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**UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
BOARD OF IMMIGRATION APPEALS**

IN THE MATTER OF)
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)
B.T.) **File No.:** -----
)
IN REMOVAL PROCEEDINGS)
)
)

**BRIEF OF PHYSICIANS FOR HUMAN RIGHTS AS *AMICUS CURIAE*
IN SUPPORT OF RESPONDENT B.T.**

INTEREST OF *AMICUS CURIAE*

Physicians for Human Rights (“PHR”) submits this *amicus curiae* brief in support of the application for asylum by B.T., a Nepalese healthcare worker. The United States Department of Homeland Security (“DHS”) demands that the Board of Immigration Appeals (“BIA”) deny asylum to B.T. because, when twice kidnapped by Maoist guerillas in Nepal, who literally put a gun to his head, he provided medical assistance to persons suffering from gunshot wounds and severe burns. Leaving aside the issue of duress, DHS’s argument – that a healthcare worker engages in terrorist activity when he provides medical treatment to sick and wounded people who are members of a terrorist organization – fundamentally conflicts with both the principles of medical ethics and the Geneva Conventions and their two Additional Protocols.¹ Furthermore, no precedent exists for DHS’s position.

Healthcare workers worldwide are obligated, according to principles of medical ethics, to treat the sick and wounded without regard to politics, nationality, religion, race, sex, or other such factors.² The Geneva Conventions and their two Additional Protocols, not only

¹ Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Aug. 12, 1949, 6 U.S.T. 3217, 75 U.N.T.S. 31 [hereinafter “Geneva Convention I”]; Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, Aug. 12, 1949, 6 U.S.T. 3217, 75 U.N.T.S. 85 [hereinafter “Geneva Convention II”]; Geneva Convention Relative to the Treatment of Prisoners of War, Aug. 12, 1949, 6 U.S. T. 3316, 75 U.N.T.S. 135 [hereinafter “Geneva Convention III”]; Geneva Convention Relative to the Protection of Civilian Persons in Time of War, Aug. 12, 1949, 6 U.S.T. 3516, 75 U.N.T.S. 287 [hereinafter “Geneva Convention IV”]; Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 3 [hereinafter “Additional Protocol I”]; Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 609 [hereinafter “Additional Protocol II”]. This brief refers to these as the “Geneva Conventions and their two Additional Protocols.”

² See, e.g., World Medical Association [WMA], *Declaration of Geneva* (adopted by the General Assembly at Geneva) (Sept. 1948).

require parties to the conventions to care for the wounded and sick, but prohibit parties from punishing those who carry out medical activities compatible with medical ethics.³

Because denying asylum to a healthcare worker for providing medical assistance pursuant to his professional and ethical obligations, in circumstances protected by the Geneva Conventions, would undermine the ability of healthcare workers to provide aid in war-torn areas, PHR submits this brief, drawing on its extensive experience in working with and supporting healthcare workers worldwide. PHR is a non-profit organization founded in 1986 that advocates for the protection of human rights by mobilizing health professionals to promote and advance the right to health for all, and to defend medical neutrality and the right of civilians and combatants to receive medical care during time of war. PHR's unique expertise in medical ethics and international humanitarian law provides a valuable perspective that can assist the BIA in addressing DHS's theory – which is unsupported by precedent – and understanding the practical and legal ramifications of the Board's decision.

QUESTION PRESENTED

Whether a healthcare worker can be denied asylum on the grounds that he provided “material support” to a terrorist organization, as defined in §212(a)(3)(B)(iv)(VI) of the Immigration and Nationality Act, because he provided medical care to injured Maoist guerillas as required by his professional and ethical obligations and in circumstances protected by the Geneva Conventions and their two Additional Protocols?

³ Jean-Marie Henckaerts and Louis Doswald-Beck (of the International Committee of the Red Cross), *CUSTOMARY INTERNATIONAL HUMANITARIAN LAW* 86 (Rule 26) (Cambridge University Press 2005) [hereinafter “*CUSTOMARY INTERNATIONAL HUMANITARIAN LAW*”].

STATEMENT OF FACTS

The facts relevant to the issues addressed are few and undisputed. The Respondent, B.T., is a Nepalese healthcare worker who was twice kidnapped by Maoist guerillas.⁴ The guerillas put a gun to B.T.’s head and directed him to treat persons suffering from gunshot wounds and severe burns.⁵ He provided medical assistance to the wounded individuals. The Royal Nepalese Army (RNA) then twice arrested B.T.⁶ – beating him with the butt of a gun and sticks,⁷ putting pins in his fingertips, cutting his fingers and hands with knives, and threatening to kill him.⁸

The Immigration Judge properly applied the INA and granted B.T.’s request for asylum. DHS appeals on the theory that B.T. engaged in terrorist activity by “provid[ing] material support in the form of medical care to the Maoists, a TEL [Terrorist Exclusion List] designated terrorist organization.”⁹ DHS does not contend that B.T. engaged in any other conduct that would constitute terrorist activity or that he was in any way allied with the Maoists guerillas.¹⁰

⁴ Merits Hearing Tr., [Oct. 21, 2005], at 38, 47, 49.

⁵ Tr. at 38-41, 47; *see also* Oral Decision of Immigration Judge, 3.

⁶ Tr. at 44-46, 49, 60, 79.

⁷ Tr. at 46.

⁸ Tr. at 63, 79.

⁹ DHS Appellate Brief at 3.

¹⁰ This brief does not analyze the issue of duress because that issue is sufficiently addressed by both the Respondent’s brief and the *amicus curiae* brief submitted by the United Nations High Commissioner for Refugees (“UNHCR”).

