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The notion of "acts harmful to the enemy" under international humanitarian law

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Abstract

This article provides a legal analysis of the largely uncharted notion of "acts harmful to the enemy" under international humanitarian law, which reconciles the humanitarian need to grant special protection to medical services (medical personnel, units and transports) in the interests of the wounded and sick with the military necessity to remove it when acts are committed contrary to good faith and for hostile purposes or with effects which harm the adverse party. The meaning of the notion is clarified by primarily looking into the legality of an attack against land-based medical services by the aggrieved party to the conflict as a consequence of harmful acts. It concludes with specific recommendations on how to interpret the law governing such an attack, considered prima facie lawful, on a hospital.

Keywords: international humanitarian law, acts harmful to the enemy, special protection of medical personnel and medical objects, general protection of civilians and civilian objects, perfidy, act of hostility, direct participation in hostilities, military objectives, proportionality, precautions.

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Introduction

In recent times – as the armed conflict in Syria demonstrates – there have been a number of attacks against hospitals and medical installations.[1] Hospitals and installations are protected under international humanitarian law (IHL) unless they are used for "acts harmful to the enemy" (AHTTE).[2] Belligerents are under an obligation to grant so-called "special protection" to "medical personnel, units and transports"[3] on account of their humanitarian function in order to ensure medical care for the wounded and sick, or shipwrecked, in all circumstances. This "special protection" is a *lex specialis* (though not of a derogable nature) with regard to the so-called "general protection" of civilian persons under Articles 48 and 51 of Additional Protocol I to the four Geneva Conventions of 1949 (AP I), and civilian objects under Article 52(2) of AP I, with their related customary international law norms. General protection is lost when an object becomes a military objective. Simply put, this is the case when that object makes a military contribution to the enemy and its destruction or neutralization offers a military advantage to the attacking belligerent. Conversely, objects under special protection are normally placed under some higher threshold regarding the loss of protection. In the case of medical services, this occurs when these carry out AHTTE and after a warning has remained unheeded.

The 1949 Geneva Conventions and their 1977 Additional Protocols do not define the notion of AHTTE,[4] nor the precise consequences of a loss of special protection.[5] The present paper tries to partially fill this gap by offering a more in-

1 See, for example, UNSC Res. 2286, 3 May 2016; Médecins Sans Frontières, *Initial MSF Internal Review: Attack on Kunduz Trauma Centre, Afghanistan*, Geneva, 5 November 2015. An older example is provided by the Italian war in Ethiopia, in 1935: see Marcel Junod, *Le troisième combattant*, Librairie Payot, Lausanne, 1947, pp. 35 ff.

2 See Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) (GC I), Art. 21; Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) (GC IV), Art. 19(1); Protocol Additional (I) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978) (AP I), Art. 13(1); Protocol Additional (II) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609, 8 June 1977 (entered into force 7 December 1978) (AP II), Art. 11(2); Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1: *Rules*, Cambridge University Press, Cambridge, 2005 (ICRC Customary Law Study), Rules 25, 28–29, available at: https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1.

3 For the definition of "medical service", see Pietro Verri, *Dictionary of the International Law of Armed Conflict*, ICRC, Geneva, 1992, p. 71.

4 ICRC, *Commentary on the First Geneva Convention: Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 2nd ed. Geneva, 2016 (ICRC Commentary on GC I), Art. 21, para. 1840; Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), *Commentary on the Additional Protocols*, ICRC, Geneva, 1987 (ICRC Commentary on AP I/AP II), AP I, Art. 13, para. 550.

depth legal analysis on the notion of "acts harmful to the enemy" in relation to medical services[6] and its precise relations to other relevant notions of IHL.[7] It will be centred on land warfare[8] and more particularly on the legality of military attacks,[9] to the exclusion of lawful capture of medical personnel in case of AHTTE. The latter situation is not specifically relevant for an analysis of AHTTE: the personnel captured retain their legal status[10] and are protected under the rules on retention.[11] What is specific to AHTTE is that under some circumstances the adverse belligerent is allowed to attack a medical unit. It is in this perspective that the notion of AHTTE has been shaped, and in this perspective that it must be scrutinized and interrogated in the first place. This, then, is the *punctum saliens* of the present article.

