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# International Review of the Red Cross



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## FRENCH EDITION OF THE REVIEW

The French edition of this Review is issued every month under the title of *Revue internationale de la Croix-Rouge*. It is, in principle, identical with the English edition and may be obtained under the same conditions.

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## SUPPLEMENTS TO THE REVIEW

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### SPANISH

Jacques Freymond: El Comité Internacional de la Cruz Roja en acción — “Panorama” y la Cruz Roja de la Juventud — Notificación sobre las embarcaciones costeras de salvamento.

### GERMAN

Jacques Freymond: Das Internationale Komitee vom Roten Kreuz am Werk — Das Jugendrotkreuz in der heutigen Welt — Notifikation der Küstenrettungsboote.

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## The Changing Role of the Nurse

by H. K. Mussallem

*There are many rapid changes taking place in the world today. This also applies to the field of nursing care which is brought out in the following article. We thank The Canadian Nurse review<sup>1</sup> for having kindly allowed us to reproduce it. The opinions expressed therein are those held personally by the writer (Ed.).*

Today, the practice of nursing and the education of nurses are going through the most exciting period in modern times. Throughout a long and turbulent history, nursing has faced almost insurmountable difficulties. In the main, these have stemmed from an attempt to maintain stability while conducting innovation, and from an attempt to change while retaining the useful part of the old. But to their credit, nurses have attempted to keep pace with the needs made by a rapidly changing social structure. It is these present needs that now should force nursing into a new, enlarged, and more crucial role in the health professions.

Over the past century, nursing has evolved from care of the sick person in hospital, to concern for his restoration, to maintenance of good health. Gradually, the role expanded to include the patient's family. Then, too, the role of the nurse extended beyond the hospital walls and nurses practiced in the community caring for families in homes, in clinics, and at work.

Nurses could make changes for the future on the basis of their own interests with the best altruistic intent, or on the basis of past

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<sup>1</sup> Ottawa, November 1968.

## THE CHANGING ROLE OF THE NURSE

traditions and on what nurses believe their role should be. But this is not enough. Change should be based on how—in collaboration with other health professionals—the best possible health care can be provided for all citizens.

Let us look for a moment and in general terms at what we see around us. All knowledge, including medical knowledge, is advancing rapidly. To keep abreast of this accumulating knowledge will require increasing specialization and larger numbers of specialists. The population of Canada is increasing. The demand for health services is increasing. This increases the amount of work for those in the health field. New machines, both for communication and treatment, are being used and being developed. These will demand new organizational development.

There is more to know than one person can know. More skills are required than one person can master. Health care must be carried on in many places at once. There can only be one type of solution for this sequence: a more creative division of responsibility and more delegation of accountability. This will inevitably change the role of the doctor and the role of the nurse. In looking into the future, it appears inevitable that circumstances alone will require the delegation of greater responsibility and greater accountability to better-educated nurses. Such a course is highly logical, if only to allow doctors to pursue medical advances.

What are some of the changes we might expect in health care and nursing practice? We have been told that it is not unreasonable to expect, from extensive research now being undertaken, a breakthrough in cancer<sup>1</sup> and there are prospects of controlling the great killers of today (diseases of the heart and blood vessels). Research may throw light on the process of aging and help bring us nearer to postponement of old age<sup>2</sup>. Facing nurses of the 21st century will be longer life and less sickness, bigger populations and less food, larger cities and less green space, and medical advances far beyond our present conceptions.

Some forces which have and will continue to cause change in the role of the nurse originate with the changing role of the other members of the health team. Medical educators report in recent

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<sup>1</sup> M. G. Candau, *Health in the World of Tomorrow*, *Unesco Courier*, March, 1968.

<sup>2</sup> M. G. Candau, *Health in the World of Tomorrow*, *Unesco Courier*, March, 1968.

## THE CHANGING ROLE OF THE NURSE

meetings and journals that the increasingly difficult task facing physicians is the changing pattern of medical practice today. Fewer and fewer of the recent medical school graduates contemplate general practice<sup>3</sup>, and there is an increase in the number of students entering specialized medicine. McCreary reveals that "Increased demands for family health care combined with a decrease in the number of general practitioners is leading to 'serious difficulty' in the pattern of health care... There are progressively fewer family doctors to meet increased demands caused mainly by modern health plans."<sup>4</sup>

There is evidence, too, that medical practice is being more effectively integrated into the health team in which doctors, nurses, dentists, pharmacists, social workers, and others share in providing health services. Medical educators indicate that the practice of medicine is rapidly becoming a team activity in which the doctor may be, at best, first among equals."<sup>5</sup> As a team member "he must be prepared to engage in several types of concerted effort... He confronts a matrix of collaboration which he cannot expect to dominate or hope to avoid."<sup>6</sup> From this we can speculate that there will be a kind of convergence of the two essential members of the health team—the doctor and the nurse.

Even more fundamental is the concept of the development of health skills on a *partnership* basis. All of us in the health professions could have provided better services if we had tried to work more cooperatively and collaboratively—especially on policy-making—with other groups, rather than searching for and implementing solutions exclusively within our own sphere. We have made changes based on needs or demands as identified by nurses, but have we made changes based on the health needs and sought solutions in collaboration with other health practitioners? If we do not alter our services in view of all the needs, then like the lovable old village smith we may quietly fade away.

From these introductory comments we can surmise that not only is there a changing role for the nurse but also a revolution in nursing.

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<sup>3</sup> J. F. McCreary, *The Future of the Teaching Hospital*, *World Hospitals*, January, 1968.

<sup>4</sup> *Health Care System Threatened*, *Winnipeg Free Press*, May, 1968.

<sup>5</sup> Richard W. Scott and Edmund H. Volkars (eds) *Medical Care*, New York, Wiley, 1966.

<sup>6</sup> Richard W. Scott and Edmund H. Volkars (eds) *Medical Care*, New York, Wiley, 1966.

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through rapid evolution, is at hand. No one can predict with accuracy what lies in the future, but we can predict that:

As the doctor moves rapidly toward new frontiers in medicine and medical practice, more and more medical-technical procedures and other ministering roles will be delegated to the nurse. This may mean that in the next decade the practice of nursing could more closely resemble the practice of today's "family doctor" than of today's nurse.

Demands of a sophisticated public for an increasingly voluminous and effective health care will compel nurses and doctors to work in a more collaborative, collegial relationship to provide optimum health care.

The unique historic function of the nurse will continue to be an essential part of the practice of nursing. The essential role has been, is, and will always be a supportive one to patients in hospital and people in the community—supportive in the fullest sense.

The new, expanded role that nurses will assume in the next decade or two must include, as a base, their primary and unique function, which is complex, service-centered, and based on both intuition and scientific knowledge.

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If certain trends continue, nurses could become medical technicians, not nurses. As noted previously, the nurse has assumed responsibility for more and more medical-technical procedures—in addition to her unique function—to the extent that, in too many instances, she has become a physician surrogate. Because of pressing demands on the doctor's time, when a new medical-technical procedure has become safer and/or more routine, he has delegated this to the nurse because of her suitability and her "fatal availability." She should, however, after careful analysis, assume responsibility for some of those procedures, but only those that keep her next to the patients and the people whom she serves.

There is a new role for tomorrow's nurse. She could in the next decade or two be responsible for the health care of a group of families in the community and for their nursing care in hospital if a member of the family required this highly specialized nursing

service. In selected instances she might provide direct nursing care. This new nurse would move freely from the home to hospital and back. She would become the family's nurse and her main concern would be *health*.

She will not replace the doctor, she will not make a medical diagnosis, but in 10 to 15 years the practice of nursing could more closely resemble the practice of the "family doctor" than that of nursing in the past century.

This may not be what nurses today wish to accept. But any thoughtful nurse will not make a decision for the future solely on the basis of present practice. She will make it in the best interest of the public. The present anxiety of nurses "to be all things to all people" has, for want of careful analysis and research, been to too large a measure treating the symptoms of such problems as "shortages of nurses" rather than studying the disease itself.

At present the Canadian Nurses' Association advocates that as part of the total health services, nursing can be provided best by two categories of nurses—the graduates of the university school and the graduates of the diploma school. In the future dramatic changes will take place in the role of both these groups, and as time progresses a clearer division of their roles will emerge. Excellence of service will be the hallmark of both groups. The description of these two categories by the Canadian Nurses' Association and by the World Health Organization Fifth Expert Committee on Nursing will pertain, but a deeper and wider interpretation of the words will be required for the description of the new nurse of the next decade.

The graduate of the university nursing program of tomorrow will be a community nurse in the fullest sense of the word. She will care for families for whom she is responsible, either in the community or in hospital and will have a key role in their overall health care. She will move from home to hospital and back to home as her services are required. She will work with families and gradually may be seen as the family's health nurse. Eventually, the nurse will be the only health practitioner who will provide continuous service in sickness and health as she now does in the hospital. She will move into this role not only because of pressures and social forces, but also because she will be prepared to do so, and the best prepared to do so.

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The nurse then moves into the sphere of a family practitioner in a very real sense of the term, and in so doing provides time for the physician to discover new medical knowledge and assist him in ways of translating it into service.

Does this new role mean, then, that the professional nurse will work 24-hours-a-day, 7-days-a-week? No. But it does mean that she will be responsible and available for the health care of her families over the 24-hour period, even though she cannot and need not be "on the job" during that time. She will work collaboratively with other professional nurses who will relieve her for days of recreation and rest. She, and her professional nursing colleagues, will assume responsibility for health services for their families—planning, supervision, and evaluation. She may personally, in selected cases, render expert nursing care and act as a resource person to others on the team where and when these services are required.

Many of you may wonder how this community nurse—the graduate of the university program—can provide any nursing service in the hospital. Let us recall that there will be graduates of the diploma program, both hospital and community based, who will be on duty for an eight-hour day (or less, according to current employment practices). This nurse will work with the community nurse to develop a plan of care for the patient in hospital during this interruption in normal living.

At present, only about five percent of the care of ill persons is given in hospitals.<sup>7</sup> Increasingly these institutions will become highly selective and only very specialized care will be carried out in them. The public will realize that these costly hospital services must be used judiciously. These factors alone will have important implications for the future educational programs of both categories of nurses.

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The new community nurse will be prepared to use, easily and intelligently, all the new technological advances. In her supervision

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<sup>7</sup> D. Curiel and others, *Trends in the Study of Morbidity and Mortality*, Geneva, World Health Organization, 1965. (Public Health Paper no. 27).

of family health in the community or hospital, the nurse will visit on a routine basis or be called on request. In her rounds, she will be assisted by the newest technological advances, such as a computer that has been programmed by a variety of experts in the health and allied professional fields. During a home visit she may, for example, detect some abnormal signs in a young child. She will pick up the telephone and describe to the computer the signs and symptoms she has observed. The computer may then tell her what to prescribe, or may ask her for more information before it will outline the required treatment.

Only when the nurse has doubts about the treatment prescribed or is confronted with a more complex medical situation will she consult one of the busy, highly specialized medical practitioners. He will be located in a modern health center and will talk with the nurse by telephone, viewing the patient on the television telephone. In these complex cases, the doctor will ask the computer to display on the television screen the family record and that of the child. From this information he will give the nurse a medical decision.

The nurse will then prepare a total plan for the care of the child and the family's responsibilities, using the medical decision as part of the plan. This is but one of the many ways in which she will combine her nursing knowledge and skills with modern technology to improve health care.

