

A CRITIQUE OF THE ICRC’S UPDATED COMMENTARY TO THE FIRST GENEVA CONVENTION: ARMING MEDICAL PERSONNEL AND THE LOSS OF PROTECTED STATUS

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I. INTRODUCTION

When addressed by commentators, the protected status of medical personnel and their units, transports and establishments is typically focused on the affirmative duties of combatants not to target medically protected persons and objects. Equally important to these, however, are the affirmative duties of medical personnel to refrain from “acts harmful to the enemy” in order to maintain their protected status, and the extent of the correlative rights of self-defense.¹ These are the concerns of military medical providers in the field at the tactical level that are typically ignored, but they are nevertheless concerns that must be discussed. This is especially true in light of some of the opinions of the International Committee of the Red Cross (ICRC) in the 2016 updated commentary on the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field.²

There are three particular suggestions in the commentary that are in error. First is the conclusion that medical personnel may only carry “light individual weapons” without losing their protected status.³ The second assertion is that a medical establishment loses its protected status solely by being placed in proximity to a valid military objective.⁴ Finally, the third assertion that the commentary makes is that once medically protected persons or objects commit an “act harmful to the enemy” their protected status may not be regained even if exclusive humanitarian duties are resumed.⁵

II. ACTS HARMFUL TO THE ENEMY

As a preliminary matter in analyzing the first two issues, it is vital to interpret Article 21 of Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949 (GC I), which provides that the *sole* reason by which protected medical personnel, units and establishments may lose protected status is the commission, “outside their humanitarian duties, [of] acts harmful to the enemy.”⁶ Though the text of Article 21 explicitly applies only to mobile

¹ ICRC, COMMENTARY ON THE FIRST GENEVA CONVENTION: CONVENTION (I) FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK IN ARMED FORCES IN THE FIELD (2d ed. 2016), <https://ihl-databases.icrc.org/ihl/full/GCi-commentary> [hereinafter 2016 COMMENTARY].

² *Id.*

³ *Id.* ¶ 1864.

⁴ *Id.* ¶ 1842.

⁵ *Id.* ¶¶ 1856–1859.

⁶ Geneva Convention For the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, art. 21, August 12, 1949, 75 U.N.T.S. 31 [hereinafter *GC I*] (“The

medical units and fixed establishments, in light of the extension of protection specifically to medical personnel in Article 24 and the fact that units are composed of medical persons, the only reasonable interpretation would apply the same standard to individual persons in the military medical service.⁷ Further, reading Article 21 and 24 together logically requires an extension of Article 21 to medical personnel and a narrowing of the seemingly absolute protections for medical personnel discussed in Article 24. Though Article 24 states that medical personnel must be “protected in all circumstances,” this protection is predicated upon a given individual’s being within the definition of “medical personnel,” which only includes those persons “exclusively engaged” in the humanitarian mission of medical operations.⁸ Thus, if medical personnel commit “acts harmful to the enemy,” they do not satisfy the conditions required by Article 24 for protection.

The operative condition of “harmful to the enemy” requires a purposeful act that in and of itself has caused harm to the enemy’s ability to conduct legitimate military operations.⁹ This is not a high threshold, it merely requires a definable present harm to the enemy, committed with the intent to cause such harm.¹⁰ The specific intent element may seem difficult to determine in the fog of war, but this is one of the purposes of the “due warning” requirement.¹¹ According to Article 21 of the Geneva Convention For the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (GC I), “[p]rotection may, however, cease only after a due warning has been given, naming, in all appropriate cases, a reasonable time limit and after such warning has remained unheeded.”¹² The drafters understood that “[i]t is possible for a humane act to be harmful to the enemy, or for it to be wrongly interpreted as so,” simply as a result of the presence of military medical units in an active theatre of operations.¹³ Such innocent humane acts that may cause harm—like

protection to which fixed establishments and mobile medical units of the Medical Service are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy.”)

⁷ *Id.* art. 24 (“Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, staff exclusively engaged in the administration of medical units and establishments, . . . shall be respected and protected in all circumstances.”).

⁸ *Id.*

⁹ ICRC, COMMENTARY ON THE FIRST GENEVA CONVENTION: CONVENTION (I) FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK IN ARMED FORCES IN THE FIELD, art. 21, ¶ A (1952), <https://ihl-databases.icrc.org/ihl/full/GCI-commentary> [hereinafter PICTET COMMENTARY TO GC I].

¹⁰ *E.g.*, using a field hospital to shelter “able-bodied combatants.” *Id.*

¹¹ *Id.*

¹² GC I, *supra* note 6, art. 21.

