Geneva Conventions (Pakistan and Papua New Guinea being two of the five), the report found that very few States have specific legislation protecting healthcare professionals and access to healthcare (the report did not distinguish between armed conflict or situations of violence where IHL protections are not applicable). The human right to healthcare for individuals and the duty of healthcare professionals to provide emergency assistance are recognized in a number of States constitutionally or under statutory law.[55]

Sometimes the protection of healthcare professionals is put into question when they are likely to be prosecuted for not reporting gunshot wound victims or injuries. There are few cases that the report found where there is a balancing of the duty of confidentiality and the duty to report.

---

[52] The Report, above note 6, p. 214.
[53] The Report, above note 6, p. 212.
[54] *Ibid*.
[55] The Report, above note 6, p. 213.

Only Nigeria and Pakistan have specific legislation to allow for emergency medical treatment before any reporting is commenced.

Further Areas to Explore Beyond the Report

As mentioned above, the report did not attempt to make conclusions across the world. The focus is solely on the twenty-two States. There are a number of similarities, but enough differences in approach that it might be worth conducting a further report with fifty or more States to get a more global overview of the legal issues around access to healthcare for gunshot victims, mandatory reporting of gunshot wounds, and protection of healthcare professionals.

The report by its nature left a number of practical questions unanswered too, such as:

- What are the practical ramifications of the law?
- Do people comply with the law and report?
- Does the fact that reporting occurs stop people from accessing healthcare?
- Does anyone die or have complications as a result of the law?
- Do healthcare professionals who do not report get punished in practice?

As noted, this is beyond the scope of the original report, which focused on the laws in each State and not how they are practically implemented. The ICRC and others will need to do further on-the-ground research in key contexts to determine the answers to these questions to guide future policies and laws, as well as protection and assistance work in this area. Some further points on this are outlined in the case studies below.

Finally, while noting the few States that have adequately implemented the Additional Protocols to the Geneva Conventions, the report did not address the different applications of domestic law in times of armed conflict and times of peace.

Country Case Study: Pakistan

Pakistan: Overview of the Legal System

Pakistan's history is speckled with varying degrees and natures of conflict—between international and non-international armed conflicts as well as other situations of violence that do not rise to the threshold of an armed conflict. These changing situations have affected the legal system as much as the political landscape and resulted in a multitude of legislation. Without going into its complex history, the prevalent legal system of Pakistan post-2010 is much different and in certain cases more complex than it was before. This decade brought with it the Constitution (Eighteenth Amendment) Act, 2010 (18th Amendment),[56] which sought to devolve legislative power to the federating units—the provinces—instead of being centred at the federal level. Although a widely commended democratic step by all concerned, and appreciated by the provinces and rightly so, the 18th Amendment has led to certain complexities. Such intricacies are most prominent in cases where the centre retains the mandate for implementing treaties[57] and for enacting national legislation on international treaties, conventions, and agreements,[58] while the topics covered in such international instruments fall exclusively within the legislative and executive domain of the provinces, such as the provision of healthcare and the right to education.

This issue is further amplified by the absence of coordination mechanisms among these units of the State, thereby leading to adverse consequences not just for national implementation of international obligations and standards, but also for reporting of such implementation. Therefore, although, the right to health as derived from Article 12 of the ICESCR[59] and the protection of the medical mission as well as healthcare

---

[56] The Constitution (Eighteenth Amendment) Act, Act No. X, 2010, available at: https://pakistanconstitutionlaw.com/18th-amendment-2010/.

[57] Constitution of the Islamic Republic of Pakistan, 1973, Fourth Schedule, Point 3, available at: https://pakistanconstitutionlaw.com/4thschedule-legislative-lists/ (Pakistan Constitution 4th Schedule).

[58] Pakistan Constitution Fourth Schedule, above note 57, Point 32.

[59] ICESR, above note 31.

personnel in times of armed conflicts[60] do exist and apply in principle, their implementation and enforcement remain a challenge. This is despite Pakistan being a party to the ICECSR[61] and to the four Geneva Conventions,[62] and especially so in the absence of explicit and comprehensive implementing legislation. It may further be noted that the Constitution of Pakistan (1973) does not explicitly recognize the "right to health." However, this has since been read into the "right to life"[63] by various superior courts,[64] thus bringing domestic legislation into conformity with international standards and/or obligations while requiring concerted and continuous effort with evidence-based advocacy and recommendations tabled at multiple legislative assemblies.