The nurse will still maintain the essential role for which she now exists—but her activities will change dramatically. Computers, television scanning, and other technological "hardware" will extend her eyes, ears, and intellectual capacity. They will not replace, nor be used in place of, the physical presence of the nurse. They will not replace the reassuring touch of the hands of the nurse, nor her compassion, nor her "cooling hand on the fevered brow," nor the cuddling of a frightened child in a clinic, nor the teaching of a young mother in her home, nor research into nursing to provide better and more highly skilled nursing care. They will, on the contrary, provide the nurse with more time so that she can perform the essential role that requires her to be with people. We must never let the computer or its mechanized descendants separate us from the patient and the family; we can use them to assist us in expanding our present usefulness.

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This is but a prediction of the nurse's changing role and its expansion in the next decade or more. It is formulated against the background of the past decades.

To review, then, from a highly personal view into the cloudy future, the new nurse:

*Will be the person on the health team who works continuously and closely with families in sickness and health, moving freely between home and hospital.*

*Will not and cannot make a medical diagnosis, will not and cannot replace the medical practitioner, but will work cooperatively to utilize their scarce numbers to provide a highly effective health service.*

*Will supervise the health of families and in the instance of illness, plan for their care in hospital, using the specialized services of the physician and other health personnel in planning the total care.*

*Will utilize new technological advances so that her personal services may be used to the best advantage.*

*Will play a key role in assisting the medical or health team in translating new scientific discoveries into health care.*

All this may seem too far out. If so, let us recall that Miss Nightingale's conception of the nurse in her day "was widely regarded as visionary and beyond all hope of realization."<sup>8</sup> This new, expanded role is "for use tomorrow"—just a decade or two away. The evidence is too positive to suggest anything else.

The new nurse will be a different person from all points of view. She was born into a new world and has lived to maturity in a newer world. She will serve people in both this new world and our present one. But let us not cast her in our own image. Let us give her elbow room to become a professional nurse who can serve her countrymen in sickness and health in the new expanded role.

**Helen K. MUSSALLEM**  
Executive Director  
of the Canadian Nurses' Association

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<sup>8</sup> K. Robert Merton, "Issues in the Growth of a Profession", In American Nurses' Association's *Proceedings of 41st Convention*, Atlantic City, New Jersey, June, 1958.

## The Military Physician in Captivity

by E. Reginato

*In his introductory address at the third International Refresher Course for Junior Medical Officers,<sup>1</sup> Dr. H. Meuli, member of the ICRC, said " No one knows war better than the military medical officer, nor measures its horror, nor hates it more. No one has greater insight into war to enable him to take a stand for peace and against war". From its very beginnings the Red Cross has been linked to medicine ; it was the ICRC which obtained for doctors the means of exercising their profession in war, which are laid down in the Geneva Conventions.*

*It therefore seems appropriate to quote extensively from a communication submitted at the Course by an Italian doctor, bearing moving testimony to the difficulties facing the medical officer, the noble character of his mission and the principles underlying his activity in the prisoner of war camp. These principles were summed up in his conclusion : " Like peace and justice, medicine loses its significance if not accompanied by charity. If it is to stay universal, it must not lose its humanity ". (Ed.).*

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<sup>1</sup> Organized by the International Committee of Military Medicine and Pharmacy, the course takes place in Madrid. The article which follows is extracted from a volume of twenty-five communications delivered at the course.

## THE MILITARY PHYSICIAN IN CAPTIVITY

*Fortuna humana fingit artatque ut ubet :  
me, qui liber fueram, servum fecit ; et summo infimum.  
Qui imperare insueveram, nonc alterius imperio odsequor.*

(PLAUTUS, *Capteivei*, II, 301-303) \*

You no doubt recognized the prisoners' lament by Plautus. Centuries have past, yet, in spite of our civilization of which we are so proud, this verse by the Roman comic dramatist is, alas, as topical as ever. Perhaps it is due to my having been a prisoner of war that I owe this invitation from the International Committee of Military Medicine and Pharmacy to be with you today. I hesitated a while to speak to you, at this Third Refresher Course for Junior Medical Officers, on "The Military Physician in Captivity". A talk on the rights and duties of a doctor who has been reduced to the most humiliating kind of human condition, might merely be an unpractical speech. At least, that is what an all too recent experience could lead me to believe.

The rights of a doctor, whether he be free or captive, are written, codified and recognized almost universally.

The doctor's duties are summarized in the Hippocratic Oath, and by the code of medical ethics.

Both rights and duties could soon be listed, confirmed and commented on.

The situation may be different when the doctor is just a prisoner among others. Does the Power in whose hands he is recognize international conventions? And if it has signed them, does it apply them? In fact, it all depends on the Power's integrity and degree of civilization.

If the Power is a civilized nation, the medical officer, free to exercise his profession, is faced only with what may be called technical problems: pathology and epidemiology on a scale in keeping with his new environment, in a sometimes quite different climate, psychology influenced by the morale of a community which may often be multinational and the confines in which men are forced to live together. In problems of this kind, all that is at stake are the

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\* *Fortune strikes or smiles at will :  
I was free; now I am a slave. I was riding high ; now I am as dust.  
I commanded yesterday ; today I am in bondage.*

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doctor's qualifications and human feelings. Scope for the doctor's personality is at its maximum.

But the Power may be far from civilized. The doctor is then only a solitary man, face to face with the science and the conscience which were his as a free man. And he is no more than that. And yet his services will be sought from all quarters. Without equipment, generally without medicaments, weakened by privation, he is alone, faced with his patients who watch in silence, waiting for him to carry out the mission to which he has dedicated himself.

I suppose that my young colleagues expect me to relate my experiences rather than give a commentary on legal texts. They should know what the mission of the military physician implies when he is caught up in the maelstrom of war. They should know what they shall inherit in the way of blood and pain, accepted with open eyes by their predecessors; an inheritance for which they are indebted to future generations.

The facts which will be revealed to them will tell them that they will have to act with zeal so that there will no longer be anywhere in the world these man-made disasters involving wasteful loss of the life of innocent victims; they will tell them that they must unite their efforts with those of doctors who, at international meetings, take a stand in favour of making war less inhuman.

\* \* \*

Wars have always brought slaughter, cruelty, epidemics and famine in their wake.

But one morning in 1859, on the terrible misery of a battle field, the dawn seemed to rise for the first time, as if disasters of this kind were henceforth to be eliminated. In 1864, an unforgettable date in world history, an international treaty stipulated in law the principle that wounded and sick soldiers were entitled to respect and care, whether they be friend or foe.

In the years that followed this urge for justice found expression in the second and third Geneva Conventions, according to which States undertook to respect and protect other categories of persons, including prisoners of war, and to permit medical personnel freely to discharge their mission.

But the blackness of hate all too frequently makes men blind.

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Civilization and technicology advance, treaties multiply, but when men stand face to face with weapons in their hands, the monster of the past awakes and grimaces in the night.

Epidemics thought to have been eliminated by hygiene and medical science soon spread when a favourable environment for their return is created; famine comes back to torture entire populations; the slavery of the pre-christian era is forced on great numbers of men of today; mass disease and misery reappear for the first time to the startled doctors.

\* \* \*

In time of peace the military physician works diligently, away from the limelight, among the men whom the State has confided to his care. In time of war his work expands. He assumes a stature which places him apart from others, from his comrades at arms, and even from his superior officers, for he helps and assists them all.

If there should be a military disaster, then the doctor in uniform can achieve greatness. Whole armies may be compelled to beat a retreat, to throw down their arms; men flee in disarray, but the doctor and his assistants remain where they are; they cannot throw down their first-aid kits. Assault troops sometimes have a moment of respite, to recover breath. Not so the doctor and his assistants, for they may be called upon at any time, expected to give themselves wholly to their mission at any moment. Our calling is hard. It demands men in good health, physical and, especially, moral.

When the turmoil rages at its worst, the first-aid box, with its red cross, is the salvation to which all hands are outstretched, and in which all hopes are confided.

A quick bandaging is not enough; it must be accompanied by a word of encouragement and a smile. How many poor men, worn out, have resisted the temptation to drop to the hot sand or frozen ground, because their doctor has urged them on or helped them by his example.

When the wounded come in in droves, each house, each hut, becomes an infirmary. Some of the men may be so seriously injured that they cannot be moved. The doctor does not leave them to their fate. He stays with them to share their gloomy future as prisoners

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of war, to protect them from “injustice and evil”,<sup>1</sup> to help them if he is permitted. Such is the law of the profession and ethical code of the military physician.

Captivity is grim and hard. Human values crumble. Outer signs of rank wear away. Suffering, hunger and epidemics are the equalizers prior to death. But doctors retain their prestige if they are capable of doing so: they alone may still give something to the others, something from their science and their heart. Tribute must be paid not only to doctors but also to their assistants, and the chaplains first and foremost. Both are united in an identical mission: the doctor endeavours to tend the body's ills, the chaplain to comfort and provide hope in life after death. The works of God and man combine and are complementary.

There have been tragic epidemics. Doctors, chaplains, nurses, all have toiled unsparingly, regardless of contagion and death.

“Name the worthy people”, said the poet, “whom fate has robbed, as it did me and others before me, of the joy of dying properly”.<sup>2</sup>

What is the good of quoting names. It is the example which counts.

They were like you, fresh from university. Unhesitatingly they gave their lives, because it was their job. “Ut fratribus vitam servare”.

They were not awarded the honours due to the heroes who fall on the field of honour; they too died on their battlefield and were buried, side by side with their brethren who they tried to snatch from death, buried in the same common grave. Their uniforms differed because they were of different nationalities, but they were so torn and stained that they were indistinguishable. Why distinguish between them anyway? The red cross on their armband was the same. That was unmistakable. Wounded, sick and dying, all turned with confidence to the bearers of that cross in a last call to life, their children and their families.

To struggle against death was in some circumstances like containing with bare hands a river in flood. Helpless against the tragedy, having lost everything, they gave what they had: their last strength, their lives.

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<sup>1</sup> Quoted from the Hippocratic Oath.

<sup>2</sup> Goethe, Faust-Zueignung.

## THE MILITARY PHYSICIAN IN CAPTIVITY

But whence came such energy? Sacrifice comes easy to those who feel the doctor's calling.

While I speak, I see emerging from the depth of my memory the faces of people now dead. There is one especially whom I would recall. The finest, no doubt, because nameless.

Typhus was taking its toll night and day in a prisoner of war camp. A young medical officer, recently arrived and of a different nationality, approached me. He wanted, he said, to leave the non-infected area to go and care for the typhus exanthematic cases.

Efforts were made to dissuade him, in view of the great danger he would be running. But he insisted, saying "I would not lose this great opportunity to be a doctor and a Christian".

He worked himself unsparingly, with all the resources of his art and his intelligence. Stricken with the disease, he no longer had the strength to overcome this illness against which he had revolted with such simple words.

He died calmly, like all who are at peace with themselves because they did not let "the great opportunity" go by.

This example shows the overriding importance of the ethics of the medical profession. "Caste" has no meaning for us, unless it implies the possession of moral qualities which give priority in the right to make self-sacrifice. Our profession, as a religion of duty, is an absorbing one.<sup>1</sup>

That is why these modern doctors remind us of our colleagues of old who were both doctor and priest, not only in the temples to Aesculapius and his daughter Hygeia but in the monasteries of the Middle Ages too.

\* \* \*

It is up to us to see that those of our colleagues who give their lives in the discharge of their duty are not forgotten. We must learn to transcend our instinct of self-preservation and impart to our existence, at least in part, the character of an apostolic brotherhood.