¹³ PICTET COMMENTARY TO GC I, *supra* note 9, ¶ A.

medical equipment affecting electronic communications signals in its vicinity—do not, however, result in a loss of protected status.¹⁴ This is because they are not only not intended to inflict harm, but also are not “committed outside [the] humanitarian duties” of the personnel.¹⁵ The “due warning” requirement provides medical units the opportunity to explain that such interference is not intentional and is directly related to the execution of humanitarian duties before the enemy may rule their protected status forfeited. In the event such action *is* an “act harmful to the enemy,” it also gives personnel a chance to cease such activity.

This standard should also be understood as more expansive than the direct participation in hostilities (DPH) standard used for determining the loss of protected status of civilians, as it includes both direct and indirect actions.¹⁶ As mentioned, however, the expansive interpretation of “acts harmful to the enemy” includes the “due warning” requirement to help resolve any possible confusion. So, on its face it may appear that medical personnel, units, and establishments have more protection than civilians, but with the “due warning” requirement it is balanced by the fact that many more actions can result ultimately in the loss of protection. If there is “doubt as to whether a particular type of conduct amounts to an ‘act harmful to the enemy,’ it should not be considered as such.”¹⁷ The generally expansive nature of this standard also necessitated the drafting of Article 22 of GC I, which covers actions that may not be considered “acts harmful to the enemy”—such as, *inter alia*, arming medical personnel.¹⁸

III. ARMING OF MEDICAL PERSONNEL

Turning to the issue of arming medical personnel, the updated commentary opines that medical personnel are only authorized to carry “light individual weapons,” and that to possess crew-served weapons (CSW) results in the “loss of specific protection of the military medical unit.”¹⁹ Admittedly this is a view expressed by some scholars, and by several states in their military manuals, but it is far from a universal view.²⁰ The

¹⁴ *See id.*

¹⁵ 2016 COMMENTARY, *supra* note 1, ¶ 1840.

¹⁶ *Id.* ¶ 1841.

¹⁷ *Id.* ¶ 1844.

¹⁸ *See id.* ¶ 1845.

¹⁹ *See id.* ¶ 1864.

²⁰ Compare YORAM DINSTEIN, *THE CONDUCT OF HOSTILITIES UNDER THE LAW OF INTERNATIONAL ARMED CONFLICT* 169 (2d ed. 2010) (citing Article 13(2) of Additional Protocol I to justify the conclusion that medical personnel, without differentiation between military medical and civilian medical personnel, may possess “light individual weapons”), and ICRC,

qualification of “light” and “individual” is a noticeable addition in the 2016 Commentary that is absent from the 1952 Pictet Commentary. This addition presents unnecessary danger to medical personnel in contemporary conflicts, in which reciprocity can no longer be presumed. Further, it is an erroneous interpretation of Article 22, which seeks to qualify unambiguous text and which is contrary to standard military planning.

By its text, Article 22 does not condition the quality or quantity of the arms that medical personnel may possess; it only limits the use of weapons by such personnel to self-defense.²¹ The 1952 Pictet Commentary focuses exclusively on the purpose and permissible use of the arms without ever opining upon the acceptable level of armament.²²

Despite the clear meaning of the text of Article 22, which is free from ambiguity, the 2016 Commentary draws a grossly inappropriate analogy to Article 13 of Additional Protocol I (AP I), which states that the equipping of *civilian* medical personnel with “light individual weapons” would not be considered an act harmful to the enemy.²³ Article 13 of AP I was not an attempt to clarify any ambiguity of Article 22, but instead pertained to a completely different class of personnel: civilian medical units. It is a highly illogical, inferential leap to assume that states would want civilians to be armed to the same degree as military medical personnel who are subject to the high standards of discipline of a uniformed service. Civilian medical personnel cannot be presumed to have the weapons and general military training associated with military medical personnel. Military medical personnel have also presumably been trained to a higher degree of specificity regarding acceptable actions, and, unlike civilian medical personnel, they are subject to the military discipline system. The U.S. Navy, for example, requires medical personnel to receive more advanced training on the law of

Rule 25: Medical Personnel, CUSTOMARY IHL (2017), https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1-rul_rule25 (citing military manuals of Germany and the Netherlands, without distinction between military medical personnel and civilian medical personnel), with OFFICE OF THE GENERAL COUNSEL OF THE U.S. DEPARTMENT OF DEFENSE, DEPARTMENT OF DEFENSE LAW OF WAR MANUAL (2015), ¶ 7.10.3.4, <http://archive.defense.gov/pubs/Law-of-War-Manual-June-2015.pdf> [hereinafter LAW OF WAR MANUAL] (“[P]ersonnel of medical units or establishments may be armed, and [GC I] does not specifically restrict the weapons that medical units or facilities may have.”).