Pakistan: Update and Comparative Analysis since the Report

Duty of Disclosure and the Provision of Emergency Medical Care

As identified in the report,[65] the legal position in Pakistan on the duty of disclosure can be bifurcated into the period prior to and after the enactment of the Injured Persons (Medical Aid) Act, 2004.

Before delving into the discussion on the changes that followed this enactment, it is necessary to have an overview of the country and its component federating units. Following the 2018 merger of the Federally and Provincially Administered Tribal Areas (FATA and PATA),[66] the Republic of Pakistan is composed of the Federal Capital, the provinces of Balochistan, Khyber Pakhtunkhwa, Punjab and Sindh, as well as other

---

[60] *See* GC I, above note 16, Arts. 19, 20, 23, 24, 26 and 35; *see also* GC II, above note 16, Arts. 36 and 37; *see also* GC III, above note 16, Arts. 18 and 20.

[61] Ratified by Pakistan on 17 April 2008.

[62] Ratified by Pakistan on 12 June 1951.

[63] *Article 9. Security of Person – No person shall be deprived of life or liberty save in accordance with law*, Constitution of the Islamic Republic of Pakistan, 1973, available at: https://pakistanconstitutionlaw.com/article-9-security-of-person/ (hereinafter "Pakistan Constitution").

[64] *See* LHC, *M/S Getz Pharma (Pvt) Ltd. v. Federation of Pakistan*, PLD 2017 Karachi 157; LHC, *Nadir Ali v. Medical Superintendent, Civil Hospital, Larkana*, PLD 2017 Karachi 448, para. 6; SC, *Shehla Zia v. the State*, PLD 1994 SC 693, pp. 712, 714.

[65] The Report, above note 6.

[66] The Constitution (Twenty-Fifth Amendment) Act, Act No. XXXVII 2018, available at: https://pakistanconstitutionlaw.com/25th-amendment-2018/.

States or territories that are or may be included in Pakistan whether by accession or otherwise. [67]

Since the devolution of legislative power to the provinces pursuant to the 18th Amendment as previously discussed, the Injured Persons (Medical Aid) Act, 2004 (Act 2004) is prevalent in the federal capital and in Balochistan, until such time as the latter legislates on it. Amended and adapted versions of this legislation are prevalent in the provinces of Punjab and Khyber Pakhtunkhwa since 2004 and 2014, respectively. Similar legislation was also applicable in Sindh up until its repeal in 2019 through the since applicable Sindh Injured Persons Compulsory Medical Treatment Act, 2019 (Act 2019). The Act 2004 and its provincial versions prioritized the provision of emergency medical assistance in various cases[68] including gunshot wounds over the duty of disclosure, which is enshrined as mandatory medico-legal procedures.

The Act 2019 in Sindh followed the refusal by a private hospital of emergency care to a minor girl who had been in a shooting incident involving security forces and was asked to move to a government hospital where medico-legal formalities could be initiated (the Amal Umer case of August 2018).[69] Police and judicial enquiries followed the child's demise within hospital premises following such refusal.[70] This incident illustrates the inadequate implementation as well as the unintended adverse ambiguities present in the existing law, which at that time was known as

---

[67] Pakistan Constitution, above note 63, Art. 1.

[68] *See* The Injured Persons (Medical Aid) Act, Act No. XII, 2004, Section 2(e) *"injured person" means a person injured due to traffic incident, assault or any other cause who is in need of an immediate treatment"* and Section 2(k) *"injured person" means a person injured due to a traffic accident, assault or any other cause and who has an emergency medical condition"* (hereinafter "Medical Aid Act"); Sindh Injured Persons Compulsory Medical Treatment Act, Act No. VIII, 2019, Section 2(g) *"emergency medical condition" means the health condition of an injured person which requires immediate medical attention and/or compulsory medical treatment and denial of which is likely to aggravate the health of an injured person or cause the death of an injured person"* (hereinafter "SIPCMTA").

[69] Beenish Umer, "How the System Failed Us", *Dawn News*, 16 September 2018, available at: https://www.dawn.com/news/1433274; The News Web Desk, "Amal death Case: Sindh Healthcare Commission's Report Raises Questions," *The News International*, 15 December 2019, available at: https://www.thenews.com.pk/latest/583931-amal-death-case-sindh-health-care-commissions-report-raises-questions.