Like our colleagues who, to borrow once more from Plautus, *e infumo summum*, we must be ready to rise above ourselves.

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<sup>1</sup> This was how our colleague who recently died in an African country in turmoil conceived his mission.

It is that, according to Pascal, which is the true essence of manhood, even more so is it that which constitutes the splendour of the military physician.

\* \* \*

One community of prisoners of war is very much like any other, irrespective of the State in whose power they are. They resemble no other group of men in aspect, composition, and the *animus* of each individual.

Compelled to live in a concentration camp, under strict supervision, prisoners of war are cut off from contact with the world or have at most but limited contact under control.

Anxiety seizes these men who have lost their freedom, who are no longer in touch with their families and their countries, who do not know how long their restricted existence will continue, who are harassed by distressing news on military operations against their country still at war. To these causes of anxiety, common to all, each individual adds his own particular worries.

All groups of prisoners have a common characteristic: a resentment of varying intensity, but ever present, against the detaining power.

Prisoner communities acquire a collective attitude. All are rightly convinced that they should be fed, respected, cared for and maintained. They feel they have grounds to demand freedom of thought and religion, and contact with their loved ones, that is to say the only human values which remain when others have crumbled away. They consider they are entitled to release when the conflict has finished.

Prisoner of war camps are melting-pots in which men of different nationality, age, origin, social condition, education, and culture mingle with each other, all reduced to one level by the life of stagnation and uniformity, and provided only with the minimum required for survival.

Captivity is a long period of days without light; a dismal immobility in which man, his hopes always disappointed, waits for the end: it is a form of suffering identical for all, with time going round in circles. As the poet said: "For us there is but one season—the season of sorrow".<sup>1</sup>

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<sup>1</sup> O. Wilde, *De Profundis*.

## THE MILITARY PHYSICIAN IN CAPTIVITY

Too close a contact between men forces on them the nauseating experience of their fellowmen who are prey to their basic requirements; it causes feelings to wither; it engenders aversion and loathing for companions in misfortune; it degenerates character; it causes the mind to retire within itself.

Victims of a single misfortune, war, prisoners have in common the fundamental lines of a bitter psychology, a powerless revulsion against the inexorable march of time lost for ever.

The result is a form of claustrophobia, which a French author (Julland) has called "captivosis".

Even if the detaining power does not refuse to supply food and medicines, or assist the sick, the doctor's task is difficult in such an abnormal and psychologically unstable form of society.

Even if normal relationships among ranks are undermined by conditions or orders from the detaining power, the military physician in captivity must obey his superior officers, respect his colleagues, and uphold the hierarchy based not only on rank but also on qualifications. He should not interfere in matters outside his own professional sphere. In the interest of the sick, he must cooperate with his colleagues of the detaining power. They, for their part, see in the captive doctor, not the vanquished who may be humiliated, but the unhappy colleague, who, for that very reason, needs their effective and constructive help.

The military physician in captivity must especially protect the profession's dignity from any political or ideological influence. The neutrality of the medical profession must be respected, by the prisoner himself in the first place.

The military physician must avoid any suspicion falling on him of injustice and corruption, that is to say, according to a modern rendering of Hippocrates' wording, any suspicion of political collaboration with the detaining power.

Even in captivity the military physician should not in any circumstances depart from the principle of professional secrecy: "If whatever you see and hear about the life in common of people should not be divulged, you will keep it secret in your soul as a sacred trust".

The military physician must conduct himself as a man and an officer: "You will not allow your science and your life to be tainted with weakness". Without confidence there is no doctor. For a

patient to confide in a doctor, the doctor must be faithful, come what may, to the moral code of his profession.

In short, the military physician must be a man in every sense of the word, even when circumstances and adversity combine to break down his resistance and submerge him in the depth of the common anxiety.

He must forget the past, the future, his own misfortune; everything but his duty. He will know and want to care for his patients in the best possible manner, and that very often implies by the example of his own character.

He will speak with wisdom and conviction. He will be the apostle of hope, but will not lie. He will retain his equanimity because tranquillity of the soul is communicative and beneficent.

Even when it is difficult, he will hide his grief when he can offer a suffering man no more than the medicinal value of a smile. Here is how a former prisoner described a military physician: "He had no equipment, but when he appeared among us, attentive, never tired, listening to us patiently, and unceasingly encouraging us by his smile, we felt ourselves revive. His example became our moral force, a call to remain calm and collected. His presence was like a ray of sunshine in the gloom of an infirmary."

Is such conduct possible?

Yes, because the doctor is the possessor of a privilege which no other prisoner may acquire: the certitude that he is useful for something. Every instant of this life, insignificant as it may be for the others, is for him an instant won if he can tend a brother, help him to live, infuse in him a little of his own strength.

Were he to snatch only one man, just one, from death or despair; if one day, after many years, he receives a letter from a former prisoner of war saying: "Thanks to you, who saved my arm, I can provide my children with food", he will feel himself amply repayed for that time which might have seemed lost.

Again, it is there where the splendour of our profession resides. That is the enormous wealth which the doctor may hoard, even in a prison camp, when he has decided "not to let the great opportunity go by".

Dr. E. REGINATO

# INTERNATIONAL COMMITTEE OF THE RED CROSS

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## HELP TO WAR VICTIMS IN NIGERIA

Each month these pages give an account of the ICRC's relief action in Nigeria and the secessionist province (Biafra). That operation has been ceaselessly developing, but cannot carry on unless the ICRC may in future count on help on a large scale. For this reason, Mr. Jacques Freymond, ICRC Vice-President, on May 30, made the following statement on world-wide television and radio.

*For over a year, the International Committee of the Red Cross, with the support of National Red Cross and Red Crescent Societies, UNICEF and many voluntary agencies, has been undertaking a large-scale relief action for the victims of the fighting between the Federal Government of Nigeria and those calling for an independent Biafra. For over a year, teams of volunteers from various parts of the world have been working alongside their comrades in Nigeria and Biafra to give food and care to women and children as well as aiding the wounded.*

*These efforts pursued in most difficult conditions have gradually shown results. Food supplies have arrived as well as medicine and also the necessary funds for the purchase of transport—lorries, boats and aircraft—and for the continuation of a vast relief operation over land and sea. Between teams from wherever they may come, co-operation has been established, the staffs responsible for orders, transport and the distribution of food have acquired experience and set up co-ordinating machinery which functions with the authorization and help of governments directly concerned. The situation of the population has improved and the number of persons assisted on both sides of a fluid front has increased. Two million in all in the first months of 1969, two million and a half in April, not counting those receiving aid direct from the Churches. The fight against epidemics has been engaged and is being pursued, against measles, smallpox and tuberculosis.*

**NIGERIA**



Photo UNICEF - Alastair Matheson

Red Cross relief goes to Uyo by helicopter...

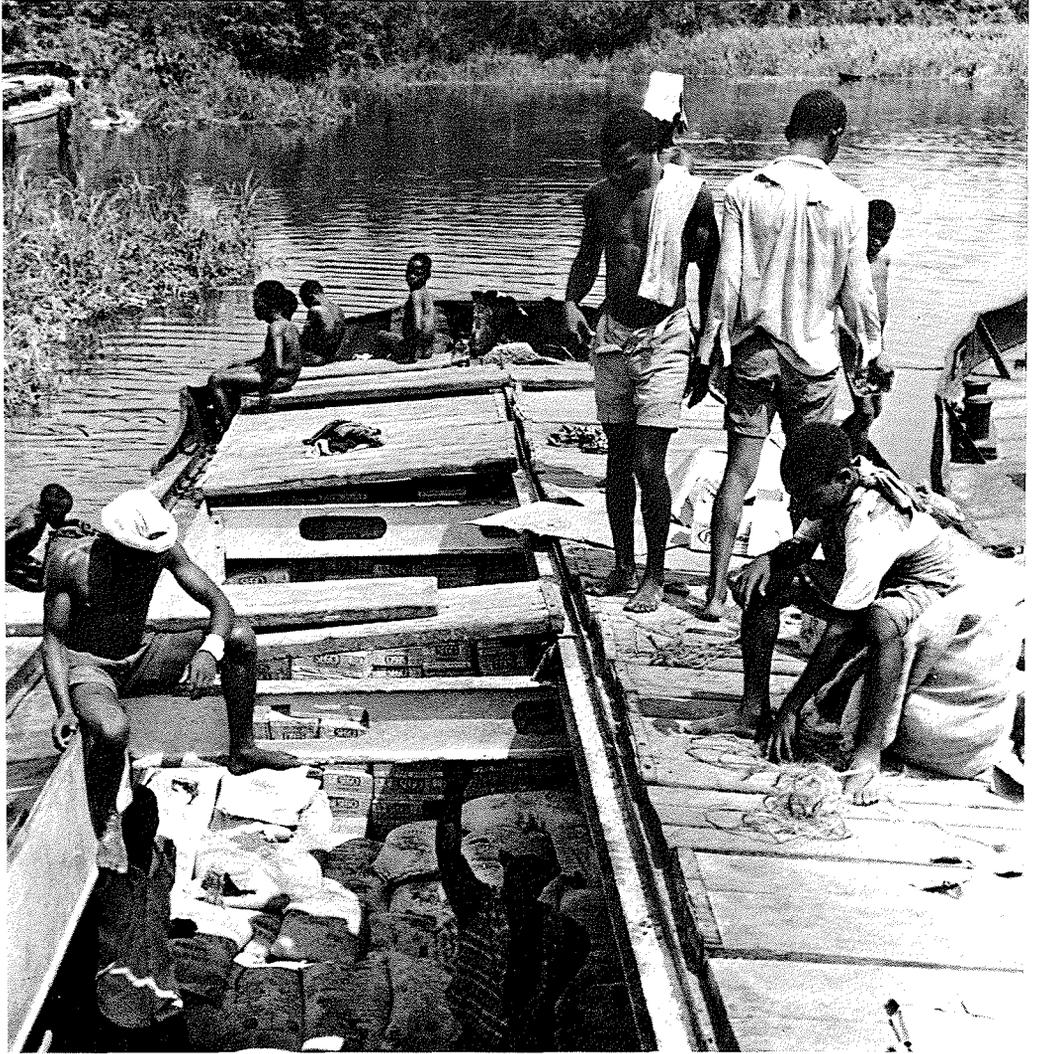


Photo UNICEF - Robin Farquharson

... Nwaniba by barge...



Photo UNICEF - Alastair Matheson

... and reaches starving children...



Photo UNICEF - Robin Farquharson

... and refugees who await its arrival patiently.

However, this operation which after having overcome numerous obstacles is in full development, must face a new and redoubtable danger: the weariness of public opinion.

Already now, when the warehouses are full, money is beginning to lack in order to ensure the distribution of relief and medicine. Financing for the six month plan (1 March - 31 August) is not yet assured. Whilst the United States have amply done their part by contributing 52 million Swiss francs out of a total of 84 million and the Swiss Government has, for its part, decided to make a payment of 6 million francs, for the whole of the period, and if other governments have promised useful contributions although still on too low a scale, Europe is still far from having supplied an amount corresponding to the emotion it feels and the sentiments which it expresses.

Now this population, over whose fate opinion has been moved and which we have helped to survive, has still been given respite. Should, however, the airlift slow down and lorries and vessels come to a halt, then famine which always threatens will return. Just because things seem to be going better and other sufferings require attention, will one allow the impetus of the action to be broken and abandon women and children who have again learnt to live?