SUMMARY OF ARGUMENT

The plain language of the INA does not support DHS's attempt to deny asylum to B.T., a Nepalese healthcare worker, on the theory that his provision of medical care to wounded Maoist guerillas constitutes "material support" to a terrorist organization. No proper reading of the statute can bring B.T.'s provision of medical care, in the circumstances of this case, within the definition of "engaging in terrorist activities" or the meaning of "material support."

Furthermore, the obligations imposed by international humanitarian law and medical ethics require not only doctors, but also healthcare workers such as B.T., to put the health of those in need above all other things, and to treat the sick and wounded without regard to their political, religious, or other beliefs or whether they are friend or foe.¹¹ Including medical care under the definition of "material support" thus violates the principles of medical ethics. It is also contrary to customary international law, which forbids States from punishing any medical personnel for giving medical care.

During his two kidnappings by the Maoist guerillas, B.T. provided medical treatment that he could not have refused without ignoring his professional, ethical, and humanitarian obligations to respect human life and provide emergency care.¹² Penalizing B.T.,

¹¹ CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, *supra* note 3 at 396 (Rule 109) (Cambridge University Press 2005) [hereinafter "CUSTOMARY INTERNATIONAL HUMANITARIAN LAW"]; *see also* Geneva Convention I, art. 12; Geneva Convention II, art. 15; Geneva Convention III, art. 3(2) and 16; Geneva Convention IV, art. 10; Additional Protocol I, art. 10; Additional Protocol II, art. 7 and 9.

¹² This case does not involve performance of medical duties contrary to the principles of medical ethics to further terrorist means. Rule 92 of ICRC's CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, *supra* note 3 at 320, provides that "Mutilation, medical or scientific experiments or any other medical procedure not indicated by the state of health of the person concerned and not consistent with generally accepted medical standards are prohibited." Moreover, torture or inhuman treatment, including mutilation and biological experiments, constitutes a war crime as a grave breach of the Geneva Conventions. *See* Additional Protocol I, art. 11(1) and (4); Additional Protocol II, art. 5(2)(e); *see also* ICC Statute, art. 8(2)(b)(x) and (e)(xi).

himself a victim of terrorism, by barring him from asylum for providing medical care to wounded individuals, constitutes forbidden punishment in violation of the United States's obligations under customary international law to protect and not punish medical personnel who carry out medical activities. DHS's position is not only unsupported by the plain language of the INA and any judicial authority, it also contradicts U.S. practice and policy as embodied in instructions to U.S. soldiers to respect the wounded and sick, and the U.S. State Department's frequent condemnation of governments that punish healthcare workers who treat wounded enemies.

ARGUMENT

Neither the plain language of the INA, medical ethics, customary international law, nor longstanding U.S. policy and practice in the field supports DHS's contention that medical care provided to wounded members of a terrorist organization constitutes "material support" barring a grant of asylum in this case.

I. NO PROPER READING OF THE INA INCLUDES THE PROVISION OF MEDICAL CARE TO THE SICK AND WOUNDED AS "MATERIAL SUPPORT" TO TERRORISTS.

A. The Board must interpret the plain meaning of the statute as a whole.

Anti-terrorism legislation adopted under the USA PATRIOT Act of 2001¹³ and the REAL ID Act of 2005¹⁴ amended section 212 of the INA and widely expanded the class of individuals considered inadmissible to the U.S. for having "engaged in terrorist activity," by, *inter alia*, providing "material support" to "terrorists" or "terrorist organizations."¹⁵ Instead of

¹³ The Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Act, Pub. L. No. 107-56, 115 Stat. 272 (Oct. 26, 2001).

¹⁴ The REAL ID Act, Division B of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005, Pub. L. No. 109-13, 119 Stat. 231 (May 1, 2005).

¹⁵ See Immigration and Nationality Act §212(a)(3)(B), 8 U.S.C. §1182(a)(3)(B).

defining the term, the statute lists examples of “material support.” Thus, this Court must apply well-settled canons of statutory interpretation to decide whether “material support” includes B.T.’s treatment of Maoist guerillas in the circumstances of this case.

In determining whether an action constitutes “material support” for a terrorist activity or organization, the Board’s “starting point must be the language employed by Congress” and the “ordinary meaning of the words used.”¹⁶ Furthermore, it is axiomatic that “[t]he plain meaning that [courts] seek to discern is the plain meaning of the whole statute, not of isolated sentences.”¹⁷

B. The relevant statutory language does not support including medical care under the definition of “material support.”

Medical care neither fits the definition of “engaging in terrorist activities” nor the examples of “material support” in the INA. To the contrary, the examples enumerated in the statute – such as hijacking a plane, kidnapping or violently attacking an internationally protected person like a healthcare worker, or using biological or chemical weapons – share the common attribute of harming or endangering the safety and lives of human beings.¹⁸

After defining the six actions that constitute terrorist activities, the statute lists examples of the type of conduct that constitutes “material support” – actions that Congress placed on the same footing as actually “engaging in terrorist activity.” Thus, one engages in terrorist activity when he commits:

¹⁶ *INS v. Phinpathya*, 464 U.S. 183, 189 (1984); *Richards v. United States*, 369 U.S. 1, 9 (1962).

¹⁷ *Beecham v. United States*, 511 U.S. 368, 372 (1994).