[70] "Supreme Court Orders Trial Court to Decide Amal Umer Murder Case in Three Months," *Daily Times*, 8 January 2020, available at: https://dailytimes.com.pk/535150/sc-orders-trial-court-to-decide-amal-umer-murder-case-in-three-months/.

the Sindh Injured Persons (Medical Aid) Act 2014 ("the Act 2014"). This Act was promulgated to prioritize emergency medical care until the injured person was stabilized but before undertaking medico-legal formalities, and was intended to cover both private and government hospitals. However, the language contained in the law is ambiguous with respect to private hospitals, and only seems to create this obligation for government hospitals.[71] The Amal Umer case further highlights the inconsistency between legal obligations and prevalent practice.

Comparative Analysis of the Act 2014[72] and the Act 2019:[73]

Through its strict phrasing, the Act 2019 seeks to further cement the obligation of providing compulsory and life-saving medical care on healthcare personnel and medical units in order to avoid incidents such as the Amal Umer case. For instance, even in their respective Preambles where the Act 2014 lays down the purpose of the legislation as "expedient to make provision for medical aid and treatment of injured persons to save their lives and protect their health during emergency,"[74] the Act 2019 goes much further in an attempt to address the gaps that led to the unfortunate demise of Amal Umer. A notable difference between the phrasing in the two Acts is that the Act 2019 refers to emergency medical care as "compulsory medical treatment".

The Preamble to the latter legislation iterates its purpose to remove misconceptions about the applicable law and procedure with respect to the provision of healthcare to injured persons before the completion of medico-legal formalities, and states:

> It is compulsory to provide medical aid and treatment without fear, to any injured person, to save his or her life and protect his or her health during an emergency … it is the duty of every citizen to assist an injured person in a time of peril and emergency.[75]

---

[71] Medical Aid Act, above note 68, Sections 2(c), and 7.
[72] Medical Aid Act, above note 68.
[73] SIPCMTA, above note 68.
[74] Medical Aid Act, above note 68, Preamble.
[75] SIPCMTA, above note 68, Preamble.

In order to give effect to this Preamble, the legislation categorically includes private hospitals.[76] While private hospitals were broadly understood to be under this obligation pursuant to the Act 2014, the lack of explicit mention led to ambiguity. The Act 2019 further obligates both private and government facilities to provide compulsory medical care on a priority basis without first complying with medico-legal formalities, or demanding payment,[77] and in certain circumstances involving life-threatening cases, to even proceed before obtaining consent from the victim's relatives.[78]

Both the Acts of 2014 and 2019 stipulate non-interference by the police during the provision of compulsory medical care without the permission of the in-charge of the hospital, while the Act 2019 also requires clearance by the attending doctor on whether the injured person is out of danger before proceeding with interrogation.[79] Corresponding duties on law enforcement personnel intend to strengthen respect for the duty of necessary medical care over the duty of disclosure.

While in most cases, the Act 2019 seems to improve the protections provided in comparison to the earlier legislation, it is not the case in one instance of particular note. In addition to the prohibition against taking an injured to the police station or undertaking medico-legal formalities before the provision of compulsory medical treatment found in the Act 2019,[80] the Act 2014 had previously gone a step further and laid down that:

> The police officer is bound to ensure that the injured person is treated in a hospital as provided in this Act before any medico-legal procedure is undertaken and he shall not in any way influence the doctor or to give any opinion about the type and details of injury of the injured person.[81]

---

[76] SIPCMTA, above note 68, Section 2(j), 2(l).
[77] SIPCMTA, above note 68, Section 3.
[78] SIPCMTA, above note 68, Section 4.
[79] Medical Aid Act, above note 68, Section 4; SIPCMTA, above note 68, Section 6.
[80] SIPCMTA, above note 68, Section 8.
[81] Medical Aid Act, above note 68, Section 8(2).

This provision previously strengthened the obligation of prioritizing emergency medical care over the duty of disclosure by imposing corresponding duties on police personnel. It also protected healthcare personnel and prohibited police officers to exert influence over doctors to breach medical confidentiality. It is pertinent to note that this provision is presently only missing from the law applicable to the province of Sindh, while the federal law of 2004 and its other provincial versions still incorporate this provision.[82]

Medical Confidentiality

As previously mentioned, the report[83] shows that varying degrees of legislation codifying mandatory reporting overriding medical confidentiality in cases of gunshot wounds is prevalent in a majority of the twenty-two countries studied. In Pakistan, however, where the duty of disclosure is incorporated in primary domestic legislation, the duty for healthcare personnel to maintain medical confidentiality is found in regulations with certain exceptions. The duty of providing indiscriminate emergency medical care to injured persons before disclosing such cases to authorities is also present.