²¹ See GC I, *supra* note 6, art. 22; LAW OF WAR MANUAL, *supra* note 20, ¶ 7.10.3.4.

²² See generally PICTET COMMENTARY TO GC I, *supra* note 9, art. 22.

²³ Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), art. 13(2), June 8, 1977, 1125 U.N.T.S. 3 [hereinafter AP I] (discussing the “[d]iscontinuance of protection of civilian medical units”).

armed conflict than general members of the force who serve in duties not involving direct combat operations.²⁴

The 2016 Commentary also opines that Article 22 of GC I limits the arming of medical personnel to portable light individual weapons through citation to Pictet's Commentary on the Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949 (GC II).²⁵ The first item of interest with respect to this citation is the fact that the ICRC did not cite the Pictet Commentary for GC I, which is the actual commentary on point. Admittedly, the Pictet Commentary of GC II does state that the personnel on hospital ships will only need "individual portable weapons," despite the fact that the text of GC II itself did not qualify arming in this way.²⁶ But, it is interesting that Pictet made no such distinction in his Commentary to Article 22 to GC I.²⁷ Pictet indicates in his Commentary to GC II that it should serve as a supplement and modification of his Commentary to GC I, but he nevertheless expresses an opinion only as to what medical personnel will need for lawful self-defense, reserving the primary defensive role to combatants.²⁸ Pictet did not state that it was a legal requirement to limit medical personnel to "individual portable weapons."²⁹ His opinion was based on his understanding that it was "inconceivable that a medical unit" was able to "resist by force of arms a systematic and deliberate attack by the enemy."³⁰ While this is certainly true of an attack on a hospital ship by a battleship or destroyer in 1949, it does not accurately characterize the asymmetric threats that exist today, even in international armed conflicts. Also, from a military perspective, the likelihood and degree of threats at sea were—both in 1949 and presently—of a different nature than those on land.

²⁴ See U.S. DEP'T OF NAVY, CHIEF, NAVAL OPERATIONS INSTR. 3800.52A, LAW OF WAR PROGRAM, ¶ 5e (Jan. 21, 2015), <https://cryptome.org/dodi/2015/opnav-3300-52a.pdf>.

²⁵ 2016 COMMENTARY, *supra* note 1, ¶ 1864. The passage in the Pictet Commentary to which this refers argues that GCII provides for the arming of medical personnel merely to keep order within and to prevent petty cries against the facility, *not* to repel foreign military powers, and that these personnel "will, therefore, need only individual portable weapons such as side-arms, revolvers or even rifles." At no point, however, is this argued to be the legal *limit* on their armaments. ICRC, COMMENTARY ON THE SECOND GENEVA CONVENTION: CONVENTION (II) FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK AND SHIPWRECKED MEMBERS OF ARMED FORCES AT SEA, art. 35 (1960) [hereinafter PICTET, COMMENTARY TO GC II], <http://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=OpenDocument&documentId=4E0242B9D4A7Ab15C12563CD00424106>.

²⁶ PICTET, COMMENTARY TO GC II, *supra* note 25.

²⁷ See PICTET, COMMENTARY TO GC I, *supra* note 9, art. 22.

²⁸ PICTET, COMMENTARY TO GC II, *supra* note 25.

²⁹ See *id.*

³⁰ *Id.*

Lastly, as one of two specially affected states with hospital ships meeting the GC II standards, the United States has CSW onboard to counter asymmetric threats like the attack on the U.S.S. *Cole* in 2000.³¹ The opinion that arms are limited to “individual portable weapons” in the GC II Commentary of Pictet is therefore no longer supported by state practice and should not be used as a justification to assert a limitation for land-based medical units interpreting an article that affects non-similarly situated personnel.

As was previously noted, in order to lose their protected status, medical personnel must purposefully commit acts that in and of themselves create a present harm to the enemy. Arming medical personnel with CSW or other heavier weapons that are necessary to counter likely threats to their lives and the lives of their patients does not result in a present harm to the enemy. In fact, the only way it could be a present harm to the enemy is if the medical personnel intended to violate the law by engaging in offensive hostilities. In reality, there is only a remote hypothetical harm that does not meet the standard of being harmful to the enemy.