¹⁸ See INA §212(a)(3)(B), 8 U.S.C. §1182(a)(3)(B) (listing six acts as “terrorist activities,” including (1) hijacking or sabotaging an aircraft, vessel, or vehicle, (2) detaining hostages to compel another to abstain or commit an act, (3) violently attacking an internationally protected person, (4) assassinating another, (5) using biological or chemical agents to endanger the safety of others or cause property damage, and (6) threatening, conspiring, or attempting to do any of the foregoing).

an act that the actor knows, or reasonably should know, affords *material support*, including a safe house, transportation, communications, funds, transfer of funds or other material financial benefit, false documentation or identification, weapons (including chemical, biological, or radiological weapons), explosives, or training...¹⁹

Each of these examples describes conduct that actively furthers the ability of terrorists to carry out defined terrorist acts.

While the statutory examples are not exhaustive,²⁰ the canon of *ejusdem generis* requires that other activities must be of the same kind or quality as those enumerated to constitute “material support.” “Where general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects *similar in nature* to those objects enumerated by the preceding specific words.”²¹ As the Supreme Court has counseled, where “several items in a list share an attribute” that attribute should guide the court in determining whether other items should be treated as also included in the list.²²

C. No authority supports DHS’s argument.

The activities specifically enumerated as constituting “material support” share a common characteristic: the contribution of money, infrastructure, and means for accomplishing a terrorist organization’s agenda. Providing medical assistance to sick and wounded human beings who also happen to be members of terrorist organizations does not share this characteristic; indeed it is of an entirely different order. DHS goes to great lengths to stretch the definition of “material support,” asserting that “saving rebels’ lives furthers the

¹⁹ INA §212(a)(3)(B)(iv)(VI), 8 U.S.C. §1182(a)(3)(B)(iv)(VI) (emphasis added).

²⁰ *Singh-Kaur v. Ashcroft*, 385 F.3d 293, 298 (3d Cir. 2004).

²¹ *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105, 114-15 (2001) (citing 2A N. Singer, *Sutherland on Statutes and Statutory Construction* § 47.17 (1991)) (emphasis added).

²² *Beecham*, 511 U.S. at 371.

ability of the Maoists to engage in terrorist activity.” Leaving aside its questionable logic, this assertion is legally unenlightening, for the statute does not make every dealing or transaction with a terrorist organization “material support”; it reserves that category for actions that promote the terrorist agenda. By contrast, the ethical imperative to give medical care to the sick and wounded aims only to heal individuals, without regard to any political beliefs or agenda at all (as discussed in Part II).²³ None of the enumerated examples of “material support” involves anything similar to medical care, and the statutory definition cannot be extended to include medical aid as a form of “engaging in terrorist activity” or “material support.”

No court has ever read the statute as DHS asks the Board to do. *Singh-Kaur v. Ashcroft* – on which DHS incorrectly, but principally, relies – involved setting up tents for terrorist meetings and providing food to militants who had committed or planned to commit acts of terrorism. Those activities share the same basic character as the listed example of setting up a “safe house” for terrorists, and are wholly unlike providing care to sick and wounded human beings.²⁴ DHS’s argument that “[m]edical aid is akin to such basic necessities as food and shelter and likewise falls within the broad spectrum of material support as that term was contemplated by Congress” is simply wrong. Medical care provided by a professional healthcare worker is not akin to a lay person’s providing food and shelter because the healthcare worker is obligated by professional ethical rules to minister to the sick and wounded without regard to the politics of the human beings in need of care.

²³ There may be circumstances, such as setting up a clinic for a terrorist group, that might more closely resemble the enumerated examples of “material support,” but no such facts exist in this case.

²⁴ *Singh-Kaur*, 385 F.3d at 298-299. Even so, the court was divided, with the dissent noting that “the majority’s holding ignores the plain language of the statute by reading ‘material’ out of ‘material support’ and that the ‘support must be both ‘important’ and ‘relevant’ to terrorism.” *Id.* at 301, 303.

Not only has DHS provided no authority to support its claim that Congress “contemplated” including medical care under the definition of “material support,” Congress had good reasons for *not* doing so, given that healthcare workers are obligated under customary international law and medical ethics to care for the sick and wounded regardless of their politics.²⁵

II. TO INCLUDE MEDICAL CARE, PROVIDED IN ACCORDANCE WITH PROFESSIONAL AND ETHICAL OBLIGATIONS AND THE GENEVA CONVENTIONS, AS “MATERIAL SUPPORT” TO TERRORISTS VIOLATES CUSTOMARY INTERNATIONAL LAW.

For the U.S. to bar B.T., who is otherwise entitled to asylum, for providing medical care, constitutes forbidden punishment under customary international law, which requires States to protect, and not punish, medical personnel who carry out their professional duties.

A. The United States is bound to follow customary international law, which obliges medical personnel to uphold the principles of medical ethics during armed conflicts.

The longstanding rule that “[i]nternational law is part of our law”²⁶ requires courts to interpret domestic law consistently with international law wherever possible, as it is here.²⁷ As the Supreme Court has ruled, courts are bound to follow customary international law, that universally acknowledged body of norms reflecting the practice of nations as

²⁵ PHR notes Respondent’s discussion of the role of 18 U.S.C. §2339B, the criminal analogue to INA §212(a)(3)(B)(iv)(VI), in interpreting “material support.” Mindful that *amici* should not repeat parties’ arguments [BIA Practice Manual 4.6(i)], PHR does not address this argument here. See Respondent’s Brief at 31.

²⁶ *The Paquete Habana*, 175 U.S. 677, 700 (1900).