Through the above examples of prevalent legislation, it is apparent that while the duty of disclosure and that of the provision of emergency medical care on humanitarian grounds are codified, the duty of healthcare personnel to maintain medical confidentiality is not found within primary domestic legislation. Instead, medical confidentiality along with other medical ethics is part and parcel of the different ethical codes for healthcare personnel.

One of these is the "Code of Ethics" to be observed by registered medical and dental practitioners in Pakistan, which is adopted in the form of regulations by the concerned authority.[84] It enshrines the duty of

---

[82] Medical Aid Act, above note 68, Section 8(2); The Khyber Pakhtunkhwa Injured Persons and Emergency (Medical Aid) Act, Khyber Pakhtunkhwa Act No.XXXVI, 25 November 2014 (effective 1 December 2014), Section 8(2) (hereinafter "Khyber Pakhtunkhwa Medical Aid Act"); The Punjab Injured Persons (Medical Aid) Act 2004 Section 8(2) (hereinafter "Punjab Medical Aid Act").

[83] The Report, above note 6.

[84] Pakistan Medical and Dental Council, *Code of Ethics of Practice for Medical and Dental Practitioners*, 24-25 August 2002, available at: http://www.pmdc.org.pk/Link

confidentiality and further goes on to stipulate that "no one has the right to demand information" except only when information is demanded under a statutory or legal obligation.[85]

This Code is not applicable to all healthcare personnel operating within the country but is limited only to medical and dental practitioners. There is a separate Code of Ethics for nursing staff that enunciates the duty of medical confidentiality while creating broad and subjective exemptions by stipulating that the staff in relation to the patient:

> [H]olds in confidence personal information about the client and uses judgment in disclosing information by seeking the client's consent … or by judicial rule where the information is required by law or by the order of a Court, or as necessary in the public interest.[86]

Such subjective exceptions tend to treat healthcare personnel as police, requiring them to make decisions on their own reasoning and understanding of the issue. Faced with such a situation, it would be safe to assume that most would err on the side of caution and disclose information rather than be held criminally liable for not reporting. Additionally, it is important to note that the duty to disclose information codified in legislation would prevail over the ethical duty of medical confidentiality found in regulations.

That said, as explained previously, a corresponding duty on police personnel to respect medical confidentiality is found in the Act 2004 and its provincial versions,[87] except in the Act 2019, which is only applicable to Sindh. It would, nevertheless, be significant to amend the Act 2019 to promulgate this duty for Sindh police personnel.

What remains unclear is whether this duty, which extends to police personnel at a police station where an injured person is brought,

---

Click.aspx?fileticket=v5WmQYMvhz4%3d&tabid=292&mid=845 (hereinafter "PMDC Code of Ethics").

[85] PMDC Code of Ethics, above note 84, Regulation 27.

[86] Pakistan Nursing Council, Professional Code of Ethics for the Registered Nurse, Midwife, Lady Health Visitor and Nursing Auxiliary, Regulation 1.4, available at: https://www.pnc.org.pk/admin/uploaded/Code%20of%20Ethics%20Page2.jpg.

[87] Medical Aid Act, above note 68, Section 8(2); Khyber Pakhtunkhwa Medical Aid Act, above note 82, Section 8(2); Punjab Medical Aid Act, above note 82, Section 8(2).

equally applies to all law enforcement and security agencies that might pursue healthcare personnel to divulge confidential information.

Pakistan Recommendations

Aligning practice with law goes beyond legislating reactively. While it remains a crucial step in addressing humanitarian problems, it is pertinent among other measures to underscore the need of wide knowledge and dissemination of existing laws to all concerned authorities, including hospital administrations, healthcare personnel, and investigating and law enforcement agencies. Such dissemination through awareness campaigns is also provided for in the Acts of 2004 (Section 10), 2014 (Section 10) and 2019 (Section 17) but not as widely in practice as anticipated or needed. In addition to dissemination of laws, it is also crucial to dig into the realities of the various concerned authorities and their interaction with each other. Refusal of healthcare personnel to provide emergency medical care over the duty of disclosure in contravention of legal obligations is a matter of much concern and the root causes for such practice must be determined.

It must also be noted that although the efficacy of the Act 2019 is yet to be seen, it is only applicable in the province of Sindh, while more or less similar versions of the Act 2004 remain applicable across the rest of the country. This fact further highlights the reactive attitude of legislative assemblies instead of being proactive and seeking to prevent or mitigate possible humanitarian issues in their own jurisdiction(s) which have been reported in other areas of the country. That said, it would be futile and inadequate to draw conclusions from the few incidents that are widely reported. Effective law and policy measures must be based on comprehensive analytical research at various levels to address humanitarian issues and curb contradictory practices.