The action on behalf of the victims of the Nigeria-Biafra conflict must be pursued. No one can ignore the fact that even if the concerted efforts of all the governments concerned in Africa or elsewhere were to lead to a cease-fire, many months will be necessary to help the population re-organize its existence. On the level of the present relief there will succeed another which the ICRC has the duty of preparing, which it is indeed preparing and for which it intends to obtain the support of governments and public opinion. It is a question of knowing now whether the aircraft which we have had to buy, the vessels we have chartered and the pilots we have engaged will be able to continue to bring relief to the population in danger. The ICRC cannot be content with fine words. Also, all surpluses generously offered are of no avail, if funds are lacking to cover transport costs to the place of distribution. The responsibility which it assumes towards the population, the engagements it has had to undertake and which amount to tens of millions of francs oblige it to speak out clearly and to ask governments which have not yet decided, to give definite answers. Of the 84 million francs necessary for the financing of the present plan, there are

## INTERNATIONAL COMMITTEE

*still twelve lacking. It must be known now at this moment, before the European holidays begin, whether we can count on their support in the autumn. Indeed on 31 August, our task will not be finished.*

The ICRC relief programme referred to by Mr. Freymond may be illustrated by a few facts, figures and dates which show the diversity and operational problems of such a vast enterprise<sup>1</sup>.

*6 May 1969.*—During the last few weeks, the work of the ICRC has been intense in Nigeria and Biafra.

In federal territory the rate of foodstuff distribution has been considerably stepped up following recent operations during which the north-eastern part of Biafra came under the control of the government in Lagos.

With a view to achieving a good harvest in July, an all-out campaign was undertaken by the ICRC. Throughout the sorely tried areas 650 tons of corn, yam and bean seeds were distributed to prevent an otherwise certain famine.

Relief supplies to Biafra in April were double those of the previous month. Flights from Cotonou (Dahomey) and Santa Isabel (Equatorial Guinea) to the Uli landing strip in Biafra during March reached the figure of 228, with a payload of 2,300 tons. In April the figures rose to 475 flights, with 5,000 tons relief goods.

From April 1968 to April 1969, in spite of operating difficulties, the ICRC airlifts carried out 1,636 flights, carrying 16,360 tons of relief supplies.

*7 May 1969.*—A freighter carrying relief supplies on the International Committee airlift into Biafra crashed last night at 10.30.

All the crew were killed, namely captain Karl Eric Baltze of Malmoe (Sweden), co-pilot Hellmut Scharck of Jügesheim (Germany), flight mechanic Carl Goesta Sternhag of Stockholm (Sweden) and loadmaster Bo Valentin Almgren of Stockholm.

The crash occurred in the forest near the village of Ihiala, some 7 miles from the Uli landing strip in Biafra.

The same night, the ICRC despatched from its base at Cotonou two specialists to enquire into the cause of the accident.

<sup>1</sup> *Plate.*—Red Cross relief goes to Uyo by helicopter, to Nwaniba by barge and reaches starving children and refugees who await its arrival patiently.

## INTERNATIONAL COMMITTEE

From the first results of the investigation, it would seem that the aircraft had not been shot down. During the night eleven other flights were carried out, without incident, by the ICRC aircraft from Cotonou, as well as others by those on the Santa Isabel/Biafra run.

The wreck and more than ten tons of foodstuffs and relief supplies were destroyed by fire. The bodies of the crew were found in the wreck. They were taken to the Uli landing strip, where they were placed in coffins with military honours by the Biafran army on the evening of 7 May. The four coffins were flown to Cotonou by another of the aircraft on the International Committee's airlift.

The Swiss Federal Commission of Enquiry into aircraft accidents will send two delegates to Biafra. In co-operation with the local authorities' special services they will endeavour to determine the exact circumstances of the crash. The ICRC will publish their findings.

*13 May.*—A further thirty seriously wounded Biafrans have been brought by the ICRC to Europe.<sup>1</sup>

They will be treated in four European countries, thanks to the co-operation of National Red Cross Societies in Finland, Austria, Netherlands and the Federal Republic of Germany, and of the Netherlands Ministry of Defence. In addition each group was escorted to the various host countries by a Biafran nurse who acts as interpreter.

\*

The following figures show the resources involved in this action on 30 May :

### **Persons fed by the ICRC**

In Federal territory . . . . .	about 1,000,000
In Biafra . . . . .	about 1,500,000

### **Personnel**

Total . . . . .	2,253
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<sup>1</sup> See *International Review*, March 1969.

## INTERNATIONAL COMMITTEE

	<i>Africans</i>	<i>Non-Africans</i>
In Federal territory . . . . .	1,073	239
In Biafra . . . . .	650	96
At Cotonou and Santa Isabel . . .	132	63
Total . . . . .	<u>1,855</u>	<u>398</u>

### **Airlift**

Total medicines, food, vehicles and fuel delivered to Biafra in May 1969 . . . . .	3,501 tons
Aircraft based at Cotonou . . . . .	6
Santa Isabel . . . . .	4
Lagos . . . . .	2

### **Distribution centres**

In Federal territory . . . . .	25
In Biafra . . . . .	11

### **Vaccinations in Biafra:**

By 24 May: 684,151 children had been inoculated against measles.

1,720,333 people had been vaccinated against smallpox.

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*EXTERNAL ACTIVITIES***Middle East**

**Reuniting of Families.** — Under the aegis of the International Committee of the Red Cross, the fifth operation for the reuniting of families took place in the region of the Golan Plateau at the beginning of May. This activity involves, with the agreement of the Israeli government, the repatriation of Arabs displaced by the war of June 1967 and part of whose families had remained in the Israeli-occupied zone. Thanks to the action of the ICRC, 367 people have been able to return to their families.

A similar operation is being carried out in Sinai, where repatriation is a two-way traffic. Egyptians in the Israeli-occupied zone may join their families in the United Arab Republic, and Palestinians who fled to Egypt are able to return to theirs in Gaza. In the latest of these operations, on 29 April, 81 Palestinians and 57 Egyptians were repatriated.

**Visits to Prisoners.** — The International Committee has undertaken its third series of visits to Arab detainees in Israel and Israeli-occupied territory. These visits are carried out by teams of two or three delegates, one of whom is a doctor.

The ICRC has been authorized to visit and talk in private with some 2,000 Arab detainees. Delegates may go regularly to prisons in Jenin, Nablus, Tulkarem, Ramallah, Jericho and Hebron on the west bank of the Jordan, and to prisons in occupied Gaza. They also have access to the Israeli prisons of Ramleh, Kfariona and Achkalon.

In addition, following recent negotiations, the ICRC has obtained authorization to visit, accompanied by a representative of the Israeli authorities, detainees held for interrogation. It then reports to the detaining Power and to the detainees' own government.

In addition, an ICRC delegate pays weekly visits to the prisons named above.

## Rhodesia and South Africa

Continuing the programme begun some years ago, the ICRC, in April and May 1969, sent delegates to visit political detainees in Rhodesia and South Africa.

The mission was carried out by three Swiss delegates; one of them a doctor.

In Rhodesia the delegates only saw the political prisoners under preventive detention. These are of two categories: " detainees " in prisons and " restrictees " in camps.

Visits were made to the prisons of Salisbury, Gwelo, Khami and Sinoia, and the camps of Wa-Wa, Sikombela and Sengwe (Gonakudzingwa).

In South Africa the only prisoners visited were those who had been sentenced and were detained in the prisons of Robben Island, Viktor Verster, Biendonné, Pretoria Central and Barberton.

As customary, the visits were strictly humanitarian in nature, with the purpose of inspecting detention conditions regardless of the reasons for detention.

The ICRC delegates were able to interview detainees of their own choosing without witnesses.

## Latin America

At the beginning of the year, the International Committee of the Red Cross decided to intensify its action in Latin America to strengthen contacts with National Red Cross Societies and governments. A programme was accordingly set afoot for the delegation of representatives from Geneva. Two missions of this nature have already been undertaken this year; one is complete, the other is still under way.

A member of the ICRC, Miss M. Duvillard, who is also a member of the International Council of Nurses, has between April and May carried out a series of visits to the National Red Cross Societies of Argentina, Uruguay, Chile, Bolivia, El Salvador and Venezuela.<sup>1</sup> She had discussions with the National Society leaders on Red Cross organization and development problems, particularly in the field of nursing, nurse-training and first aid.

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<sup>1</sup> See *International Review*, May 1969.

In addition, the ICRC delegate general for Latin America, Mr. S. Nessi, has visited Haiti, Guatemala, Panama and Colombia. Whilst in Haiti he was able to meet the leading members of the National Red Cross. In the other countries he obtained permission from the authorities to visit all places of detention in which there were prisoners and political detainees.

In Guatemala, 18 political prisoners were interviewed in private at the Quetzaltenango penal camp, the Salama penitentiary and the Pavon penal camp. Mr. Nessi also visited the two main police lock-ups in Guatemala city where detainees generally stay only a few days before being transferred to a penitentiary.

In Panama, the ICRC delegate met some hundred political prisoners at the Carcel Modelo in Panama city. He interviewed almost every one of them in private, including a dozen being held in solitary confinement. He then inspected the whole prison.

In Colombia, from 16 to 22 May, Mr. Nessi inspected the Carcel Modelo in Bogota, the Picota prison on the outskirts of the capital and the prisons of the towns of Neiva, Ibagué, Chaparral, Armenia and Cartago. He met more than 200 political detainees.

A report was issued on each visit and forwarded by the International Committee of the Red Cross to the Detaining Power.

All these visits were carried out strictly for humanitarian reasons as is customary. They were restricted to a study of detention conditions, irrespective of the reasons for detention. The purpose was to obtain improved conditions. The ICRC endeavours to arrange, where not already provided:

- the segregation of political and common law detainees;
- regular medical treatment;
- adequate accommodation;
- hygienic conditions;
- food adapted to detention conditions;
- daily exercise out-of-doors and
- regular visits, mail and reading matter.

In June, the ICRC representative is scheduled to go to Peru, Venezuela and Barbados.

The ICRC appreciated the co-operation given by the governments of the countries visited and their understanding for the humanitarian problems of concern to it.

## South Arabia

*Visit to Political Detainees.*—ICRC delegate general for South Arabia, André Rochat, after receiving authorization, carried out further visits to civilian detainees in the Mansura prison at Aden between 3 and 13 May. The previous visit was on 7 and 8 October 1968.

On 30 April, Mr. Rochat also visited two political detainees at the central Crater prison who had been sentenced to death for subversion. As is customary, these visits were strictly humanitarian in nature, being for the purpose of inspecting material conditions of detention irrespective of the reasons for detention.

The ICRC appreciated the better facilities granted by the government to its delegate by allowing him to carry out these visits, thereby testifying to its understanding of the humanitarian problems which are of concern to the Red Cross.

*Material Assistance to Detainees and their Families.*—Following Mr. Rochat's observations on the straitened circumstances of detainees and their families, the ICRC has made a credit available to its delegate to enable him to undertake emergency action to assist them.

*Relief to Civilian Populations.*—Thanks to the surplus dairy products made available by the Swiss government, the ICRC sent 11 tons of milk powder by air to Aden on 24 May. A second consignment of 10 tons was sent by sea, and arrived on 27 May. These 21 tons of milk powder have been delivered to the local Red Crescent Society for distribution to the most needy sections of the population, particularly women and children. This action is being carried out with the assistance and under the supervision of the ICRC delegation in Aden.