²⁷ See *The Charming Betsy*, 6 U.S. (2 Cranch) 64, 118 (1804) (holding that “an act of Congress ought never to be construed to violate the law of nations if any other possible construction remains”); *MacLeod v. United States*, 229 U.S. 416, 434 (1913) (establishing that statutes should be construed consistently with American obligations under international law); see also *Filartiga v. Pena-Irala*, 630 F.2d 876, 887 (2d Cir. 1980) (stating that U.S. courts bound by the law of nations).

developed over time and accepted by States as binding legal rules.²⁸ In particular, the Geneva Conventions and consistent State practice acknowledging and following the Conventions form the basis of customary international law rules pertinent to this case.²⁹ As recently as June of this year, the Supreme Court, in *Hamdan v. Rumsfeld*,³⁰ reaffirmed the United States's obligations under international law and the role of the Geneva Conventions as part of U.S. law.

The relevant principles of customary international humanitarian law were recently summarized in a 2005 study by the International Committee of the Red Cross (“ICRC”);³¹ we rely on that summary, the language of the two Additional Protocols, and relevant official commentary from the ICRC, in our discussion of the context and meaning of relevant customary international humanitarian law.³² The Additional Protocols remain pertinent, even though the United States has not ratified them, for it has not adopted any reservations regarding the obligations to observe the principles of medical ethics and to protect healthcare workers.

²⁸ Restatement (Third) Foreign Relations Law § 102 (2) (1987).

²⁹ ICRC, Press Release 06/96, *Geneva Conventions of 1949 achieve universal acceptance* (Aug. 21, 2006), available at <http://www.icrc.org/web/eng/siteeng0.nsf/html/geneva-conventions-news-210806>. See, also, *Report of the Secretary-General Pursuant to Paragraph 2 of the Security Council Resolution 808*, ¶35, delivered to the Security Council, U.N. Doc. S/25704 (May 3, 1993) (adopted by the Security Council, S.C. Res. 827 (May 25, 1993)) (stating that the Geneva Conventions have “beyond a doubt become part of customary international law”); Theodor Meron, *The Geneva Conventions as Customary Law*, 81 Am. J. Int’l L. 348 (1987).

³⁰ *Hamdan v. Rumsfeld*, 126 S.Ct. 2749 (2006) (holding that an alien could invoke the Geneva Conventions to challenge procedures used by military commission in his trial).

³¹ CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, *supra* note 3. Based on extensive research, a 5000-page study by the ICRC identified 161 rules found to be customary international law today. The ICRC was mandated by States to undertake this study to clarify the content of customary humanitarian law.

³² The four Geneva Conventions and Additional Protocol I apply to international armed conflicts; Common Article 3 to the Geneva Conventions and Additional Protocol II apply to non-international armed conflicts. Although the discussion presented here relies primarily upon the language of Additional Protocol II in explaining the customary international humanitarian rules, the provisions concerning medical ethics and protections of healthcare workers transcend all types of conflicts and parallel language is noted in citations.

Reflecting widespread agreement on the norms of medical ethics, these principles have been adopted as part of the body of customary international humanitarian law. Thus, Article 10 of Additional Protocol II to the Geneva Conventions provides that “[p]ersons engaged in medical activities shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol.”³³ Given that the relevant standards relating to the protection of medical personnel form part of customary international law, U.S. courts must apply these rules.

B. The obligations of medical ethics apply to all healthcare workers.

The obligations imposed by international humanitarian law and medical ethics apply “not only [to] doctors, but also [to] any other persons engaged in such activities professionally, . . . such as nurses, midwives, pharmacists and medical students who have not yet qualified.”³⁴ Health professionals are bound to follow the principles of medical ethics in carrying out all of their duties. The ICRC’s official commentary provides that “[t]he term ‘medical activities’ should be interpreted very broadly”³⁵ and refers “to the tasks which personnel perform in accordance with their professional obligations when they give care or treatment.”³⁶ The medical assistance provided in this case by B.T., a trained and licensed

³³ See also, Additional Protocol II, art. 10(2).

³⁴ *Id.* at 1426 (para. 4686). See also, American Nurses Ass’n, *Code of Ethics for Nurses* (approved by the ANA House of Delegates at Washington DC) (June 2001); Int’l Council of Nurses, *Statement of Nurse’s Role in Safeguarding Human Rights* (adopted by the Council of National Representatives at Brasília) (June 1983); Nursing and Midwifery Council, *The NMC Code of Professional Conduct: Standards for Conduct, Performance, and Ethics* (Apr. 2002).

³⁵ International Committee for the Red Cross [ICRC], Commentary to Additional Protocol II, art. 10, 1426 (para. 4687) [hereinafter “ICRC Commentary”].

³⁶ *Id.* at 1424 (para. 4679).

healthcare worker, was subject to both the ethical rules governing the medical profession and customary international law.

C. Healthcare workers must put the needs of the sick and wounded first in times of peace and war.

Healthcare workers worldwide are bound to observe common tenets of medical ethics, which find expression in a variety of codes and forms. The most familiar is the Hippocratic Oath, whose the central premise is to help and “above all, do no harm.”³⁷ The most widely-accepted modern codification is the *International Code of Medical Ethics* of the World Medical Association, an international organization representing physicians, which provides ethical guidance to physicians worldwide. The *International Code of Medical Ethics* affirms a physician’s duties by providing that:

A physician shall always bear in mind the obligation to respect human life.

A physician shall always act in the patient’s best interest when providing medical care.

A physician shall owe his/her patients complete loyalty...

A physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.³⁸

Similarly, the “Geneva Oath” requires members of the medical profession to treat the patient’s health as their “first consideration” and to “maintain the utmost respect for human life..., even

³⁷ Cedric M. Smith, MD, *Origin and Uses of Primum Non Nocere—Above All, Do No Harm!*, 45 J. CLINICAL PHARMACOLOGY 371-377 (1995) (noting that this commonly quoted phrase does not appear in the text of the Oath itself but is a central axiom drawn from its principles).