Lastly, a unified mechanism for coordination among the various federating units should also be considered by the State in order to not only better address humanitarian problems, but to do so in a uniform, standard manner. This would assist the provinces in learning from each other's experiences, identify common lacunae, and prevent foreseeable humanitarian issues. Just as importantly, such measures would pave the way for increased compliance with international legal obligations—

whether under IHL or human rights law—thereby enhancing protection of healthcare and ensuring provision of healthcare services to the population in times of conflict by strengthening compliance in peacetime.

Country Case Study: Papua New Guinea

Papua New Guinea: Overview of the Legal System

After a chequered history of colonialism, Papua New Guinea became independent from Australia in 1975. It retains a common law legal system with reference to United Kingdom and Australian case law, and some residual laws from Australia. It also has reliance on customary legal practice, which takes into account the precedents of village courts.[88]

Papua New Guinea has had a non-international armed conflict in the past in Bougainville and continues to have a high level of violence including knife crime, sexual violence, domestic violence and election related violence.[89] There has been an upsurge in inter-community violence leading to some massacres in 2019.[90] Homicides are not disaggregated by type of weapon,[91] but it seems that knives and machetes are the majority of causes. The lack of disaggregation could indeed be a factor of lack of reporting of such information.

In terms of international legal obligations, treaties only have the force of law in Papua New Guinea if they are adopted in specific legislation by Parliament.[92] Papua New Guinea is a party to the four Geneva Conventions and has a Geneva Conventions Act 1975 but it is

---

[88] Papua New Guinea Underlying Law Act 2000, No. 13, 2000, Section 3(1); for an explanation of the law *see* Bruce L Ottley, "Reconciling Modernity & Tradition: PNG's Underlying Law Act", *Reform*, Issue 80, Autumn, 2002.

[89] Human Rights Watch, "World Report 2019: Papua New Guinea", available at: https://www.hrw.org/world-report/2019/country-chapters/papua-new-guinea.

[90] Jo Chandler, "The Karida massacre: fears of a new era of tribal violence in Papua New Guinea", *The Guardian*, 23 July 2019, available at: https://www.theguardian.com/world/2019/jul/23/the-karida-massacre-the-start-of-a-new-era-of-tribal-violence-in-papua-new-guinea.

[91] E.g., Gunpolicy.org (NGO addressing international firearm prevention and policy which collects data around the world on gun injuries and availability) does not have data on gunshot wounds for Papua New Guinea, available at: https://www.gunpolicy.org/firearms/region/papua-new-guinea.

[92] Constitution of the Independent State of Papua New Guinea, Art. 117 (7).

not a party to the Additional Protocols to the Geneva Conventions as yet, although there are indications that they are interested in becoming a party. Papua New Guinea would therefore be able to apply (subject to the limited scope of the Geneva Conventions Act which mostly addresses grave breaches of the Geneva Conventions) the principles related to the protection of wounded and sick and the protection of healthcare professionals in an international and non-international (CA 3; although the Act is not clear on its application to CA 3) armed conflict.[93]

Papua New Guinea: Update and Comparative Analysis since the Report

Papua New Guinea is one of the only four States studied which impose no explicit duty to disclose gunshot wounds or crimes. Indeed, it is also one of seventeen States studied where the duty of confidentiality has the force of law under common law as adjudicated by the courts under the constitutional right of privacy.[94] The exception is where there is patient consent, or the patient brings the case to court.[95] There is an inherent contradiction between the common law and the professional code in Papua New Guinea. The non-legally binding Code of Medical Ethics says "doctors owe their patients absolute confidentiality on all matters, with exceptions for disclosures where the patient gives his/her consent; in the interest of all concerned; where required by law; and where there is a question of danger to society."[96] Therefore, there is no clarity in the current position on gunshot wound reporting in Papua New Guinea, whether in peacetime or during armed conflict.

---

[93] *See* ICRC, State Practice of Papua New Guinea, *IHL Database: Customary IHL*, available at: https://ihl-databases.icrc.org/customary-ihl/eng/docs/v2_cou_pg. Indeed, at the time of the Study, ICRC classified Papua New Guinea as having an armed conflict: Sandesh Sivakumaran, "Asia-Pacific States and the Development of International Humanitarian Law", in Suzannah Linton, Sandesh Sivakumaran and Tim McCormack (eds), *Asia Pacific Perspectives on International Humanitarian Law*, Cambridge University Press, Cambridge, 2019, p. 126.