Before delving into the subject matter, some preliminary definitions of the relevant notions – notably, "special protection", "medical personnel" and "medical units and transports" – are discussed, followed by an analysis of the conditions for the loss of special protection. The notion of AHTTE is then examined through its negotiating history and its relations with other concepts of IHL, such as "perfidy", "direct participation in hostilities" and "military objective". Building on the distilled findings, the consequences of the loss of special protection, as a result of AHTTE and not heeding a warning, are explored. Lastly, specific recommendations are provided on how to interpret the rules that govern an attack, considered *prima facie* lawful, on a hospital.

5 ICRC, *International Humanitarian Law and the Challenges of Contemporary Armed Conflicts*, report prepared for the 32nd International Conference of the Red Cross and Red Crescent, Geneva, 8–10 December 2015, p. 32.

6 An analysis of the same term in relation to civilian civil defence organizations provided in Article 65(1) of AP I will be excluded.

7 This article will remain centred on IHL. For a double IHL and international human rights law perspective on the protection of medical services, see Alexander Breitegger, "The Legal Framework Applicable to Insecurity and Violence Affecting the Delivery of Health Care in Armed Conflicts and Other Emergencies", *International Review of the Red Cross*, Vol. 95, No. 889, 2013. IHL is largely *lex specialis* in this context, which entails the application of the conduct of hostilities paradigm: cf. *ibid*., p. 91.

8 See ICRC, *Commentary on the Second Geneva Convention: Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea*, 2nd ed. Geneva, 2017 (ICRC Commentary on GC II), Art. 36, para. 2481. According to the ICRC Commentary, it is more pertinent to analyze the notion of AHTTE in the context of land rather than sea warfare. The hospital ship's personnel constitute an "integral part of the protected platform" and engagement in such an act becomes relatively less consequential.

9 The definition of "attack" is provided in Article 49 of AP I as "acts of violence against the adversary, whether in offence or in defence".

10 For an exploration of divergent views, see ICRC Commentary on GC I, above note 4, Art. 24, para. 2010; Marco Sassòli, "When Do Medical and Religious Personnel Lose What Protection?", in *Vulnerabilities in Armed Conflicts: Selected Issues*, Proceedings of the 14th Bruges Colloquium, 17–18 October 2013, pp. 55–57; Tom Haeck, "Loss of Protection", in Andrew Clapham, Paola Gaeta and Marco Sassòli (eds), *The 1949 Geneva Conventions: A Commentary*, Oxford University Press, Oxford, 2015, pp. 848–849.

11 GC I, Arts 28–32. Cf. Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950) (GC II), Art. 37.

Special protection

Medical personnel, units and transports, as well as the wounded and sick, are entitled to protection against direct attack in both international armed conflict (IAC) and non-international armed conflict (NIAC). This special protection is granted by a series of specific rules of IHL.[12] Originally, IHL only protected "wounded and sick" combatants;[13] today, civilians are included in that notion. Indeed, AP I established a uniform protective regime.[14] To be wounded or sick under IHL, two cumulative criteria have to be fulfilled: (1) a person must require medical care; and (2) he or she must refrain from any act of hostility.[15] Thus, wounded or sick persons who commit an "act of hostility"[16] (to be defined below) do not qualify as such under IHL and do not benefit from the protective regime granted to this category of persons.[17] The legal status of being wounded or sick therefore depends as much on a person's actual conduct as on their medical condition. This binary definition is relevant for both IAC and NIAC.[18]

The notion of "medical personnel" was similarly extended to cover both military personnel and civilians.[19] Under contemporary IHL, the definition, which builds upon Articles 24–26 of Geneva Convention I (GC I) and Article 20 of Geneva Convention IV (GC IV), is codified in Article 8(c) of AP I. Qualifying as medical personnel under IHL supposes again the fulfilment of two cumulative criteria: (1) medical personnel must be assigned to their medical duties by a party to the conflict under whose control they are placed;[20] and (2) the assignment, whether temporary or permanent, must be exclusive – i.e., limited to the "search for, collection, transportation, diagnosis or treatment, including first-aid treatment, of the wounded, sick and shipwrecked, and the prevention of disease"[21] – for all the time that the person is assigned to medical tasks. This definition is considered applicable in both IAC and NIAC,[22] subject to the differences resulting from the presence of non-State armed groups. When civilian medical personnel do not fulfil the conditions set out above, they may still be protected against attacks by the general protection accorded to civilians.[23]

Protected objects are in the first place "medical units and transports", extending once again to both military and civilian ones.[24] Special protection is