³⁸ WMA, *International Code of Medical Ethics* (adopted by the Third General Assembly at London) (Oct. 1949) (as amended in Aug. 1968, Oct. 1983, and Oct. 2006). *See also* International Conference on Islamic Medicine, *Islamic Code of Medical Ethics* (selected from the Declaration of Kuwait) (Jan. 1981) (requiring physicians “to protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain, and anxiety”).

under threat.”³⁹ Under these principles, B.T. had an ethical duty to provide emergency assistance to the wounded guerillas.

Not only do the principles of medical ethics apply equally in times of peace and war, but international humanitarian law also requires medical personnel who provide their services in armed conflicts to respect the principles of medical ethics.⁴⁰ As in times of peace, the primary task of the medical profession during armed conflicts is to preserve health and save life.⁴¹ International humanitarian law also provides that the wounded and sick “shall be treated humanely,”⁴² consistent with the fundamental purpose of the Geneva Conventions: to protect the wounded, sick and others no longer taking part in hostilities, in order to minimize suffering and loss of life.

D. Customary international law requires States to provide treatment to the sick and wounded without regard to their political or other beliefs.

Healthcare workers are obliged to treat the sick and wounded “without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria.”⁴³ The only acceptable criterion for distinguishing between persons in need of

³⁹ WMA, *Declaration of Geneva* (adopted by the General Assembly at Geneva) (Sept. 1948) (as amended in Aug. 1968, Oct. 1983, and Sept. 1994 and editorially revised in May 2005 and May 2006); *see also* World Medical Association, *International Code of Medical Ethics* (adopted by the Third General Assembly at London) (Oct. 1949).

⁴⁰ *See* Additional Protocol I, art. 16(2); Additional Protocol II, art. 10(2).

⁴¹ WMA, *Regulations in the Time of Armed Conflict* (adopted by the Tenth General Assembly at Havana) (1956) (amended by the 35th World Medical Assembly in 1983).

⁴² Geneva Convention I, art. 12; Geneva Convention II, art. 12; Additional Protocol I, art. 10(2); Additional Protocol II, art. 7(2).

⁴³ CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, *supra* note 3 at 396 (Rule 109) and at 308 (Rule 88); Geneva Convention I, art. 12; Geneva Convention II, art. 15; Geneva Convention III, art. 3(2) and 16; Geneva Convention IV, art. 10; Additional Protocol I, art. 10; Additional Protocol II, art. 7 and 9. For non-international armed conflicts, the basis of this rule comes from Common Article 3 of the Geneva Conventions, which mandates that “[p]ersons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* [out of combat] by sickness, wounds, detention, or any other cause,

medical care is that of medical need. The “fundamental role” of persons subject to the principles of medical ethics is “to alleviate the distress of his or her fellow men, *and no motive, whether personal, collective, or political shall prevent against this higher purpose.*”⁴⁴ A healthcare worker who compromises this duty and his clinical independence by placing the interests of the state or political, personal, or religious allegiance above those of the patient violates these ethical obligations.

Civilians and combatants alike are entitled to medical treatment in times of conflict. As codified in the Geneva Conventions and their two Additional Protocols, “[t]he duty to care for the wounded and sick combatants without distinction is a long-standing rule of customary international law.”⁴⁵ Likewise, compliance with the standards of medical ethics requires healthcare workers to assist *all* those in need, on *all* sides of an armed conflict.⁴⁶ In a approaching a wounded person, a healthcare worker “must see only a patient, and not a friend or an enemy.”⁴⁷ As framed by the ICRC:

Medical assistance should always be neutral; it should not be considered as taking a stand on the conflict because of those benefiting from this assistance. The criterion of when to undertake medical activities is based on purely humanitarian

shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.”

⁴⁴ WMA, *Declaration of Tokyo* (adopted by the 29th General Assembly at Tokyo) (Oct. 1975) (emphasis added).

⁴⁵ CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, *supra* note 3 at 400 (Rule 110); *see also* Additional Protocol I, art. 16; Additional Protocol II, art. 7 and 9.

⁴⁶ *See, e.g.*, WMA, *Declaration of Geneva* (adopted by the General Assembly at Geneva) (Sept. 1948) (requiring healthcare workers to abstain from any “considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient,” and to “maintain the utmost respect for human life..., even under threat”); WMA, *Regulations in the Time of Armed Conflict* (adopted by the Tenth General Assembly at Havana) (1956) (amended in 1983) (requiring physicians to “give the required care impartially” even in emergencies).

⁴⁷ Dr. Alma Baccino-Astrada, *MANUAL ON THE RIGHTS AND DUTIES OF MEDICAL PERSONNEL IN ARMED CONFLICTS* 40 (ICRC 1982).

considerations, regardless of any other factors. To perform medical activities for the benefit of any person, including persons belonging to the adverse party, is not only lawful, but even a duty for those who are professionally bound.⁴⁸

Customary international law similarly requires that “[t]he wounded, sick, and shipwrecked must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition.”⁴⁹ Under no circumstances shall the wounded be willfully left without medical assistance and care.⁵⁰

DHS argues that B.T. should not have fulfilled his ethical and professional obligations to treat the sick and wounded, but should instead have left the Maoist guerillas he treated during the seven days he was kidnapped to die, without any medical treatment whatsoever to heal them or to alleviate their pain. DHS’s position is antithetical to the well-settled and widely observed norms of customary international law, for it asks the Board to penalize B.T. for *not* discriminating against the people he treated. Even in the absence of duress,⁵¹ B.T. had an ethical obligation to treat the wounded Maoist guerillas not as foes, but as sick and wounded human beings, whose health is of paramount concern as a matter of his ethical obligations and international law.