[94] The Report, above note 6, pp. 207-208; Constitution of the Independent State of Papua New Guinea, Art. 49.

[95] S.C.R. No. 2 of 1984; Re Medical Privilege, PNGLR 247, cited in The Report, above note 6, p. 134.

[96] The Report, above note 6, p. 134.

The extent to which people do not access healthcare as a result of injuries or reporting requirements is not known by the authors, but there remain problems of accessible healthcare and protection of healthcare for all, let alone gunshot wound victims. For example, the ICRC 2018 report on Papua New Guinea noted that "[i]n 2018, the ICRC ran a number of public awareness campaigns seeking to prevent ... attacks against public infrastructure like schools or hospitals, encouraging respect for human life. ... The ICRC also supplied medical equipment to health-care facilities in Hela and Enga while running training and development programmes for staff."[97]

Papua New Guinea: Recommendations

Some recommendations for Papua New Guinea and for future work pose a challenge since the necessary first step is to collect more information on the practical situation in Papua New Guinea—are people treated for their gunshot wounds, are they reported, and if so how and does this affect their access to healthcare? After these issues are addressed on the ground, the more practical policy recommendations can be made. One way to collect information is to require reporting of gunshot wounds by medical professionals. Papua New Guinea could adopt laws on the reporting of violent injuries in an anonymized way to allow for collection of statistics but not lead to prosecutions or punishment of those affected. Such laws could also strengthen the patient confidentiality (currently only in common law and soft instruments) by ensuring that data collected is only for statistical purposes and it will also clarify the circumstances in which aspects of confidentiality can be breached which are otherwise very unclear under the law as it stands. As has been outlined above, such collection would be consistent with IHL ((in an armed conflict) and human rights in peacetime) and with current medical ethics duties in the State. Papua New Guinea is not a party to the Additional Protocols to the Geneva Conventions, but the duty to comply with medical ethics is a customary IHL duty (ICRC Customary law study Rule 26).

---

[97] ICRC, "Papua New Guinea: Operational Highlights", 2018, available at: https://www.icrc.org/en/document/papua-new-guinea-operational-highlights-2018.

A further recommendation would be for Papua New Guinea to ratify and implement the Additional Protocols to the Geneva Conventions to provide for greater clarity in the obligations that should attach to strengthen protection for healthcare professionals and victims of conflict and violence and on the application of medical ethics and information sharing rules under those treaties. If Papua New Guinea were to then amend its Geneva Convention Act to apply AP I and II, the laws would be able to be applied alongside the principles of medical ethics that already exist in Papua New Guinea, and would allow for greater clarity of the law as it can be directly applied in the country around application of medical ethics and reporting obligations in conflict.

Country Case Study: Philippines

Philippines: Overview of the Legal System

Previously a Spanish colony and ceded to the United States of America after the Spanish-American War, the Philippines was granted Commonwealth status in 1935. It was subsequently occupied by the Japanese during the Second World War. It became one of the founding members of the United Nations and in 1946 was officially recognized as independent. The legal system is a mix of civil and common law with the Congress passing legislation approved by a Senate and courts having great power of review over the interpretation of the 1987 Constitution and legislation.[98]

The Philippines has around five non-international armed conflicts underway at the present time. In his recent chapter on the consideration of IHL by national courts in the Philippines, Candelaria usefully characterizes two main groups of conflicts: Moro secessionist movements and the communist insurgency.[99] There is also considerable gun violence outside of the armed conflict. According to Gunpolicy.org, the estimated total number of guns (both licit and illicit) held by civilians in the Philippines is between 2,666,4181 and 3,977,237. Gunshot wounds were only reported until 2011.

---

[98] Sedfrey M. Candelaria, "International Humanitarian Law in the Philippines Supreme Court", in S. Linton, S. Sivakumaran and T. McCormack (eds), above note 96, p 540.

[99] S. Candelaria, above note 101, pp. 545-554.

The Philippines is party to the Geneva Conventions and all three of its Additional Protocols. It has recently withdrawn from the Rome Statute of the International Criminal Court.[100] Treaties are ratified by the President, subject to the concurrence of a two-third majority of the Senate[101] and thereby have the force of law in the Philippines with no further legislation required. Nonetheless, the Philippines has enacted several pieces of legislation to promote and protect IHL, including Republic Act 9851, which criminalizes all relevant war crimes and other international crimes which can be adjudicated in national courts that have been given special jurisdiction.