*Surgical Assistance.*—The surgical service started by the ICRC in Aden in November 1967 is being carried on. At present a Bulgarian Red Cross team runs the Gamuriah hospital operating services. This is the only civilian hospital for the population of about 1.5 million inhabitants. The team, comprising 2 surgeons and an anaesthetist, took over on 30 April for six months, relieving the previous team provided by the Rumanian Red Cross and which had just completed a second tour of six months in Aden.

In addition, the ICRC has sent a second surgical team, comprising a surgeon and an anaesthetist, both of them Swiss, to Mukallah, the capital of the Hadhramout, due to the trouble prevailing in that region where military wounded and the civilian population had no medical facilities, due to the lack of physicians. This ICRC team at Mukallah has proved its worth, for it is alone in providing surgery for a population of about 400,000. It performs three or four major operations each day as well as a number of minor operations. In view of the signal service which this surgical team provides, the ICRC has decided to maintain it for six months.

*War Disabled.*—Another serious problem of concern to the ICRC is the existence of some 500 war disabled victims of the war in the Yemen.

For several months the ICRC has been seeking help to start up, for the benefit of these unfortunate people, a workshop in Aden for the fitting of artificial limbs and the training of local technicians to take over the workshop.

### **Yemen Arab Republic**

The milk and cheese distribution to children and the maternity and tuberculosis sections of the hospitals in Sanaa, which was started with the help of local authorities towards the end of 1968, is still being carried on under the supervision of the ICRC delegates. The Taiz and Hodeidah hospitals have also been sent milk powder for their tuberculosis patients.

In addition, following the ICRC's appeal to a number of National Societies, those of Bulgaria, Rumania, Hungary and the Democratic Republic of Germany have sent large donations of medical supplies and clothing to the Sanaa hospital through the intermediary of the ICRC.

### **North Yemen**

The ICRC's mobile clinic continues treating the Yemeni population of Najran and Bir-al-Khadra. The medical team each day deals with about 150 cases.

# IN THE RED CROSS WORLD

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## OPEN HOUSE AT THE LEAGUE

Under this heading, the League of Red Cross Societies, to celebrate its jubilee—which we mentioned in our last month's issue—organized an exhibition which was held at its headquarters in Geneva on 3 and 4 May 1969. The thousands of visitors were initiated into the history and activities of the Red Cross by word and picture, first aid demonstrations by the French Red Cross, and film shows.

The numerous exhibits along the pathways of the large grounds depicted international Red Cross disaster relief, from the launching of an appeal by telex in Geneva to the rapid and effective assistance provided to the victims by the National Societies.

Items of particular interest were the Italian Red Cross ambulance, the mobile operating theatre of the German Red Cross in the Federal Republic of Germany, an Austrian Red Cross vehicle especially equipped for blood transfusion, a Swiss Red Cross mobile kitchen and a coach for the handicapped, as well as prefabricated houses and tents. The Geneva branch of the Swiss Red Cross demonstrated the variety of its work by eloquent posters and panels.

Through demonstrations ranging from the transport of casualties by helicopter to home nursing, the public no doubt acquired a convincing picture of the practical scope of Red Cross work in so many fields where the League plays the essential role of initiator and co-ordinator.

## Poland

The Polish Red Cross celebrated the fiftieth anniversary of its foundation on 27 April 1969 in Warsaw. An official ceremony took place in the morning at the Palace of Culture and Science, in the presence of the country's highest authorities.

The first speaker was Professor Dr. Han Kestrzewski, Minister of Health and Social Welfare. He greeted the Polish Red Cross on behalf of the government and spoke of the outstanding service which it had rendered the Polish people and the humanitarian cause in the world.

Mrs. Irena Domanska then recalled the birth of the Polish Red Cross over which she to-day presides, and she outlined the ever-increasing task and usefulness of the Society within and for the benefit of the nation and the international community. We might mention, incidentally, that our February issue contained an important article written by her, summarizing the work of the Polish Red Cross, showing clearly the effectiveness of its action under our common sign both in the social and medical fields, and the variety of its assistance to the population.

As an example of progress achieved, Mrs. Domanska singled out the constant increase in membership, the extensive training of first-aiders, home-help for the sick and service in hospitals. She concluded: " To-day, on the occasion of this fine ceremony uniting voluntary workers old and young, including youth who, in a few years, will direct the humanitarian activities of the Polish Red Cross, I wish to thank warmly, on behalf of all Polish Red Cross voluntary workers, the representatives of our country who are with us to-day, and express the conviction that the Polish Red Cross, which is about to start its second half-century, will, as it has always been throughout its history, be ready to serve the people and the nation, and develop its activities for the benefit of man and peace ".

The Countess of Limerick, Chairman of the Standing Commission of the International Red Cross, Mr. José Barroso, Chairman of the League Board of Governors, and Mr. Roger Gallopin, Vice-President and Director-General of the ICRC, payed tribute to the fine work accomplished by the National Society in circumstances which were often dramatic.

Referring to the Second World War and the years which followed, Mr. Gallopin said: " One cannot help expressing admiration for the way in which you have worked to reconstruct, to heal wounds, trace the missing and restore your country to health. Your Society, exemplifying united good will, has raised to a high degree the effectiveness of all forms of Red Cross assistance to the community ". He also pointed out " the interest which the Polish Red Cross has constantly displayed for the progress of humanitarian law and, of course, of peace. In that spirit, it has contributed constructively to the work of various meetings convened by the ICRC, either to obtain guarantees of immunity for civil defence personnel, or for the intensification of Red Cross efforts to promote peace ".

This moving ceremony was concluded by a concert.

In the afternoon, the Central Committee of the National Society gave a reception at its headquarters for the leading members of several National Red Cross Societies who then conveyed congratulations and good wishes from the institutions they represented.

Other events took place on the following days. One of these was a reception offered by the President of the State Council and Marshal of Poland, Mr. Marian Spychalski, which was attended by leading members of the International Red Cross and National Societies.

## THE HENRY DUNANT INSTITUTE

### Research

For a century Red Cross activities have ceaselessly diversified and multiplied. However, the effectiveness of an action depends to a very great extent on the sum of thought and study which has preceded it. Hence the fundamental and often misunderstood importance of the immense research work which the Red Cross has to undertake in so many fields: sociology, law, the study of conflicts, the study of natural disasters, social medicine, military medicine, pedagogy, etc...

As the "instrument for study and research" its founders intended it to be, the Henry Dunant Institute is faced in this connection with specific responsibilities.

As has already been explained in a previous article<sup>1</sup>, the Institute has undertaken to draw up as complete an inventory as possible of research needs for the International Committee, the League and National Societies. This work can only be carried out through close contacts among all agencies of the Red Cross and the first circular will soon be sent to National Societies requesting them to state in what fields research would be useful for them.

The Institute will not limit itself to this work of *recording* subjects for scientific research. It will especially endeavour to *promote* research on specific points brought to its attention. It will disseminate these themes for research in universities and specialised institutes throughout the whole world, in order to interest aspirants for doctor degrees or other university honours, as well as research workers.

After finding a person competent to deal with a particular subject suggested by it, the Institute will follow his work closely. It will remain available to that person throughout the research

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<sup>1</sup> International Review of the Red Cross, April 1969.

## IN THE RED CROSS WORLD

work. In this field of documentation, the Institute has already assisted several research workers. It has also contributed to the general guidance of their efforts. In some cases, where it appeared justified, it also gave material assistance.

In a somewhat more distant future, when the Institute will have been able to build up its services, it will itself undertake to reply to requests for research by Red Cross agencies. Already its staff are preparing several publications and for that purpose are carrying out historical, legal and sociological studies. In addition, they are intensifying their contacts with other institutes in Geneva and elsewhere, thereby preparing the ground for fruitful co-operation.

V. S.



# M I S C E L L A N E O U S

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## MEDICINE AND SOCIETY

*The theme of the 21st World Medical Assembly at Madrid was "humanism" in the sense of concern for the well-being of the individual in a rapidly changing society with constantly evolving social structures. Discussions revealed the medical profession's concern about the demographic explosion, its desire to adapt treatment and medical teaching, its anxiety over the conflicts sometimes engendered by unacceptable legislation and over other problems posed by the march of science. The official journal of the World Medical Association (W.M.A.) summarizes some of the papers delivered<sup>1</sup> and we would single out that of Dr. de la Quintana, Sub-director of the National School of Hygiene, Madrid, showing how, in the course of history, medicine has been affected by social thought, the different types of culture and structure of human groups of each epoch everywhere.*

The speaker recalled the influence of political and social thought on the assumption of responsibility by society and the state for the sick and the healthy, pointing out also the importance of moral, religious and economic considerations. Social philosophy exercised pressures on the doctor, his professional structure, the organization of medical care and the relations between doctor and state.

The relation between the individual and society amounts to a permanent tension between the free development of individual personality and the subjection of the individual to the herd. Ever since the state appeared as a coordinator of social life for the common good, it has sought to establish an equilibrium between the two tendencies. The realization that health is not only a personal good but a social and community good has been slow to penetrate. Once it penetrated, the consequence was the assumption by the state of the role of defender of health and assistant in sickness.

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<sup>1</sup> *World Medical Journal*, Oslo, 1968, No. 1.

## MISCELLANEOUS

It is true that medical care in history has been influenced by what doctors think about the sick and how they treat and prevent sickness, but it has also been affected by the prevailing ideas of society at any epoch or in any culture. What society thinks about sickness colours the doctor-patient relation, just as much as the development of science does.

Historical examples show to what extent this is true. In Plato's *Republic* he envisaged a medical corps who would look after those sick citizens who were basically sound in mind and body but let the unsound ones die. This was the concept of the Greek world and it is far away from the idea of the modern welfare state and even from Christian thinking. Thus the concept of medicine as a social activity is a very ancient one. Alongside private medicine in the better moments of every civilization there has been a public medicine, usually with medical care dispensed by the less qualified healers, surgeons and midwives. In Greece for the first time there appeared the idea that orthodox medicine should not be reserved for a small portion of the population but available to all, with the establishment of the office of municipal doctor. In Rome preventive medicine was separated off from curative medicine but public physicians existed alongside the persons responsible for environmental sanitation.

With the fall of Rome the public organization of medical care disappeared and was replaced by the action of Christian charity. The Christians in contrast to the Greeks glorified suffering and thought of sickness as a way to perfection rather than a punishment for sin or a sign of inferiority. We have to wait for the Middle Ages before the concept of certain forms of sickness as the wages of sin appears. At the same time as Christian charity was being exercised in the west, the Buddhists of the east were practising the same virtue and it is recorded that the great emperor of India, Ashoka, provided free medical services to his subjects.

Among the historical examples cited by Dr. de la Quintana was the great Spanish humanist Juan Luis Vives who in 1526 published his book *De subventione pauperorum, sive de humanis necessitatibus* in which for the first time he proclaimed the modern doctrine of the *right* of the sick and the poor to help, a doctrine which found general acceptance only in this century. He felt that Christian charity was not enough and proposed that the state establish

officials to supervise charitable works. This and later works show the trend towards a new type of social thought, with the idea not of casual relief of misery but of the cure and rehabilitation of the sick. Daniel Defoe (1697) in England and Chamousset (1757) in France suggested the development of sickness insurance, but it is only from the eighteenth century on that the concept spread that physical and mental illness was of importance not only to the individual but to the community: a logical consequence was the extension of medical care. Hobbes in his *Leviathan* showed that his absolute state should protect the health of its subjects in the common interest and thus introduced the concept of public health as an instrument of policy. Later the industrialists in England and on the Continent were beginning to realize that loss of work through sickness affects production and is therefore of interest to the whole of society, while on the other hand the philosophers who followed Locke, the physician friend of Sydenham, championed the individual's right to the good life without interference from the state. Locke raised the flag which eventually led us to many of the concepts of the modern welfare state in which welfare is achieved without loss of liberty of the individual.