Under applicable rules of customary international law and medical ethics, all persons have a right to medical aid. “Health care is a right of all individuals... regardless of financial, political, geographic, racial, or religious considerations, [and healthcare

⁴⁸ ICRC Commentary, *supra* note 35 at 1426 (para. 4687).

⁴⁹ *Id.* at 400 (Rule 110).

⁵⁰ *See, e.g.*, Geneva Convention I, art. 12.

⁵¹ This issue has been raised by Respondent, and PHR will not further address it. *See infra* note 10.

professionals] should seek to ensure such impartial treatment.”⁵² There is neither legal nor ethical support for DHS’s position that some people do not deserve – must even be denied – medical care. Leaving aside the facially reprehensible nature of this proposition, adopting DHS’s argument would undermine the United States’s efforts against terrorism by implicitly sanctioning terrorists who deny essential medical care on political, religious, or other invidious grounds, in violation of the same international norms DHS disregards before this Board. Encouraging disrespect of these rules potentially puts at risk sick and wounded U.S. citizens who find themselves in war zones throughout the world.

Finally, putting into practice DHS’s position that medical aid is “material support” would put healthcare workers in the untenable position of deciding whether a life is worth saving, whether a person has committed a crime or terrorist act, and whether a group should be denied medical treatment – a form of political decision-making incompatible with medical ethics and international law.

E. Penalizing a healthcare worker for performing his duties violates the United States’s obligations under customary international law to protect, not punish, persons carrying out medical activities.

Customary international humanitarian law prohibits “[p]unishing a person for performing medical duties compatible with medical ethics.”⁵³ To adequately perform their jobs of preserving health and saving lives, healthcare workers need assurance that they will not be punished for carrying out their responsibilities to provide care. The official ICRC

⁵² International Council of Nurses, *Statement of Nurse’s Role in Safeguarding Human Rights* (adopted in Brasília) (1983).

⁵³ CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, *supra* note 3 at 86 (Rule 26); *see also* Geneva Convention I, art. 18 (providing that “[n]o one may ever be molested or convicted for having nursed the wounded or sick”; Additional Protocol I, art. 16; Additional Protocol II, art. 10 (providing that “[u]nder no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom”).

Commentary to Additional Protocol II states that “it is a matter of ensuring immunity for civilian doctors who care for patients without forming part of medical personnel assigned to medical units.”⁵⁴ According to the ICRC, “someone carrying out medical activities could not be punished for the mere fact of carrying out the duties incumbent upon him, irrespective of whether he acted spontaneously or whether he was asked to do so.”⁵⁵ This rule flows from the understanding that “[t]hose who have sworn the Hippocratic Oath to protect human life in all circumstances are allowed a wide margin of appreciation under medical ethics.”⁵⁶

Furthermore, “[v]iolations of this rule inherently constitute violations of the right of the wounded and sick to protection and care,” not just the healthcare worker’s own rights.⁵⁷

Therefore, barring from asylum a healthcare worker, who fulfilled his ethical obligations by providing medical care to the sick and wounded, violates the United States’s obligations under customary international law to protect and not punish persons carrying out medical activities. In this case, such a bar would be particularly perverse because B.T. was himself a victim of terrorism and suffered grave abuse at the hands of the Royal Nepalese Army, which twice arrested and tortured him.⁵⁸ Following this persecution from his own government, and fearing for his life, B.T. sought asylum in the United States. There is simply no basis in law, medical ethics, or fundamental American values for denying asylum to a healthcare worker for carrying out his obligations to provide medical care to all sick and wounded persons on a non-discriminatory basis.

⁵⁴ ICRC Commentary, *supra* note 35 at 1424 (para. 4680).

⁵⁵ *Id.* at 1426 (para. 4689).

⁵⁶ *Id.* at 1426 (para. 4689).

⁵⁷ CUSTOMARY INTERNATIONAL HUMANITARIAN LAW, *supra* note 3 at 87 (Rule 26).

⁵⁸ *See supra* at 3.

III. INCLUDING MEDICAL CARE UNDER THE DEFINITION OF “MATERIAL SUPPORT” CONTRADICTS U.S. POLICY.

Not only does DHS’s position have no legal support, it is contrary to U.S. policy regarding care of the sick and wounded in combat zones, as articulated by the State and Defense Departments. United States policy and practice is to provide medical treatment to detained terrorist suspects; soldiers are instructed to abide by customary international humanitarian law by respecting the rights of the wounded and sick. In addition, the U.S. State Department repeatedly has condemned foreign governments for not protecting medical personnel who provide medical assistance to enemy combatants, classifying such persecution as “human rights violations” in State Department country reports.

A. DHS’s contention is contrary to U.S. military policies.

DHS’s contention cannot be reconciled with the United States Armed Services’ policies governing the provision of medical care to terrorist suspects and enemy combatants. The U.S. Field Manual, the U.S. Air Force Pamphlet, and the U.S. Naval Handbook all require U.S. military personnel to treat the wounded and sick humanely.⁵⁹ U.S. military manuals also codify the customary international law prohibition against denying medical care based on the politics or similar attributes of a wounded or ill person. Thus, the U.S. Army Field Manual provides that the wounded and sick falling into enemy hands “shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse

⁵⁹ THE UNITED STATES ARMY FIELD MANUAL NO. 27-10, “The Law of Land Warfare,” §215, Department of the Army, July 19, 1956 [hereinafter “U.S. ARMY FIELD MANUAL”]; THE UNITED STATES AIR FORCE PAMPHLET 110-31, “International Law – The Conduct of Armed Conflict and Air Operations,” §3-4(d), Department of the Air Force, Nov. 19, 1976 (The Air Force designated AFP 110-31 obsolete as of Dec. 20, 1995) [hereinafter “U.S. AIR FORCE PAMPHLET”]; THE UNITED STATES COMMANDER’S HANDBOOK ON THE LAW OF NAVAL OPERATIONS, NWP 1-14, “The Law of Naval Warfare,” §11-4, Department of the Navy, 1995 [hereinafter “U.S. NAVAL HANDBOOK”].

distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria.”⁶⁰ This requires providing medical care to friend and foe alike, on equal terms.