Philippines: Update and Comparative Analysis since the Report

In the Philippines, the legislation requires healthcare professionals to report the existence of an injury, the criminal character of which is apparent.[102] The reporting requirements are designed to maintain statistics on criminal activity.[103] The provisions to enforce this used to be quite draconian but have been reduced to a fine, although if healthcare professionals do not report, the third offence can result into suspension of their licence to practise.[104] The report notes that Presidential Decree No. 169, issued 4 April 1973, on "Requiring Doctors, Hospitals, Clinics, etc. to Report Treatment for Physical Injuries" (amended on 10 July 1987 by Executive Order No. 212) states that the health practitioner of any health facility who has treated any person for serious or less serious physical injuries (as defined in Articles 262-265 of the Revised Penal Code) shall report the fact of such treatment to government health authorities.[105]

There is less of a concern for healthcare professionals if they do report to a health authority rather than a law enforcement agency as was the case previously. However, it does seem to be the case in the report that in practice, police officers are sent to the bedside of the patient recovering

[100] The Philippines was a party until 17 March 2018 when it withdrew, available at: https://www.icc-cpi.int/philippines.
[101] 1987 Philippine Constitution, Art. VII, Section 21.
[102] The Report, above note 6, p. 210.
[103] The Report, above note 6, p. 212.
[104] The Report, above note 6, pp. 137, 213.
[105] The Report, above note 6, p. 136.

from a gunshot wound to collect data for criminal prosecutions.[106] This means that the healthcare professional is not implicated, and therefore somewhat protected, but it places a lot of pressure on a wounded person. If indeed the healthcare professional were required to corroborate information about the patient's treatment and wounds, this could be inconsistent with IHL and medical ethics, as it would put the patient at risk of prosecution.

It also seems to mean somehow that statistics have not been collected or shared publicly as the data is from 2011. There is no information as to whether the quite lengthy information that must be collected[107] dissuades gunshot victims from seeking medical care.

Despite a strong law on Red Cross, Red Crescent and Red Crystal emblem protection,[108] there are no laws which implement protection of healthcare personnel or the principle of confidentiality or impartiality. Nonetheless, the ICRC Customary IHL Study (ICRC CIHL Study) notes in its State practice for the Philippines that:

> An agreement, concluded in 1990 between several Philippine governmental departments, the National Police, and a group of NGOs involved in the delivery of medical services, provides for the protection of health workers from harassment and human rights violations. The preamble to the agreement states that the parties are adhering to generally accepted principles of IHL and human rights law.[109]

The ICRC CIHL Study State practice also notes that in practice, healthcare professionals are given protection when conducting medical

---

[106] The Report, above note 6, p. 137.

[107] The Report, above note 6, pp. 136-137.

[108] An Act Defining The Use And Protection Of The Red Cross, Red Crescent, And Red Crystal Emblems, Providing Penalties For Violations Thereof And For Other Purposes, Republic Act No. 10530, 7 May 2015.

[109] J. Henckaerts and L. Doswald Beck (eds), above note 26, citing Memorandum of Agreement on the Delivery of Health Services between the Departments of Foreign Affairs, Justice, Local Government, National Defense and Health and the Philippines Alliance of Human Rights Advocates (PAHRA), the Free Legal Assistance Group (FLAG) and the Medical Action Group (MAG), 10 December 1990.

duties in the conflict. There is no information about whether they are required to treat patients impartially in the conflict and to ensure patient confidentiality at this time as required under IHL.

Philippines: Recommendations

Once again there are a number of questions which remain to be answered by further study: are patients deterred from seeking healthcare assistance if they are confronted by a police officer? How many people die from gunshot wounds because they fail to seek healthcare?

Healthcare professionals in the Philippines should be given training or awareness-raising about the reality of the law: that they report to a health authority and not to the police. They should also be better protected under the law, and not just under a soft agreement.

Particularly in the Philippines, as it is currently involved in several armed conflicts, legislative and policy steps should be taken to ensure that laws related to injury reporting can be applied consistently with IHL or amended for times when they occur in armed conflict. As noted, the Philippines has an applicable IHL law that requires prosecutions for war crimes in specially-mandated courts. However, to not have alongside or in this law requirements for the protection of healthcare professionals means that much of the ability of the courts to have a full overview of IHL principles and protections is stymied. Impartial healthcare should be protected in a coherent law that is able to be applied by courts in the Philippines so that the law is consistent with IHL when applied during armed conflict. Finally, the reporting requirements that currently exist are potentially inconsistent with IHL—while they allow treatment before reporting, they do not take into account the principles of beneficence and justice under medical ethics, and do not account for consistent reporting of information which would be allowed under IHL. They should be amended to allow for a more coherent approach to reporting on wounds.