States must be able to arm their medical personnel to the degree they see fit to counter the likely threats to medical personnel in a theater of operations.³² Certainly, such arms may only be used in self-defense, but to limit medical personnel to side-arms and small assault rifles while the enemy or “marauders” attack them with CSW and other anti-material weapons mounted on mobile platforms is unjust. To paraphrase Pictet in his Commentary, it is not proper to require medical personnel to be the sacrificial lamb to unlawful actions of the enemy or criminals without resistance.³³

It is not hard for an individual with combat experience to envision situations in which medical personnel may have a need to defend themselves with CSW and anti-material weapons. For example, field hospitals may be present in a combat zone in which enemy tactics could include suicide vehicle-borne improvised explosive devices (SVBIEDs). To defend themselves and patients that are in their care, medical personnel in this scenario may require the use of a .50 caliber machine gun—a weapon primarily designed for anti-material purposes—to address the imminent threat of death or serious bodily injury to all personnel within the hospital.

There may be times when the state does not have adequate forces to use combatants to serve as sentries guarding medical facilities. As a result, the

³¹ LAW OF WAR MANUAL (2015), *supra* note 20, ¶ 7.12.6.3.

³² *See id.* ¶ 7.10.3.4 (“The type of weapon that is necessary for defensive or other legitimate purposes may depend on the anticipated threats against the medical unit or facility.”).

³³ PICTET COMMENTARY TO GC I, *supra* note 9, art. 22(1) (“[I]ts personnel cannot be asked to sacrifice themselves without resistance.”).

medical unit must be prepared to defend itself and its patients from all likely threats. Generally in military planning, however, the concept of defense in depth is axiomatic. In application, armed sentries may be a primary defense plan of a military medical unit, but the planned defense of the military medical unit and its patients must have, at a minimum, secondary or even tertiary sources of defense; for a commander to plan otherwise would be irresponsible. Articles 22(1) (referring to armed medical personnel) and (2) (referring to armed orderlies, picket, sentry, or escort) are not mutually exclusive.³⁴ The text does not limit the medical unit or establishment to one or the other.

For the discussion of this issue, the critical importance of protecting medical personnel cannot be overstated. They possess a low-density critical skillset to mitigate death and unnecessary suffering in warfare for combatants and civilians alike. As a result, they are a priority of defense.

It may not be the best policy choice in every scenario to arm medical personnel with heavier weapons, due to the risk of confusion that can be created as to their protected status, especially if the situation is one in which medical personnel are not displaying Red Cross armlets—as is often the case with U.S. military medical personnel.³⁵ But, this is ultimately a policy and operational choice of the responsible commander that should not be confused with status of law. It is for the commander to balance the risk of misidentification of military medical personnel as combatants and the known and likely threats against the military medical personnel. This type of operational decision—determining the capabilities of a unit—is inherent in command authority, which is restricted by operational considerations and policies, not by the law. Instead, the law generally provides constraint to the employment of capabilities, as, for example, though medical personnel may be capable of engaging in armed operations, the law constrains the employment of this capacity to the defense of self and others only.

This is not an argument for medical units to be armed with tanks or attack helicopters, weapons platforms that require highly specialized training of occupational specialists and are primarily designed for offensive purposes. It is however, an argument that medical units are not limited by the law to light, individual, portable weapons. Medical units may be armed with individual weapons (light or heavy) or CSWs to engage in self-defense as deemed appropriate for the threat environment. These are weapons that

³⁴ See *GCI*, *supra* note 6.

³⁵ See *LAW OF WAR MANUAL* (2015), *supra* note 20, ¶ 7.10.3.4 (“[M]edical units or establishments *should* not be armed such that they would appear to an enemy military force to present an offensive threat.” (emphasis added)); *id.* ¶ 7.8.4 (noting the general U.S. practice not to wear the Red Cross armlets in the field).

military personnel are trained to operate in basic military training and that do not require extensive specialized training that would distract medical personnel from continuing specialized medical training. Most importantly, these are the types of weapons that are likely required to fulfill their lawful purpose of defense if they are faced with an unlawful attack by enemy armed forces or criminals. Blind faith in the notion of reciprocity is no longer tenable and in fact would be a naïve judgment that could unnecessarily endanger military medical personnel. Commanders certainly expect and hope for reciprocity and respect for the law among belligerents, but military planners always prepare to adapt to the least favorable contingency.