In keeping with its adherence to the very law DHS asks the Board to disregard, the U.S. teaches its soldiers that they are bound to respect the wounded and sick and may not summarily execute or intentionally harm wounded combatants or terrorist suspects. With respect to the wounded and sick, the U.S. Army instructs personnel that “[a]ny attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated” and “shall *not wil[l]fully be left without medical assistance and care...*”⁶¹ Thus, the Army itself has rejected DHS’s contention that “saving rebels’ lives furthers the[ir] ability... to engage in terrorist activity,”⁶² with its inescapable conclusion that the wounded and sick must be left without medical assistance lest those providing care be deemed, and penalized as, terrorists.

Recent instructions regarding medical program support for detainee operations, issued by the Department of Defense have “reaffirm[ed] the responsibility of health care personnel to protect and treat... all detainees in the control of the Armed Forces” and “to uphold the humane treatment of detainees to ensure that no individual..., regardless of nationality..., shall be subject to cruel, inhuman, or degrading treatment or punishment.”⁶³

Likewise, U.S. military policies instruct medical personnel treating detainees – including

⁶⁰ U.S. ARMY FIELD MANUAL, §215, *see also* §92 ; U.S. NAVAL HANDBOOK, §11-4 (providing that “wounded and sick personnel falling into enemy hands must be... cared for without adverse distinction”).

⁶¹ U.S. ARMY FIELD MANUAL, *supra* note 59, §215 (emphasis added).

⁶² DHS Appellate Brief at 21.

⁶³ Department of Defense, Instruction, Subject: Medical Program Support for Detainee Operations, 2310.08E, 4.1.1 (June 6, 2006).

terrorists – to “be guided by professional judgments and standards similar to those applied to personnel of the U.S. Armed Forces.”⁶⁴

B. The U.S. Department of State repeatedly condemns governments that punish or harass healthcare workers for carrying out their medical duties.

All too often healthcare workers in Nepal and around the world are put in harm’s way and persecuted for alleviating the suffering of others. Thus, a decision by this Board adopting DHS’s novel argument could adversely affect many health professionals who are forced to seek asylum in this country as a result of home-country persecution for carrying out their medical duties.

The U.S. Department of State actively monitors and strongly condemns the persecution of healthcare workers as human rights violations, as set out in its Country Reports on Human Rights Practice submitted annually to Congress.⁶⁵ For example, in Serbia, “[l]ocal human rights monitors reported that Serbian police threatened and intimidated doctors working in the province to prevent them from treating [Kosovo Liberation Army] members.”⁶⁶ Other human rights abuses condemned by the State Department included the Serbian force’s violation of medical neutrality through killings, torture, detention, imprisonment, and forced disappearances of Kosovar physicians. Many physicians were forced to leave their practice, limit their involvement, and/or flee the country or go into hiding.⁶⁷

⁶⁴ *Id.* at 4.1.2.

⁶⁵ The U.S. State Department submits these reports in compliance with sections 116(d) and 502(b) of the Foreign Assistance Act of 1961 (FAA), as amended, and section 504 of the Trade Act of 1974, as amended.

⁶⁶ Bureau of Democracy, Human Rights, and Labor, U.S. Department of State, *Serbia-Montenegro - Country Reports on Human Rights Practices 1999* (Feb. 23, 2000). By today’s definitions, the KLA would be considered a “terrorist organization” under the INA.

⁶⁷ *Id.*; see also Physicians for Human Rights, “Medical Group Documents Systematic and Pervasive Abuses by Serbs against Albanian Kosovar Health Professionals and Patients,” Dec. 23, 1998, *available at* <http://www.phrusa.org/research/mneutrality/kosovo4.html> (noting that an Albanian Kosovar general practitioner,

Likewise, the State Department condemned Russian forces that opened fire on doctors and other medical staff at a hospital in Chechnya.⁶⁸ Non-government organizations also reported that Russian forces detained and ill-treated several medical professionals who had treated wounded Chechen fighters,⁶⁹ and Chechen doctors reported being treated as criminals and subjected to threats, constant watch, blackmail, harassment, arrest and other forms of intimidation.⁷⁰

Year after year, the State Department condemns the human rights abuses in the form of medical personnel persecution committed by both the Colombian government and guerilla forces. Repeatedly, Colombian paramilitary groups and the Revolutionary Armed Forces of Colombia (FARC) failed to respect the injured and medical personnel. The State Department found that “[d]octors and hospitals suspected of treating guerillas were frequently declared military targets.”⁷¹ Paramilitary forces even prepared a “hit list of health care personnel accused of providing medical care to guerillas.”⁷² The Colombian judiciary prosecuted, sentenced, and imprisoned a doctor and a nurse for providing medical treatment to

Dr. Leci, was tortured and killed because he was fulfilling his professional obligation to provide care to patients in need).

⁶⁸ Bureau of Democracy, Human Rights, and Labor, U.S. Department of State, *Russia - Country Reports on Human Rights Practices 1999* (Feb. 23, 2000).