The industrial revolution brought in its wake the modern public health movement, and during the second half of the nineteenth century the problem of providing medical care to the masses of a growing population gave rise to much activity in all western countries, and particularly in Britain and Germany. Even the "laissez-faire" state of Adam Smith recognized the duty to protect every member of society against misfortune. According to Ebenstein the forces which led to the transition from the "laissez-faire" views of the late 18th and early 19th centuries to the welfare state were economic, political and psychological. From the economic viewpoint, a greater and greater proportion of the population were dependent on their work. From the political viewpoint, democracy and the vote led to demands for increase in social security. Psychologically, men were no longer prepared to accept misery as a sort of predestination. It is now commonplace to consider that everyone has a right to the benefits of modern technology, and to aid in sickness and old age.

### **NOTIFICATION OF COASTAL RESCUE CRAFT**

The Royal Ministry of Foreign Affairs of Sweden has officially requested the International Committee of the Red Cross to notify States parties to the IIInd Geneva Convention of August 12, 1949 for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Arm Forces at Sea, of the names and characteristics of twenty coastal rescue craft used by the Swedish Sea Rescue Institution. The ICRC has sent out this notification.

This notification was made in application of articles 22, 24 and 27 of the said Convention. These lay down that coastal rescue craft used by the State or by the officially recognized Life-Boat Institutions shall, in the event of conflict, be respected and protected, subject to certain conditions, one of which is that their names and characteristics shall be notified at least ten days before they are employed. There is no reason why such notification should not be made in peace time. It is a wise move, and one already officially advocated in 1951.

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## BOOKS AND REVIEWS

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GEORG SCHWARZENBERGER: "INTERNATIONAL LAW AS APPLIED BY INTERNATIONAL COURTS AND TRIBUNALS"<sup>1</sup>

The *Law of Armed Conflict* has now appeared as the second volume of an important work by the well-known legal expert Mr. Georg Schwarzenberger, Professor of International Law at the University of London and Director of the London Institute of World Affairs. The author here deals with all juridical problems connected with war and its consequences.

The book is divided into nine parts as follows:

1. Fundamentals
2. The Law of Land Warfare
3. The Law of Air Warfare
4. The Law of Belligerent occupation
5. The Law of Sea Warfare
6. Enforcement of the Rules of Warfare
7. The Law of Neutrality
8. Internal Armed Conflict
9. The Termination of Armed Conflicts.

At the end of the volume there are a voluminous bibliography and indexes of persons and subjects. There is also a list of States parties to the Hague Conventions of 1899 and 1907, to the 1949 Geneva Conventions and to the Geneva Protocol of June 17, 1925 on asphyxiating gases.

This then is a very complete handbook and most useful for all who need to know the problems raised by the laws and customs of war.

C. P.

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<sup>1</sup> Stevens & Sons Ltd., London, 1968, 881 p.

HANS HAUG: «ANSÄTZE ZUR WEITERBILDUNG  
DES KRIEGSRECHTS»<sup>1</sup>

President of the Swiss Red Cross and Professor at the University of St. Gallen, the author in a pamphlet of some twenty pages makes his contribution to present work relating to the law of war. This contribution is made by "taking bearings", to use a term in navigation.

The rules of war, Mr. Haug asserts first of all, are those parts of international law which come into play, in case of war, in relations between States in the place of the law of peace and which regulates their reciprocal relations and conduct by submitting them to a "minimum order". He also considers that the "fundamental principle of the law of war is in no way humanitarian, as it is recognized in law by the Parties that harm can be inflicted on the adversary. . . ."

Since the end of the Second World War, mankind at present knows a particular type of conflict, that of "internationalized civil war". The great Powers are seeking to realize their political aims, to a certain extent, through civil wars or internal disturbances in other countries, avoiding at the same time direct confrontation which would moreover expose them to the nuclear risk. Now, it is undeniable that the present rules of the law of war are not adapted to this sort of conflict. It is also all the more difficult to remedy this situation in view of the fact that the present combatants do not even have the wish to be subjected to any legal order whatsoever.

Another aspect of the problem of modern war consists in technological developments which force war to become total. Civilians are threatened with annihilation and the largest gap perhaps existing in the law of modern war is not to have known, or to have been able to decide which are military objectives. This explains why the efforts of the Red Cross tend today to protect the rescuers, that is to say not civilians, but the teams charged in time of war with saving what can be saved. However, it quite often happens that rescue work is still an integral part of the national defence system itself.

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<sup>1</sup> Off-print of "Festschrift für Walter Hug", Berne, 1968.

The problem of the United Nations had to be broached and this the author has not failed to do. Only intervening in conflicts of the "internationalized civil war" type, the United Nations have declared that they are willing to submit to the principles of the international Conventions. Mr. Haug none the less very clearly expresses the hope that the UN will become a direct party to the Geneva Conventions of 1949.

As regards the indispensable development of the law of war, he only sees the Red Cross capable of promoting it, at least in the present circumstances.

Clarity, concision and objectivity are the characteristics of these few pages in which the author gives exposition of a problem as complex as it is important.

*J. de P.*

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J. J. G. de RUEDA: "CIENCIA HUMANITARIA" <sup>1</sup>

The author, who is Chairman of the Mexican Red Cross International Relations Commission and that National Society's representative in Europe, was adviser to the ICRC and the League for many years. In addition, he has published studies in several Red Cross publications and, in 1963, a book entitled "La Cruz Roja en mi vida y mi vida en la Cruz Roja" in which he gave an account of his broad experience of humanitarian work. His new book, sponsored and distributed by the Mexican Red Cross, will therefore be sure of arousing interest.

This book gives his personal views on what he calls the "humanitarian science". This is based, in his opinion, on Red Cross principles but far exceeds the Red Cross field of action. The title should be taken to signify the knowledge which, being concentrated with ever increasing intensity, is now acquiring greater importance for its basic purpose is to protect mankind from the threat of so many attitudes and inventions: man's attitude to man, too often negative, even hostile, and scientific discoveries which in themselves are favourable but the practical applications of which seem too

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<sup>1</sup> Mexico, 1969, 108 pages.

## BOOKS AND REVIEWS

often harmful. Mr. de Rueda mentions *inter alia* biology and physics and he explains in a convincing manner the need of the world today to safeguard the human character of certain undertakings and administrations whose constant growth and mechanisation are becoming dangerous. He has some eloquent passages on the humanisation of hospitals, a subject with which he is very familiar and in connection with which he recalls the memory of Dr. P. Delore, who was one of the first to stress the urgency of the problem. The author also shows the extent of the threats hanging over us, pointing out with justified concern the changes being wrought to nature everywhere; and which cannot fail to have repercussions on man's physical and mental health.

Mr. de Rueda has subtitled his book *Difusión de los Convenios de Ginebra*. He no doubt thereby wishes to give a reminder that it was the Red Cross which originated these Conventions and also began the struggle, amidst the fighting, to safeguard human lives and human dignity. This implies also the defence of man's true environment in which he continually draws renewed strength. And the spirit of the Geneva Conventions is the same: ensure respect for the distressed, all too often humiliated and helpless, victims of war and internal disturbances.

Also in time of peace victims need help and the Red Cross gives it them. The work which is carried out under this sign throughout the world is testimony to the usefulness of such actions. Its prodigious growth and the fact that it reaches so many new fields show how urgent it is. That, presumably, was the first idea which induced Mr. de Rueda to write a book where the spirit of generosity for which he is known is evident throughout.

J.-G. L.

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HANS G. KNITEL: « LE ROLE DE LA CROIX-ROUGE DANS LA PROTECTION INTERNATIONALE DES DROITS DE L'HOMME » <sup>1</sup>

The author of a report submitted to the French Section of the International Law Study and Research Centre made a welcome contribution to International Human Rights Year.

<sup>1</sup> *Österreichische Zeitschrift für öffentliches Recht*, Vienna, vol. 19, 1969.

We must of course not confuse human rights, which are valid both in time of peace and of war, with the protection of human beings in conflicts and to which the ICRC has devoted particular attention. It is however true that human rights are the most general principles of humanitarian law, of which the law of war is only a special and exceptional case which occurs precisely when war arises to restrict or hinder the exercise of human rights.

After a historical introduction, in which Mr. Knitel gives a timely reminder that "ICRC action, engendered by humanitarian necessities, precedes and instigates the framing of written international law", the report attempts to define international humanitarian law and analyse the present structure of the Red Cross. It then goes on to describe, by stressing the common features of human rights legislation and "Red Cross Law", to show how international humanitarian law and the Red Cross fit into the international legal system.

The second and most important part of the report gives a very condensed summary of the tasks assumed by the ICRC in virtue of the Geneva Conventions in time of war and of peace.

The scope of the Geneva Conventions, the "protective bodies" and the ways and means available to them to act, are the headings of this study. It is first and foremost for the contracting States themselves to ensure respect for the provisions of the Conventions, as, "in the absence of bodies specially constituted by States, the enforcement of the rules of the law of nations devolves largely on national legislative bodies, a phenomenon which Georg Scelle called 'functional duplication' ". But "it would be unrealistic to believe that in the event of war States alone would be able to strictly discharge all the obligations incumbent on them under the 1949 Conventions." That is why provision is made for assistance from and supervision by the Protecting Power and the ICRC. By their regular visits to detention centres they can the better carry out their important mission. This system of protection and supervision, the author adds, has greatly contributed to safeguarding human rights.

In addition, and irrespective of international conflicts, the ICRC can, in the absence of extensive legal grounds therefor, exercise its "right of initiative" conferred by the common article 9 of the

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Conventions. In this connection, Mr. Knitel writes: "Does not ICRC action, prompted by human necessity and consented to by States, constitute case law! It is for this reason that we consider the provisions conferring the right of initiative on the International Committee as the international community's invitation to the ICRC to establish precedents in the humanitarian law of nations and thereby bridge the gaps of positive international law. Any other construction could only deprive this article of its significance, for what would be the use of these provisions stipulating that the Conventions shall not stand in the Committee's way if this right of initiative had not previously been granted it?"

The stipulation of article 3 of the Geneva Conventions that "in the case of armed conflicts not of an international character . . . the ICRC . . . may offer its services to the Parties to the conflict" is but another aspect of its right of initiative. Since 1949 the ICRC's offer can no longer be labelled as interference in the internal affairs of a State.

"It would be desirable", the author concludes, "that specific rules should reinforce the ways in which the ICRC can act in all situations which are not of the nature of an international armed conflict, without however restricting its right of initiative."

J. P.

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**Perspectives d'application de l'ordinateur au domaine médical (Scope for the Computer in Medicine)**, by Dr. G. Mérier, *Revue Suisse des Infirmières*, Soleure, April 1969.

Every day, the computer is breaking into new fields of human activity. It is obvious that it will not be only a status symbol, a passing fashion, but will be a landmark in modern progress, an important step forward in history like the discovery of the wheel, the harnessing of energy and the development of printing.