The overarching object and purpose of Chapters III and IV of GC I is to maximize the protection of military medical personnel, mobile medical units and fixed establishments. To accept the ICRC's view is to narrow the scope of such protection, and in fact to legitimize the targeting of military medical personnel based on their presumed capability to violate the law rather than the actual legal standard of the purposeful commission of "acts harmful to the enemy." This seems absurd on its face considering the inherent capability of *any* person to violate the law. It would prevent medical personnel from possessing the necessary and effective means to protect their lives and the lives of their patients. Going without such effective means of protection jeopardizes the ability of medical personnel to continue to exclusively engage in their humanitarian duties without adverse distinction—duties that accomplish the broad goal of the law of armed conflict to mitigate human suffering in war.

IV. MEDICAL ESTABLISHMENTS IN PROXIMITY TO MILITARY OBJECTIVES

The 2016 Commentary regards the "placing of a medical unit in proximity to a military objective with the intention of shielding it from the enemy's military operations" as an act harmful to the enemy and resulting in the loss of protected status.³⁶ In fairness, this is a sentiment generally expressed in the Pictet Commentary to GC I as well.³⁷ Nevertheless, this is a position that should be discarded due to the changing nature of battlefield environments; the difficulty of evaluating subjective intent and positively responding to any "due warning"; the fact that such an act will not typically impede military operations against the proximate military objective; and the fact that a medical unit or establishment would not meet the standards for a military objective even if its placement was intentional.

³⁶ 2016 COMMENTARY, *supra* note 1, ¶ 1842.

³⁷ See PICTET COMMENTARY TO GC I, *supra* note 9, art. 21(A).

First, the battlefield environment has changed since 1949, such that urban conflict is now the prevalent mode. In a densely-populated environment, it is quite likely that fixed medical establishments will be adjacent to or well within the proximate weapons effect range of numerous military objectives. This may not be the ideal situation, but it is in many situations a necessary risk. Traversing long distances in an urban environment is a time-consuming endeavor that may result in losing the critical minutes necessary to save a life. Further, medical evacuation by helicopter may not be feasible in an area of dense infrastructure, which means hospitals must be in closer proximity to the front lines.

Second, as the act that strips a medical unit or establishment of its protected status must be purposeful with the specific intent to cause harm to the enemy, there must be an evaluation of subjective intent. As is noted in greater detail in the next section, the “due warning” requirement is meant in part to evaluate the subjective intent of an action that is harmful to the enemy before protected status is lost. The problem in the contemporary conflict environment is that it may not be feasible for the medical unit to heed a warning to relocate its operations.

Third, the location of the military medical unit or establishment, even if placed with the subjective intent to shield a military objective, typically will not impede military operations anyway, and so could not be considered an act “harmful to the enemy.” A primary argument that their presence would not impede a military operation against a proximately located military objective is that military medical and religious personnel are excluded from a proportionality analysis.³⁸ This is not a view shared by the ICRC, who—ironically in light of its firm stance that such an action would result in a loss of protected status—still views the principle of proportionality and the obligation to take all feasible precautions as applicable.³⁹ The view that neither the proportionality principle nor the obligation to take precautions with regard to military medical personnel and wounded combatants within apply in this scenario is supported by the general expressions of both in terms of protecting innocent civilians from the hardships of war.⁴⁰

³⁸ OFFICE OF THE GENERAL COUNSEL OF THE U.S. DEPARTMENT OF DEFENSE, DEPARTMENT OF DEFENSE LAW OF WAR MANUAL (2016), ¶ 7.8.2.1 (“The incidental killing or wounding of [medical and religious] personnel, due to their presence among or in proximity to combatant elements actually engaged by fire directed at the latter, gives no just cause for complaint. Because medical and religious personnel are deemed to have accepted the risk of death or further injury due to proximity to military operations, they need not be considered as incidental harm in assessing proportionality in conducting attacks.”).

³⁹ 2016 Commentary, *supra* note 1, ¶ 1854.

⁴⁰ See AP I, *supra* note 22, art. 51(5)(b) (“[a]n attack which may be expected to cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination

Intuitively, it makes sense to exempt those that presumably entered the combat environment as military professionals accepting the risks associated with such, including death, in contrast to innocent civilians that are truly helpless victims of the crossfire of war. Admittedly, this is likely a minority view, but presented in this context, it actually works to reinforce the protected status of the medical unit or establishment, as its location would not impede military operations, and so it cannot be said to be a harmful act resulting in the loss of protected status.