⁶⁹ Human Rights Watch, *World Report 2001, The Russian Federation*, available at <http://www.hrw.org/wr2k1/europe/russian.html>.

⁷⁰ American Enterprise Institute for Public Policy Research, *Catastrophe in Chechnya Escaping the Quagmire* (transcript) (Dec. 10, 2004) available at http://www.aei.org/events/filter_.eventID.675/transcript.asp; Médecins du Monde, *Report Chechnya* (Mar. 2003) available at <http://www.mdm-international.org/international/pages/rapportchechnyamarch2003.htm> [hereinafter “Doctors of the World Report”].

⁷¹ Bureau of Democracy, Human Rights, and Labor, U.S. Department of State, *Colombia - Country Reports on Human Rights Practices 2002* (Mar. 31, 2003) [hereinafter “Colombia 2002 Country Report”].

⁷² *Id.*

guerrillas.⁷³ Similar to this case, the FARC, a designated terrorist organization by the State Department, kidnapped and assaulted a nurse from Colombia. The FARC forced her, often at gunpoint, to give medical treatment to their members. She fled with her daughter to the United States, and her request for asylum is now pending.⁷⁴

As these examples demonstrate, carrying out medical duties in armed conflicts often place medical personnel at risk for their lives. Many healthcare workers are punished by governments or guerilla forces for helping others and must flee their country to avoid further persecution or to save their own lives. For the United States to penalize such persons by denying them asylum validates an erosion of ethical standards and obligations under international law. Barring B.T. from asylum would set a precedent that discourages other healthcare workers from performing their duties to the fullest, contrary to U.S. law and policy.

C. Equating the provision of medical care to “engaging in terrorist activity” does not fulfill the purpose of the statute and leads to absurd results not intended by Congress.

The anti-terrorist legislation invoked by DHS was aimed at thwarting further terrorist attacks and protecting, not harming, victims of terrorist violence. Yet including medical care under the rubric of “engaging in a terrorist activity” by “affording material support” harms, not protects, victims of terrorism who seek refuge in the U.S. As discussed *supra* part I, the plain language of the INA provides no support for DHS’s contention that B.T.’s actions constitute material support for terrorism. Nowhere else in the statute or its legislative history is there any indication that Congress intended to bar from the U.S. persons who are themselves victims of terrorism and who conform their conduct to international law

⁷³ Bureau of Democracy, Human Rights, and Labor, U.S. Department of State, *Colombia - Country Reports on Human Rights Practices 1999* (Feb. 23, 2000).

and ethical norms by treating the sick and wounded. Certainly, denying asylum to individuals who provide medical assistance, as B.T. did, does not make Americans safer and, as noted above, may ultimately put them at risk. To contend that honoring the duty of health professionals to treat wounded individuals undermines U.S. security also lacks sound logic. Again, the reality is that DHS's proposal is more likely to undermine that security by setting the wrong precedent and example through condoning violations of well-settled customary international law principles.

Furthermore, in reaching its decisions, the Board should avoid "interpretations that would produce absurd results."⁷⁵ Including medical activities under the definition of "material support" leads to absurd and unconscionable results. For example, an emergency room doctor who treats a patient considered to be a terrorist suspect could be classified as "affording material support" to a terrorist. Likewise, non-citizen U.S. military personnel in medical units, who provide medical assistance to detained terrorist suspects, could be deemed to providing "material support" to someone engaged in terrorist activity. Given that more than 40,000 non-citizens serve in the military (active and reserve) and about 8,000 permanent resident aliens enlist for active duty every year, many of whom enlist to qualify for citizenship, Congress could not have intended to penalize its own military personnel for fulfilling their duty to provide indiscriminate medical care in accordance with humanitarian law.⁷⁶ Yet under

⁷⁴ Human Rights First, *Abandoning the Persecuted: Victims of Terrorism and Oppression Barred from Asylum 2 and 14* (2006).

⁷⁵ *Azarte v. Ashcroft*, 394 F.3d 1278, 1287 (9th Cir. 2005).

⁷⁶ *Hearing on Immigration: Hearing before the Senate Armed Services Comm.*, 109th Congress (2006) (statement of The Honorable David S.C. Chu, Under Secretary of Defense (Personnel and Readiness)).

DHS's definition of "material support," these non-citizen U.S. soldiers could be deemed inadmissible and removable from the United States.

In addition, DHS's interpretation, if accepted by the Board, could impede the work of humanitarian organizations to provide disaster relief throughout the world. For instance, to provide for people's immediate medical needs and combat subsequent public health problems following the 2004 tsunami, many humanitarian aid workers were forced to work with the Liberation Tigers of Tamil Eelam ("LTTE"), an armed group fighting against the government of Sri Lanka that controls about one fifth of the country and is designated as a Foreign Terrorist Organization by the U.S. State Department. These international humanitarian organizations provided healthcare under extreme circumstances to thousands in need. Accepting DHS's contention would put healthcare and humanitarian aid workers in the position of prejudicing their own ability to relocate to the United States by providing assistance to victims of natural disasters. For this reason too, the Board should reject DHS's argument that the medical care provided by B.T. is "material support" under the INA.

CONCLUSION

Medical care does not come within the statutory definition of "material support" as a matter of law. To hold otherwise would penalize a victim of terrorism, violate the United States's obligations under customary international humanitarian law, undermine medical ethics, and contradict U.S. policy as espoused by the Departments of Defense and State. For the foregoing reasons, Physicians for Human Rights, as *amicus curiae*, respectfully urges that the decision of the Immigration Judge be affirmed.

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