Conclusions and Recommendations

The point of the initiative on healthcare in danger is to enhance the many protections for healthcare professionals and their work, and for the wounded and sick, that apply during conflicts by taking measures in

peacetime to ensure domestic implementation. In some contexts, domestic laws might not be consistent enough with IHL protections or might require some nuancing to ensure that they are applied correctly in times of armed conflict. This article has given an overview of an important report into global gunshot wound reporting legislation which has not been done before.[110] It should assist us to understand where States are positioned with regard to reporting on gunshot wounds, protection of patient confidentiality and protection of healthcare professionals, which as has been outlined are key provisions of IHL. It takes a step towards going beyond the existing guidelines on national legislation on healthcare protection, and attempts to thresh out some inconsistencies and concerns around mandatory reporting and barriers to healthcare. Nonetheless, as this article also points out, there are a number of recommendations which can be made to go even further in exploring the complexities of gunshot wound reporting legislation and patient confidentiality. Particularly in armed conflicts and other situations of violence, these include ensuring that gunshot wound victims receive better and faster care, protecting healthcare professionals, and even ensuring that better data on gunshot wounds can be collected so that better understanding of the extent of the problem around the world may be attained and IHL is better upheld.

In that regard, there are a number of practical questions that require in-depth field work to ensure better understanding of the application of the laws in reality. These questions were addressed above in the section devoted to the report and need no repetition here. However, there are questions which each of the States that we addressed in this article also need to pose in order to have a better understanding as to how the law works in hindering accessible healthcare.

There are also a number of recommendations for each of the States that we considered in this article—Pakistan, Papua New Guinea and the Philippines—that could serve as a platform for action for those working on healthcare access, gunshot wound reporting and IHL implementation.

Overall, there are two main recommendations which we would say are global, arising from the gunshot wound reporting report and from

[110] The Report, above note 6.

our analysis further of each of these three contexts in the Asia-Pacific region.

First, we propose that States revisit their gunshot wound reporting laws to ensure that they are consistent with IHL when gunshot wounds occur in times of armed conflict. The report looked very briefly at the protection of healthcare professionals, but it did not consider the two other aspects of IHL highlighted in this article—protection of medical ethics and impartial treatment. More work could be done on studying the laws around the application of these principles in times of armed conflict. The principle of impartiality and following medical ethics should be enshrined into law in particular. In many contexts in Asia-Pacific and beyond, there is a continual overlap or blurring of the lines between when IHL applies and when it does not. Basic principles of humanity, human rights laws and ethical principles should all be protected at all times to ensure fewer gaps in protection of victims as well as healthcare professionals. States should look at amending their laws to ensure consistency of application of IHL.

Second, we recommend that gunshot wound reporting legislation be adopted by States around the world. IHL provides that healthcare professionals can give information to the authorities.[111] Moreover, IHL requires healthcare personnel to act consistently with medical ethics (API, Article 16; APII, Article 10) and while they should not be obliged to disclose information that would be detrimental to a patient, if certain conditions are adhered to, it would not be inconsistent with medical ethics to require reporting of gunshot wounds. Indeed, it would in the authors' contention be consistent with the medical ethical principle of justice, with the complementary human rights principle of due process and fulfilment of legislative measures, to have laws which require reporting of a certain amount of information on gunshot wounds. There is a paucity of data around gunshot wounds and if there was greater data, there could be better prevention measures which likewise would not only ensure justice for victims, but also ensure that more victims receive appropriate medical treatment. The data must be collected in a consistent and effective way to be of any use, and in line with the concerns this article has highlighted, there are several caveats to this recommendation:

[111] J. Henckaerts and L. Doswald Beck (eds), above note 26, Rule 26.

- The laws should ensure that adequate patient confidentiality is accorded—anonymising details of patients so that it is the gunshot wound information that is collected, but the person is not affected directly by the reporting.
- Greater information is needed by healthcare professionals on when they are required to report and when they are not, and what information they are required to report, so that emergency treatment is provided, and the right authorities are notified of the injury with relevant details.

As we have said numerous times, more work is needed on this important topic, but perhaps our recommendations, if implemented, could go some way to ensuring that gunshot wound victims receive the necessary medical care that they require in an impartial and confidential manner, regardless of whether the injury occurs in relation to an armed conflict or not. They should then also ensure greater protection of the medical mission around the world and therefore better adherence to and respect for IHL.