Fourth and most importantly, whether the principle of proportionality is applied or not, it cannot generally be said that even the intentional placement of a medical unit to serve as a shield for a military objective converts such unit or establishment into a military objective itself. The 2016 Commentary attempts to parse out a difference between the loss of protected status and a secondary analysis of whether the military medical unit or establishment has become a military objective.⁴¹ But, even the ICRC admits that “it is hard to conceive of circumstances in which the commission of an ‘act harmful to the enemy’ would not transform the facility in question into a military objective” after it cited this scenario as a definitive example of an “act harmful to the enemy.”⁴²

If a state subscribes to the legal theory that military medical units and establishments, along with wounded combatants, are exempted from consideration in application of the principle of proportionality, then the mere location itself would not result in a loss of protected status. As it would not impede military operations of the belligerent seeking to engage an adjacent military objective, it is not an “act harmful to the enemy.”⁴³ Therefore, it cannot be directly targeted as a military objective since its “nature, location, purpose or use [do not] make an effective contribution to military action.”⁴⁴ Its attack would also not offer a “definite military advantage,” as it is understood that its presence was an assumed risk, which would not preclude an otherwise lawful attack on an adjacent military objective.⁴⁵

If a state applies the principle of proportionality to military medical personnel and to wounded combatants being treated at a military medical establishment that was placed for the purpose of attempting to shield a

thereof, which would be excessive in relation to the concrete and direct military advantage anticipated” is prohibited); *see also id.* art. 57(2)(a)(ii) (“[T]ake all feasible precautions in the choice of means and methods of attack with a view to avoiding, and in any event to minimizing, incidental loss of civilian life, injury to civilians and damage to civilian objects.”).

⁴¹ *See 2016 Commentary, supra* note 1, ¶ 1847.

⁴² *Id.*

⁴³ *Id.* ¶¶ 1841, 1847.

⁴⁴ *AP I, supra* note 23, art. 52(2).

⁴⁵ *Id.*

military objective from attack, then the establishment should still not be considered a military objective subject to attack. This is a more tenuous argument to make on its face because the location of the facility may—but will not necessarily—impede a military operation if the likely incidental harm to the military medical personnel and patients therein is thought to be excessive in relation to the military advantage expected to be gained by destroying the adjacent target. If that is the case, it would constitute an act "harmful to the enemy," which normally would result in the loss of protected status after a "due warning," if feasible, is not heeded.⁴⁶

It can be said that its location would "make an effective contribution to military action," but is illogical to conclude that it meets the second element of the military objective: that its "total or partial destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage."⁴⁷ To come to this conclusion would require the assumption that because the personnel within the facility impeded an attack on an adjacent objective as a result of a proportionality analysis, that the state can now simply attack the building in which they reside to kill them so that they no longer impede targeting the adjacent objective. This is, of course, an absurd result, but it is the one that logically flows from the ICRC's position, both in the Pictet Commentary to GC I and again, more forcefully in the 2016 Commentary.

Instead, a state in this position should treat the military medical personnel in the facility as something akin to voluntary human shields. To do so is based on the presumption that the facility is intentionally located to attempt to shield an adjacent military objective and the facility personnel are generally aware of this purpose.⁴⁸ So, even if they normally would be included in a proportionality analysis as military medical personnel, they would now be exempt on the basis of being a voluntary human shield. Under this application, the wounded patients would still need to be considered for proportionality purposes, but it is much less likely that the incidental harm will be excessive when the staff is removed from consideration.

No matter which legal position regarding proportionality is adopted, intentionally locating a military medical facility in proximity to a military objective for the purpose of shielding it should not be considered a black line rule of application. As demonstrated, in most cases, either the act would not impede operations at all due to exclusion of consideration from proportionality, or the facility would still not be a legitimate military objective.

⁴⁶ *GC I*, *supra* note 6, art. 21.

⁴⁷ *AP I*, *supra* note 23, art. 52(2).

⁴⁸ *LAW OF WAR MANUAL* (2016), *supra* note 38, § 5.12.3.3.

V. THE TEMPORAL SCOPE OF THE LOSS OF PROTECTED STATES FOR
MEDICAL PERSONNEL OR ESTABLISHMENTS AFTER COMMITTING AN ACT
HARMFUL TO THE ENEMY

While addressing two competing theories for the temporal scope of the loss of protected status after committing “act[s] harmful to the enemy,” the 2016 Commentary seems to argue that once the protected status “cease[s]” it cannot be regained.⁴⁹ This specific issue was not discussed in the Pictet Commentary to GC I, but it is reasonable to conclude that Pictet would have disagreed with the permanent cessation theory based on his emphasis of a reasonable time period for a medical unit or establishment to cease actions harmful to the enemy.⁵⁰ This theory contravenes the logic behind the “due warning” requirements before engaging medical targets that commit “act[s] harmful to the enemy” and frustrates the overall purpose to maximize the protections for medical personnel and units.