Medicine will not remain on the fringe of this evolution. The computer's methodological approach will change medical work and thinking. However, the fascinating possibilities opened up by electronics should frighten no one. The fear that the computer will come between the doctor and nurse and the patient must be dissipated. Computer language is becoming more and more adapted to medical logic, and software more

flexible and more appropriate to hospital and public health work, thus bringing the computer within easier reach. In addition, the computer is used for processing data on clinical research, for automatic monitoring or statistical appraisals. Put to proper use, the computer performs all sorts of repetitive jobs and relieves nurses and doctors of part of their work on medical charts thus leaving them more time for the patient. At the same time, analytical capacity reinforced by statistical method, probability and operational research, will reform medical thinking.

Computer feeding and automatic processing of medical data necessitates their being broken down into simple and logical elements. This effort alone is often at the origin of worthwhile methodological reforms. From the nurse's point of view, the change will undoubtedly involve an improvement in the accuracy of noting vital symptoms, the observation of patients (particularly in intensive treatment and post-operation wards) and the administration of medicaments. This effort will be largely offset by the release from repetitive and tedious tasks and a certain amount of detailed recording on charts.

**War, the imponderable**, by René Carrère, *Guerres et Paix*, Paris, 1969, No. 1.

On the road to Thebes, Oedipus was confronted by the Sphinx which he vanquished by giving the right answer to its riddle. His destiny was to continue developing in keeping with the fatality of old or the will of the gods, with a succession of murders and a war against Thebes. Like the course of history, we cannot change mythology which reflects civilizations' awareness of their destiny. All we can do is to formulate a hypothesis of no particular value.

If, instead of proposing a relatively simple enigma, the Sphinx had asked Oedipus a more difficult question: "What is war and what is the reason for war?" the answer would have been more difficult and, in any case, controversial. The Sphinx would have devoured Oedipus as he had done previous travellers. Man would have been vanquished by the Monster, for to define war and its function has proved, over the centuries, to be a matter of chance, as, like Proteus, it assumes various and unexpected forms.

Yet this question "What is war, as a social phenomenon and what is the reason for war?" is capital. The reply has been sought for a long time but never found.

Some twenty years ago, with the threat of nuclear war, a new approach was tried: *polemology, or the sociological study of war, the scientific study of war and peace, in themselves and in relation to each other*. Although, by reason of the subject studied, it is akin to the traditional sciences of warfare (strategy, tactics, logistics, sociological and

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military institutions) and of peace (politics, diplomacy, law), polemology is clearly distinct. Its sphere is fairly wide and new enough for it to overlap theirs only incidentally, when it is necessary for it to refer to them.

We must first define this new discipline and its limits. It is distinct from the five traditional approaches to the phenomenon of war-peace:

— *the philosophical and moral approach* which, in the absolute terms of conscience and dogma, and in the relative terms of attitudes, opinions and interests, judges war and peace;

— *the political approach* which conducts general strategy to meet or avoid war under the best conditions;

— *the legal approach* which, through a network of texts and treaties, endeavours to prevent or at least limit the effects of war;

— *the pacifist approach* which, as various as its underlying motives, rejects war;

— *the military approach* of theorists and practitioners of war who study war as if it were a science, conduct it as if it were an art—a fearful art indeed—and endeavour to preserve peace or win war whose aims are fixed by policy.

\* \* \*

Polemology cannot, of course, ignore any of these traditional approaches and their respective merits. Moreover, it covers part of their particular spheres, but viewing their limits and failures, proposes a new approach to the phenomenon of war and peace, *the sociological approach*, with recourse to all kindred disciplines which may throw light upon the problem.

Why the term *polemology* (proposed by Prof. Gaston Bouthoul)? First of all to confer on this new discipline, by use of a dead classical language, precision and identical significance for all men; second, to make it clear that although its aim is peace, considered as one of the most fragile assets of the city (*polis*), the subject it studies is war (*polemos*); and third, by semasiology, to distinguish the two human trends within any city: the giving of a political and dialectic aspect, both of which run counter to the scientific character (*logos*) which polemology is intended to maintain.

The three aspects of polemology which we shall consider are its discovery explained by the growing threat of war; the definition of its aim, its research method and prospects through the discovery of an original line of thought and conduct; the computation of the probability and scope of its discoveries. This exploration should enlighten us on polemology's future. . . .

**Employment of young people in developing countries, *ILO panorama*, International Labour Office, Geneva, 1969, No. 35.**

... In all its work of special interest to youth the ILO seeks to co-operate with other organisations of the United Nations family, knowing that the solution of youth problems requires the concerted efforts of all, each working in its special field. Interagency co-operation has developed steadily, from the planning on through the implementation and evaluation stages. The priority given to youth needs and problems, and to work with as well as for youth, within the United Nations system is highly significant.

Finally, in these concerted efforts it is appreciated that youth problems are not special to youth: they are the problems of society as a whole. As the Director-General of the ILO has pointed out, if we had an ordered, mature society and reasonable prospects of economic and social growth and development and of world peace and understanding, youth problems in the form in which we know them today—and in the form in which they exist with special acuteness in the developing countries—would not exist. The best service we can render youth, as the ILO enters its second half century, is to dedicate ourselves to the attainment of such a society.

**Guidance in nursing education, by Mary Ann C. Iafolla, *The Journal of Nursing Education*, New York, Volume Eight, January, 1969, No. 1.**

... In conclusion, it is the co-responsibility of guidance and teaching to assist all students in the process of learning, adjusting, and maturing. A sound program of guidance in nursing education, when comprehensively organized and professionally conducted, should culminate in a substantial decrease in the school's attrition rate, a general improvement in interpersonal relationships among students, a higher quality of graduate nurses prepared to assume the responsibilities of a nursing career; improved patient care services, and finally, more responsible and well-adjusted citizenry. It would, therefore, behoove the nursing profession to grant the guidance specialist his rightful niche within the organizational structure of nursing education.

***ILO Panorama*, International Labour Office, Geneva, 1969, No. 36.**

A glance at some of the tables in *The State of Food and Agriculture in 1968* fills the layman alternately with elation and despair. At first, the figures seem heartening. Everywhere in the world food production is expanding. The over-all figures show that 44 per cent more food was produced in 1967 than in an average year about 12 years ago; and if

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one goes back to the years 1948 to 1952 it can be simply calculated from the tables that world food production has expanded by 65 per cent in less than 20 years. That is no mean achievement.

If population had stood still, all the world's peoples might be having enough to eat, for the first time in human history. When the effect of the so-called population explosion is taken into account, however, the picture is rather different, especially in the developing world.

Increased food supplies produced for each person in the last dozen years in Latin America came to only 3 per cent, in the Far and Near East to only 8 per cent and in Africa they stood still, the actual increase in production of 38 per cent being totally offset by population growth.

Over the longer term, the picture looks only faintly brighter. In Latin America, for example, the total increase in food production between the 1948-52 period and 1967 was nearly 70 per cent, surely a remarkable achievement; yet the increase per person came to only 5 per cent. As fast as the land yielded its additional bounty, more mouths cried out for food.

Remember: they were hungry already. To feed the world's millions adequately, it is not enough for food production to keep pace with population growth: it must forge well ahead. Yet the demographers tell us that the world's people will multiply at an increasing pace for as far into the future as one can see. At the beginning of this century, world population was approximately 1,300 million. In 1945 it was about 2,000 million. Today it is approaching 3,500 million. At the end of the century it is expected to reach 6,000 million. (*Robert Plant*).

### **Emergency Care for Accident Victims, *WHO Chronicle*, World Health Organization, Geneva, 1969, No. 3.**

To sum up, the universal application of all that is now known about the pathophysiology of injury would lead to a tremendous increase in the survival and recovery of accident victims. The main problem now is not what should be done, but how to arrange that it is done. The answer lies largely in training physicians and others in modern first-aid techniques, in providing specially designed and well-equipped ambulances, manned by skilled personnel, and in making a highly developed system of communications available to everyone who has to deal with an accident.

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EXTRACT FROM THE STATUTES OF  
THE INTERNATIONAL COMMITTEE OF THE RED CROSS

(AGREED AND AMENDED ON SEPTEMBER 25, 1952)

ART. 1. — The International Committee of the Red Cross (ICRC) founded in Geneva in 1863 and formally recognized in the Geneva Conventions and by International Conferences of the Red Cross, shall be an independent organization having its own Statutes.

It shall be a constituent part of the International Red Cross.<sup>1</sup>

ART. 2. — As an association governed by Articles 60 and following of the Swiss Civil Code, the ICRC shall have legal personality.

ART. 3. — The headquarters of the ICRC shall be in Geneva.

Its emblem shall be a red cross on a white ground. Its motto shall be "Inter arma caritas".

ART. 4. — The special rôle of the ICRC shall be:

- (a) to maintain the fundamental and permanent principles of the Red Cross, namely: impartiality, action independent of any racial, political, religious or economic considerations, the universality of the Red Cross and the equality of the National Red Cross Societies;
- (b) to recognize any newly established or reconstituted National Red Cross Society which fulfils the conditions for recognition in force, and to notify other National Societies of such recognition;

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<sup>1</sup>The International Red Cross comprises the National Red Cross Societies, the International Committee of the Red Cross and the League of Red Cross Societies. The term "National Red Cross Societies" includes the Red Crescent Societies and the Red Lion and Sun Society.

- (c) to undertake the tasks incumbent on it under the Geneva Conventions, to work for the faithful application of these Conventions and to take cognizance of any complaints regarding alleged breaches of the humanitarian Conventions;
- (d) to take action in its capacity as a neutral institution, especially in case of war, civil war or internal strife; to endeavour to ensure at all times that the military and civilian victims of such conflicts and of their direct results receive protection and assistance, and to serve, in humanitarian matters, as an intermediary between the parties;
- (e) to contribute, in view of such conflicts, to the preparation and development of medical personnel and medical equipment, in co-operation with the Red Cross organizations, the medical services of the armed forces, and other competent authorities;
- (f) to work for the continual improvement of humanitarian international law and for the better understanding and diffusion of the Geneva Conventions and to prepare for their possible extension;
- (g) to accept the mandates entrusted to it by the International Conferences of the Red Cross.

The ICRC may also take any humanitarian initiative which comes within its rôle as a specifically neutral and independent institution and consider any questions requiring examination by such an institution.

ART. 6 (first paragraph). — The ICRC shall co-opt its members from among Swiss citizens. The number of members may not exceed twenty-five.