12 ICRC Customary Law Study, above note 2, Rules 25–26, 28–30, 109–111, and the rules referred to therein.
13 ICRC Commentary on GC I, above note 4, Art. 12, para. 1321.
14 AP I, Art. 8(a). See also ICRC Commentary on AP I, above note 4, Art. 8(a), para. 304; Jann K. Kleffner, "Protection of the Wounded, Sick, and Shipwrecked", in Dieter Fleck (ed.), *The Handbook of International Humanitarian Law*, 3rd ed., Oxford University Press, Oxford, 2013, pp. 323–324.
15 AP I, Art. 8(a). See also ICRC Commentary on GC I, above note 4, common Art. 3, para. 737, and Art. 12, para. 1341.
16 IHL does not clearly define the term "act of hostility". See J. K. Kleffner, above note 14, p. 324.
17 ICRC Commentary on AP I, above note 4, Art. 8, para. 306.
18 ICRC Commentary on GC I, above note 4, common Art. 3, para. 738.
19 J. K. Kleffner, above note 14, pp. 338–339.
20 ICRC Customary Law Study, above note 2, commentary on Rule 25, p. 82.
21 *Ibid.*, p. 81.
22 ICRC Commentary on AP II, above note 4, Art. 9, para. 4663.
23 AP I, Arts 48, 51; AP II, Art. 13; ICRC Customary Law Study, above note 2, Rule 1.

restricted to medical units and transports that are assigned to medical purposes by a party to the conflict. Unauthorized medical units or transports are protected according to the rules on the protection of civilian objects (general protection). Again, these rules are regarded to be applicable in both IAC and NIAC.[25] Both military and civilian medical objects are also under the purview of protection as civilian objects (AP I, Article 52).[26] Civilian objects are negatively defined as "all objects that are not military objectives".[27] This is manifestly the case for both military and civilian medical units and transports.

The notion of special protection entails the substantive obligation to "respect and protect". This term was first introduced in treaty law in the 1906 Geneva Convention[28] governing land warfare to safeguard the immunity, inviolability and neutrality enjoyed by ambulances, medical personnel and, by implication, the wounded and sick. The obligation to respect entails a series of obligations of a negative nature, notably to refrain from attacking protected persons. The obligation to protect implies a series of obligations of a positive nature – i.e., to take measures for the benefit of the protected persons.[29] This double obligation applies both in the relationships between a party to the conflict and the protected persons of the enemy, and in those with persons of its own armed forces.[30] Special protection of persons or units applies "in all circumstances"[31] except when acts are committed for hostile purposes or with effects which harm the adverse party. The formulation indicates that operational reasons or military necessity cannot be invoked, as such, to justify non-compliance.[32] The obligation exists regardless of whether or not the enemy complies with it;[33] belligerent reprisals are prohibited against protected persons in both IAC and NIAC.[34]

The main aspect of special protection relevant for the present article relates to the prohibition against attacking protected persons and objects. This obligation concerns in the first place direct attacks on such persons or objects, but the question is also whether in attacking some military objective the proportionality

24 For units: GC I, Art. 19; GC IV, Art. 18; AP I, Art. 8(e). For transports: GC I, Art. 35; GC IV, Art. 21; AP I, Art. 8(g).
25 ICRC Commentary on AP II, above note 4, Art. 11, paras 4711–4712.
26 ICRC Commentary on GC I, above note 4, Art. 19, para. 1794; Laurent Gisel, "Can the Incidental Killing of Military Doctors Never Be Excessive?", *International Review of the Red Cross*, Vol. 95, No. 889, 2013, pp. 219–220.
27 Cf. ICRC Customary Law Study, above note 2, Rule 9.
28 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 202 CTS 144, 6 July 1906 (entered into force 9 August 1907).
29 ICRC Commentary on GC I, above note 4, Art. 24, para. 1984.
30 *Ibid*., para. 1986.
31 For the wounded and sick: GC I, Art. 12(1); GC IV, Art. 16(1); AP I, Art. 10(1); AP II, Art 7(1). For medical personnel: GC I, Arts 24, 25; AP I, Art. 15(1); AP II, Art. 9; ICRC Customary Law Study, above note 2, Rule 25. For medical units and transports: GC I, Arts 19(1), 35; GC IV, Arts 18(1), 21; AP I, Arts 12(1), 21; AP II, Art. 11(1); ICRC Customary Law Study, above note 2, Rules 28–29.
32 ICRC Commentary on GC I, above note 4, Art. 24, para. 1983; J. K. Kleffner, above note 14, p. 326.
33 ICRC Commentary on GC I, above note 4, para. 1994.
34 GC I, Art. 46; GC II, Art. 47; AP I, Art. 20; ICRC Customary Law Study, above note 2, Rules 146, 148.