Article 21 of GC I states in part: “[p]rotection may, however, cease only after a due warning has been given, naming, in all appropriate cases, a reasonable time limit and after such warning has remained unheeded.”⁵¹ The 2016 Commentary notes that the stipulation that “protection will ‘cease’, without any further qualification, appears to suggest that once protection is lost, it cannot be regained for the duration of hostilities.”⁵² This would be a reasonable interpretation only if that section is not read in context with the “due warning” requirement for the cessation to occur. It is well understood that there may be situations in which the provision of a “due warning” may not be feasible, such as in response to a barrage of gunfire coming from a medical establishment that must be immediately addressed for the defense of a combatant unit.⁵³

The intent of the “due warning,” at least in part, is to encourage medical units to terminate “acts harmful to the enemy” and return to exclusive engagement in humanitarian duties. Or, in other words, “due warning” is designed to balance “the military necessity to attack medical units and transport, which are abused for military purposes, with the humanitarian concern for those who are in need of medical assistance or care and others who use the unit or transport for legitimate, that is medical, purposes.”⁵⁴ If

⁴⁹ See 2016 Commentary, *supra* note 1, ¶¶ 1855–1859.

⁵⁰ See Pictet Commentary to GC I, *supra* note 8, art. 21(B).

⁵¹ GC I, *supra* note 5, art. 21.

⁵² 2016 Commentary, *supra* note 1, ¶ 1856.

⁵³ Pictet Commentary to GC I, *supra* note 8, art. 21(B).

⁵⁴ THE HANDBOOK OF INTERNATIONAL HUMANITARIAN LAW 338 (Dieter Fleck ed., 3d ed. 2013).

such warning is not heeded, protection may be lost, which may result in an attack on the medical unit or establishment. If the goal is to bring the rogue medical unit back into the fold after any subsequent attack when a warning is unheeded, then when a medical unit or establishment takes measures to permanently cease actions harmful to the enemy, resuming its medical mission exclusively, it should regain its protected status. The warning may not have worked, but in this scenario a subsequent attack did. To advocate for a permanent loss of protected status despite a change of behavior only serves as a continuous belligerent reprisal instead of fulfilling the purpose of the “due warning” requirement. The goal is not to punish the medical unit, however, but to entice it back into conformance.

The “due warning” concept reflects the natural reluctance to take offensive military action against what should be medically protected persons or objects. This is not simply a conditional response of legal training. It is a matter of well-thought-out policy regarding the protection of critical assets. Medically trained personnel and medical equipment are not easily replaced in the battlefield. For general combatants, the principle of mass in warfare results in states putting forth vast amounts of infantrymen who can, for better or worse, continue to accomplish the mission in the face of combat losses. Medical personnel, however, possess a low-density skill-set that simply cannot be easily replaced—militaries are made up of fighting persons, not legions of doctors and nurses. Partially, the reluctance to attack military medical units and establishments of an enemy state is a hope for reciprocity. But, this reluctance also reflects an ideal that, no matter the state affiliation, it is expected that military medical personnel will treat all wounded and sick in the field without adverse distinction for nationality. Preservation of this capability, therefore, benefits all sides to a conflict. This is why as a result of providing a “due warning,” states would rather compel a medical establishment to expel able-bodied combatants taking shelter and risk their escape than to otherwise destroy a hospital or kill the wounded and sick as collateral harm of engaging the hospital.

The analysis above supports a conclusion that cessation of protection should ideally be for a limited temporal scope in most scenarios. The 2016 Commentary does not indicate that the theory of limited duration is supported by the practice of targeting, which evaluates a potential objective at the time of an attack to determine if it meets the requirements of a military objective.⁵⁵ However, it also notes that military medical units and establishments should be reliably expected to not engage in “acts harmful to the enemy” so that a limited duration could “lessen the protective value of

⁵⁵ 2016 Commentary, *supra* note 1, art. 21, ¶ 1857.

the Convention in general.”⁵⁶ Further, if the theory is designed to “discourag[e] the future commission of ‘acts harmful to the enemy’, a definitive loss of protection may be justified.”⁵⁷

