

# CONFERENCE ON THE 2016 ICRC COMMENTARY ON THE FIRST GENEVA CONVENTION

## AFTERNOON RAPPORTEUR SESSION TWO

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### I. WEAPONRY FOR MEDICAL PERSONNEL

The Session began by discussing concerns surrounding loss of protection for medical personnel. Currently, medical personnel lose formal protected status based on the quality and quantity of arms that medical personnel use.<sup>1</sup> One panelist illustrated this concern with the example of a medical vehicle facing conflict with a Toyota truck equipped with a mounted 50-caliber gun. The panelist understood the commentaries to require the medical vehicle to counter the Toyota truck with light arms. The panelist noted that, for purposes of defense, a “light” weapon would not provide sufficient defense against a 50-caliber mounted gun, but use of a “heavy” weapon would cause medical personnel to lose protection. Without more flexible classifications of weaponry relating to protection, medical personnel are faced with a difficult choice—either use the weapon and lose protection or face enemy combatants with no method of defense. As a possible solution, panelists advocated for a system where loss of protection is not based on whether the arms are “heavy” or “light,” but whether the medical personnel are committing “acts hostile to the enemy” with such arms. This distinction would allow for the use of all weapons available to medical personnel while also ensuring that medical personnel cannot go beyond the defensive measures allowed in the commentaries.

### II. LOCATION OF HOSPITALS

A large portion of the panel was devoted to discussing hospitals as military objects when they are located near military bases. The current

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<sup>1</sup> See 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), art. 19 [hereinafter 2016 Commentary GWS].

commentaries take the position that such placement of a hospital warrants loss of protection.<sup>2</sup> However they also express the view that damage to hospitals should be minimized “in all circumstances.” The panelists raised a number of questions about this provision. First, some hospitals were built prior to the construction of military bases. Should this subject them to loss of protection? Second, placing hospitals next to operations centers is more convenient for injured soldiers and medical personnel and also allows hospitals to be better protected. Shouldn't parties be incentivized to place hospitals close to bases to allow for better care and protection? One panelist suggested that as long as the hospital pursues purely humanitarian ends, it should not lose its protected status. Just as loss of protection for medical personnel should depend on whether one is committing “acts hostile to the enemy,” so should protection in regards to location of hospitals. It was also stated that the commentaries could be understood as only withdrawing protection in the event that a hospital is used as an intentional shield. In this case, the party would be charged with a war crime. Additionally, pursuant to the 1st Protocol to the Geneva Conventions, parties should take into account surroundings when choosing military objectives so to minimize civilian casualties and damage to cultural property. While this is the goal, it is difficult to separate military objectives from civilian objects in densely populated areas, and there have been instances of success as well as failure.

### III. GENDER-RELATED ISSUES

Next, the panel noted that the new commentary made significant improvements in recognizing the importance of gender and sex. The updated Article 12 states that women must be given all due consideration because of their sex, and recognizes a new category of crimes related to men and boys.<sup>3</sup> Though the critical question of how gender intersects with IHL still remains, there was a consensus on the wonderful improvements and the clear indication that gender and sex-related issues were of the utmost importance.

### IV. PROPORTIONALITY AND “ALL POSSIBLE MEASURES”

At the end of the panel, a dynamic discussion occurred regarding the role of Article 15 and paragraph 1491 in the 2016 commentary. Article 15 uses the phrase “all possible measures” to refer to the steps that an actor must take after a military operation, and the commentary suggests that an actor engaged in an armed conflict must involve third parties in order to facilitate

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<sup>2</sup> *Id.* art 21.

<sup>3</sup> *Id.* paras. 1426–1437.

rescue operations.<sup>4</sup> Though the paragraph begins with the acknowledgment that an actor may be limited in scope, the panel nonetheless was divided on what the implications of this should be, particularly surrounding feasibility and proportionality.

A stark divide emerged between panelists who approached the section from a theoretical or idealistic standpoint and those who were thinking about practical implications. Both sides agreed that caring for and protecting the sick and wounded was a priority, but there was much disagreement as to what should be required in order to achieve this goal.

For example, consider an aerial operation. After the attack, the actor's first objective would be to conduct a damage assessment after a bombing, which could take longer than forty-eight hours to complete. During this evaluation, the actor's primary objective is to assess whether the operation was successful and the military objective was achieved. Involving a neutral third party would significantly complicate this assessment and could impair the overall success of the operation. It was stated that in most cases, one side of an armed attack will strike enemy territory. In this situation, providing advance notice to another party for purposes of collecting the sick and wounded would both complicate and undermine any possible advantage.

Thus, the issue became at what point actors were responsible for including the sick and wounded in their proportionality analyses. Using the aerial example and assuming the operation included more than one wave of bombing, reassessing the damage to the sick and wounded mid-attack would necessarily impede the end goal. The practical side of the debate was firm in their belief that it is hard, if not impossible, to gauge how many are sick or wounded at any point during any attack. While it could be straightforward in some instances, this will not always be the case.

Ultimately, it was determined that the sick and wounded should be a part of the initial feasibility analysis when actors are determining how any given military objective can be achieved. An actor has a duty to investigate the existence of any nearby structures that may contain large populations and to account for any possible consequences. Once the feasibility analysis has been completed, the actor must then contemplate proportionality in finalizing any military operations. While caring for the sick and wounded is an ideal goal, IHL must include both military and humanitarian logic, and this inevitably involves some level of collateral damage.

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<sup>4</sup> *Id.* para. 1491.