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## ADDRESSES OF CENTRAL COMMITTEES

- AFGHANISTAN — Afghan Red Crescent, *Kabul*.
- ALBANIA — Albanian Red Cross, 35, *Rruga Barrikadavet, Tirana*.
- ALGERIA — Central Committee of the Algerian Red Crescent Society, 15 bis Boulevard Mohamed V, *Algiers*.
- ARGENTINE — Argentine Red Cross, H. Yrigoyen 2068, *Buenos Aires*.
- AUSTRALIA — Australian Red Cross, 122-128 Flinders Street, *Melbourne, C. 1*.
- AUSTRIA — Austrian Red Cross, 3 Gusshausstrasse, Postfach 39, *Vienna IV*.
- BELGIUM — Belgian Red Cross, 98, Chaussée de Vleurgat, *Brussels 5*.
- BOLIVIA — Bolivian Red Cross, Avenida Simon Bolivar, 1515 (Casilla 741), *La Paz*.
- BRAZIL — Brazilian Red Cross, Praça da Cruz Vermelha 10-12, Caixa postal 1286 ZC/00, *Rio de Janeiro*.
- BULGARIA — Bulgarian Red Cross, 1, Boul. S.S. Biruzov, *Sofia*.
- BURMA — Burma Red Cross, 42, Strand Road, Red Cross Building, *Rangoon*.
- BURUNDI — Red Cross Society of Burundi, rue du Marché 3, P.O. Box 1324, *Bujumbura*.
- CAMBODIA — Cambodian Red Cross, 17 R Vithei Croix-Rouge, P.O.B. 94, *Phnom-Penh*.
- CAMEROON — Central Committee of the Cameroon Red Cross Society, rue Henry-Dunant, P.O.B. 631, *Yaoundé*.
- CANADA — Canadian Red Cross, 95 Wellesley Street, East, *Toronto 284*, (Ontario).
- CEYLON — Ceylon Red Cross, 106 Dharmapala Mawatte, *Colombo VII*.
- CHILE — Chilean Red Cross, Avenida Santa Maria 0150, Casilla 246 V., *Santiago de Chile*.
- CHINA — Red Cross Society of China, 22 Kanmien Hutung, *Peking, E*.
- COLOMBIA — Colombian Red Cross, Carrera 7a, 34-65 Apartado nacional 1110, *Bogotá D.E*.
- CONGO — Red Cross of the Congo, 41, Avenue Valcke, P.O. Box 1712, *Kinshasa*.
- COSTA RICA — Costa Rican Red Cross, Calle 5a Apartado 1025, *San José*.
- CUBA — Cuban Red Cross, Ignacio Agramonte, 461, *Havana*.
- CZECHOSLOVAKIA — Czechoslovak Red Cross, Thunovska 18, *Prague I*.
- DAHOMEY — Red Cross Society of Dahomey, P.O. Box 1, *Porto Novo*.
- DENMARK — Danish Red Cross, Ny Vestergade 17, *Copenhagen K*.
- DOMINICAN REPUBLIC — Dominican Red Cross, Calle Galvan 24, Apartado 1293, *Santo Domingo*.
- ECUADOR — Ecuadorean Red Cross, Calle de la Cruz Roja y Avenida Colombia 118, *Quito*.
- ETHIOPIA — Ethiopian Red Cross, Red Cross Road No. 1, P.O. Box 195, *Addis Ababa*.
- FINLAND — Finnish Red Cross, Tehtaankatu 1 A, Box 14168, *Helsinki 14*.
- FRANCE — French Red Cross, 17, rue Quentin-Bauchart, *Paris (8<sup>e</sup>)*.
- GERMANY (Dem. Republic) — German Red Cross in the German Democratic Republic, Kaitzerstrasse 2, *Dresden A. 1*.
- GERMANY (Federal Republic) — German Red Cross in the Federal Republic of Germany, Friedrich-Ebert-Allee 71, 5300 *Bonn 1*, Postfach (D.B.R.).
- GHANA — Ghana Red Cross, P.O. Box 835, *Accra*.
- GREAT BRITAIN — British Red Cross, 9 Grosvenor Crescent, *London, S.W.1*.
- GREECE — Hellenic Red Cross, rue Lycavittou 1, *Athens 135*.
- GUATEMALA — Guatemalan Red Cross, 3.º Calle 8-40 zona 1, *Guatemala C.A.*
- GUYANA — Guyana Red Cross, P.O. Box 351, Eve Leary, *Georgetown*.
- HAITI — Haiti Red Cross, Place des Nations Unies, B.P. 1337, *Port-au-Prince*.
- HONDURAS — Honduran Red Cross, Calle Henry Dunant 516, *Tegucigalpa*.
- HUNGARY — Hungarian Red Cross, Arany Janos utca 31, *Budapest V*.
- ICELAND — Icelandic Red Cross, Ølduggøtu 4, *Reykjavík*, Post Box 872.
- INDIA — Indian Red Cross, 1 Red Cross Road, *New Delhi 1*.
- INDONESIA — Indonesian Red Cross, Tanah Abang Barat 66, P.O. Box 2009, *Djakarta*.
- IRAN — Iranian Red Lion and Sun Society, Avenue Ark, *Teheran*.
- IRAQ — Iraqi Red Crescent, Al-Mansour, *Baghdad*.
- IRELAND — Irish Red Cross, 16 Merrion Square, *Dublin 2*.
- ITALY — Italian Red Cross, 12, via Toscana, *Rome*.
- IVORY COAST — Ivory Coast Red Cross Society, B.P. 1244, *Abidjan*.
- JAMAICA — Jamaica Red Cross Society, 76 Arnold Road, *Kingston 5*.
- JAPAN — Japanese Red Cross, 5 Shiba Park, Minato-Ku, *Tokyo*.
- JORDAN — Jordan National Red Crescent Society, P.O. Box 10 001, *Amman*.
- KENYA — Kenya Red Cross Society, St Johns Gate, P.O. Box 712, *Nairobi*.
- KOREA (Democratic People's Republic) — Red Cross Society of the Democratic People's Republic of Korea, *Pyeongyang*.
- KOREA (Republic) — The Republic of Korea National Red Cross, 32-3 Ka Nam San-Donk, *Seoul*.
- KUWAIT — Kuwait Red Crescent Society, P.O. Box 1359, *Kuwait*.
- LAOS — Lao Red Cross, P.B. 650, *Vientiane*.
- LEBANON — Lebanese Red Cross, rue Général Spears, *Beirut*.
- LIBERIA — Liberian National Red Cross, National Headquarters, Corner of Tubman boulevard and 9th Street Sinkor, P.O. Box 226, *Monrovia*.

## ADDRESSES OF CENTRAL COMMITTEES

- LIBYA** — Libyan Red Crescent, Berka Omar Mukhtar Street, P.O. Box 541, *Benghazi*.
- LIECHTENSTEIN** — Liechtenstein Red Cross, *Vaduz*.
- LUXEMBURG** — Luxemburg Red Cross, Parc de la Ville, C.P. 234, *Luxemburg*.
- MADAGASCAR** — Red Cross Society of Madagascar, rue Clemenceau, P.O. Box 1168, *Tananarive*.
- MALAYSIA** — Malaysian Red Cross Society, 519 Jalan Belfield, *Kuala Lumpur*.
- MALI** — Mali Red Cross, B.P. 280, route de Koulikora, *Bamako*.
- MEXICO** — Mexican Red Cross, Avenida Ejército Nacional, n° 1032, *Mexico 10, D.F.*
- MONACO** — Red Cross of Monaco, 27 Boul. de Suisse, *Monte-Carlo*.
- MONGOLIA** — Red Cross Society of the Mongolian People's Republic, Central Post Office, Post Box 537, *Ulan Bator*.
- MOROCCO** — Moroccan Red Crescent, rue Benzakour, B.P. 189, *Rabat*.
- NEPAL** — Nepal Red Cross Society, Tripureswore, P.B. 217, *Kathmandu*.
- NETHERLANDS** — Netherlands Red Cross, 27 Prinsessegracht, *The Hague*.
- NEW ZEALAND** — New Zealand Red Cross, 61 Dixon Street, P.O.B. 6073, *Wellington C.2*.
- NICARAGUA** — Nicaraguan Red Cross, 12 Avenida Noroeste, *Managua, D.N.*
- NIGER** — Red Cross Society of Niger, B.P. 386, *Niamey*.
- NIGERIA** — Nigerian Red Cross Society, Eko Akete Close, off. St. Gregory Rd., Onikan, P.O. Box 764, *Lagos*.
- NORWAY** — Norwegian Red Cross, Parkveien 33b, *Oslo*.
- PAKISTAN** — Pakistan Red Cross, Frere Street, *Karachi 4*.
- PANAMA** — Panamanian Red Cross, Apartado 668, *Panama*.
- PARAGUAY** — Paraguayan Red Cross, calle André Barbero y Artigas 33, *Asunción*.
- PERU** — Peruvian Red Cross, Jiron Chancay 881, *Lima*.
- PHILIPPINES** — Philippine National Red Cross, 860 United Nations Avenue, P.O.B. 280, *Manila*.
- POLAND** — Polish Red Cross, Mokotowska 14, *Warsaw*.
- PORTUGAL** — Portuguese Red Cross, General Secretaryship, Jardim 9 de Abril, 1 a 5, *Lisbon 3*.
- RUMANIA** — Red Cross of the Socialist Republic of Rumania, Strada Biserica Amzei 29, *Bucarest*.
- SALVADOR** — Salvador Red Cross, 3a Avenida Norte y 3a Calle Poniente 21, *San Salvador*.
- SAN MARINO** — San Marino Red Cross, Palais gouvernemental, *San Marino*.
- SAUDI ARABIA** — Saudi Arabia Red Crescent, *Riyadh*.
- SENEGAL** — Senegalese Red Cross Society, Bld. Franklin-Roosevelt, P.O.B. 299, *Dakar*.
- SIERRA LEONE** — Sierra Leone Red Cross Society, 6 Liverpool Street, P.O.B. 427, *Freetown*.
- SOUTH AFRICA** — South African Red Cross, Cor. Kruis & Market Streets, P.O.B. 8726, *Johannesburg*.
- SPAIN** — Spanish Red Cross, Eduardo Dato 16, *Madrid, 10*.
- SUDAN** — Sudanese Red Crescent, P.O. Box 235, *Khartoum*.
- SWEDEN** — Swedish Red Cross, Artillerigatan 6, 10440, *Stockholm 14*.
- SWITZERLAND** — Swiss Red Cross, Taubensstrasse 8, B.P. 2699, 3001 *Berne*.
- SYRIA** — Syrian Red Crescent, 13, rue Abi-Ala-Almaari, *Damascus*.
- TANZANIA** — Tanzania Red Cross Society, Upanga Road, P.O.B. 1133, *Dar es Salaam*.
- THAILAND** — Thai Red Cross Society, King Chulalongkorn Memorial Hospital, *Bangkok*.
- TOGO** — Togolese Red Cross Society, Avenue des Alliés 19, P.O. Box 655, *Lomé*.
- TRINIDAD AND TOBAGO** — Trinidad and Tobago Red Cross Society, 48 Pembroke Street, P.O. Box 357, *Port of Spain*.
- TUNISIA** — Tunisian Red Crescent, 19, rue d'Angleterre, *Tunis*.
- TURKEY** — Turkish Red Crescent, Yenisehir, *Ankara*.
- UGANDA** — Uganda Red Cross, 57 Roseberry Street, P.O. Box 494, *Kampala*.
- UNITED ARAB REPUBLIC** — Red Crescent Society of the United Arab Republic, 34, rue Ramses, *Cairo*.
- UPPER VOLTA** — Upper Volta Red Cross, P.O.B. 340, *Ouagadougou*.
- URUGUAY** — Uruguayan Red Cross, Avenida 8 de Octubre, 2990, *Montevideo*.
- U.S.A.** — American National Red Cross, 17th and D Streets, N.W., *Washington 6 D.C.*
- U.S.S.R.** — Alliance of Red Cross and Red Crescent Societies, Tcheremushki, J. Tcheremushkinskii proezd 5, *Moscow W-36*.
- VENEZUELA** — Venezuelan Red Cross, Avenida Andrés Bello No. 4, Apart. 3185, *Caracas*.
- VIET NAM (Democratic Republic)** — Red Cross of the Democratic Republic of Viet Nam, 68, rue Bà-Triết, *Hanoi*.
- VIET NAM (Republic)** — Red Cross of the Republic of Viet Nam, 201, đường Hồng-Tháp-Tu, No. 201, *Saigon*.
- YUGOSLAVIA** — Yugoslav Red Cross, Simina ulica broj 19, *Belgrade*.
- ZAMBIA** — Zambia Red Cross, P.O. Box R. W. 1, Ridgeway, *Lusaka*.