This discussion sounds eerily similar to the revolving-door concerns regarding the interpretation of direct participation in hostilities to determine when a civilian loses his or her protected status. For example, a military medical person attached to a ground combat unit to care for the wounded on a hot battlefield may engage in offensive actions (shooting at the enemy) in between treating wounded soldiers or Marines. In such a scenario, it would not be reasonable to argue that this person is “exclusively engaged” in the treatment of the wounded or sick to be considered protected medical personnel.⁵⁸ On the other hand, a military medical establishment may provide safe harbor to able-bodied combatants or permit call-for-fire communications to be conducted in its facility followed by expulsion of such combatants or radio operators when faced with a “due warning” by a belligerent.⁵⁹ In this scenario, as the warning was heeded, the protection would not have ceased. Consequently, the hospital could resume its normal operations without immediate fear of attack. But, if the hospital did not heed such warning and the able-bodied combatants or radio operators were targeted through engagement upon the facility, the protected status would be lost. Assuming the targets were destroyed or that they subsequently fled the scene, it should be understood that the protected status is restored when the hospital returns to exclusive engagement in the treatment of its patients.

There may be military medical units or establishments that could develop a pattern of practice that would be akin to the continuous combat function discussed in the ICRC’s *Interpretive Guidance on the Notion of Direct Participation of Hostilities Under International Humanitarian Law* such that their performance of medical operations was no longer distinguishable from their commission of harmful acts.⁶⁰ In these cases, such units or establishments should no longer be thought to have a protected status. However, this should not be used to justify a general permanent cessation of protected status in all cases to punish wrongdoers, as this would have a disproportionately adverse effect against the wounded and the sick. Instead, it should be understood that these units and establishments do not meet the

⁵⁶ *Id.* ¶ 1858.

⁵⁷ *Id.*

⁵⁸ *Id.* art. 24.

⁵⁹ *GCI*, *supra* note 6.

⁶⁰ See generally NILS MELZER, ICRC, INTERPRETIVE GUIDANCE ON THE NOTION OF DIRECT PARTICIPATION IN HOSTILITIES UNDER INTERNATIONAL HUMANITARIAN LAW (2009), <https://www.icrc.org/eng/assets/files/other/icrc-002-0990.pdf>.

definition of protected military medical personnel pursuant to Article 24 of *GC I* and are therefore not protected as distinguishable from combatants.⁶¹

To ensure the adequate treatment of the wounded and sick, it should be presumed that the duration of the cessation of protected status is limited to the point at which the medical personnel, unit, or establishment rectifies or ceases the commission of the “acts harmful to the enemy” that resulted in the loss of protected status.⁶² This meets the policy goals of the “due warning” on a continuing spectrum, and it is the logical understanding of the rule in light of the overwhelming need to treat the wounded and sick.⁶³

VI. CONCLUSION

The protected status of medical personnel, units, transports, and establishments is one of the most basic fundamentals of the law of armed conflict. It is certainly the object and purpose of Chapters III and IV of *GC I* to maximize this protected status to the greatest extent feasible. But, as with all protected classes of people and objects in the law of armed conflict, the protection is not absolute. It is conditioned upon compliance with the corresponding affirmative duty to exclusively engage in humanitarian activities without committing acts harmful to the enemy.

It is this standard that solely governs the loss of the protected status. Any lower standard—such as remote hypothetical harms based on a presumption of unlawful activity—which the ICRC commentary advocates through its conclusion on the arming of personnel and mere proximate location of protected medical sites to military objectives, runs afoul of the intent to ensure that there are medical providers to treat the wounded and sick in war.

Contemporary conflicts may require preparing medical personnel for more dangerous and prevalent threats than faced in previous generations. Consistent with the desire to protect this critical capability to treat the wounded and sick without adverse distinction as outlined in the law, medical personnel must therefore also be able to defend their ability to fulfill their mission without losing the protection of the law. Additionally, in contemporary conflicts, many of which are centered in dense urban areas, it may not be feasible for medical establishments to be located at a safe distance from military objectives. The simple nature of the changing battlefield environment cannot serve as a justification for the deprivation of legal protection. Such proximate location should at most result in inclusion

⁶¹ A consequence is that if these units and establishments display the protective emblem, persons within that engage in certain hostile actions may commit the war crime of perfidy.

⁶² *GC I*, *supra* note 6.

⁶³ 2016 COMMENTARY, *supra* note 1, art. 21, ¶ 1856.

into a proportionality analysis and proper precautions taken in the attack of legitimate military objectives, and not the conversion of a protected site into a lawful target.

As outlined in the analysis above, the ICRC should reconsider its legal opinions or the wording of its 2016 Commentary to *GC I* to ensure military medical personnel maintain the full protection of the law while they are exclusively engaged in humanitarian duties, instead of providing potential legal reasoning for unlawful actions.