rule requires us to take account of the collateral losses to *military* medical personnel and installations (it is clear that the collateral losses to *civilian* medical personnel and objects must be taken into account). The answer to this question is controversial.[35] For some, the proportionality restriction fully applies also in this context.[36] There would be no apparent reason why the obligations under special protection should be limited to direct attacks and not extended to the conduct of hostilities in general. It would also be inadequate to conclude that specially protected persons should enjoy a lesser degree of protection than ordinary civilians.[37] Moreover, the opposite interpretation would hamper the fulfilment of the purpose of special protection: in order to provide medical care to the wounded and sick, the personnel and objects dedicated to that task have to operate in proximity of the fighting, and it is thus essential to uphold their protection against incidental harm. For some other authors, the obligation applies but the equation may be slightly more lenient than the one for civilian collateral damage, on account of the military nature of the personnel and objects at stake, especially in the midst of combat operations.[38] Lastly, there are authors denying that the proportionality requirement applies to military medical personnel and objects, or to the military wounded and sick, those persons remaining combatants.[39]

The first or second view are the better ones: there is no reason to consider that protected persons, including those placed *hors de combat*, are protected less than civilians. On the contrary, IHL provides for obligations not to attack such persons,[40] notwithstanding their combatant status; when such an obligation against direct attack is stipulated, the lesser obligation not to exceed in collateral damage against these persons must be considered *a fortiori* as being contained in the main rule against attack (i.e., special protection). This is all the more true given that the principle of precautions in attack (as enshrined in Article 57 of AP

35 For a recent literature review that provides an assessment of the law and State practice regarding this question and develops further clarification in relation to protected military persons, see Aurel Sari and Kieran Tinkler, "Collateral Damage and the Enemy", *British Yearbook of International Law*, 2019.

36 ICRC Commentary on GC I, above note 4, Art. 19, para. 1797, and Art. 24, para. 1987; Laurent Gisel, "Relevant Incidental Harm for the Proportionality Principle", in *Urban Warfare*, Proceedings of the 16th Bruges Colloquium, 15–16 October 2015, pp. 121–123.

37 This does not imply that medical personnel, due to their humanitarian function, are assigned a higher normative value in comparison to the lives of civilians under the proportionality calculus. See, for example, Laurent Gisel (ed.), *The Principle of Proportionality in the Rules Governing the Conduct of Hostilities under International Humanitarian Law*, Report of the International Expert Meeting, Quebec, 22–23 June 2016, ICRC and Université Laval, 2018, pp. 61, 63.

38 Robert Kolb, *Advanced Introduction to International Humanitarian Law*, Edward Elgar, Cheltenham and Northampton, MA, 2014, pp. 174–175; Jann K. Kleffner, "Military Collaterals and *Jus in Bello* Proportionality", *Israel Yearbook on Human Rights*, Vol. 48, 2018, pp. 49–50. See also Geoffrey Corn and Andrew Culliver, "Wounded Combatants, Military Medical Personnel, and the Dilemma of Collateral Risk", *Georgia Journal of International and Comparative Law*, Vol. 45, No. 3, 2017, pp. 455 ff. In this latter article, the authors conclude that the Martens Clause provides a basis for belligerents to consider a limited application of the proportionality obligation to protected military persons and military medical objects where operationally feasible.

39 Ian Henderson, *The Contemporary Law of Targeting: Military Objectives, Proportionality and Precautions in Attack under Additional Protocol I*, Martinus Nijhoff, Leiden and Boston, MA, 2009, pp. 195–196, 206–207.

40 For example, AP I, Arts 41–42.

I) undisputedly applies to such persons and objects.[41] The obligation of precaution requires a belligerent to take measures to minimize collateral damage. Some provisions in Article 57 of AP I even make explicit reference to special protection, notably its paragraphs (2)(a)(i) and (2)(b), though such reference is not made in the paragraphs dealing with proportionality issues.[42]

Let us now turn to the question of how special protection, an integral component of it being protection against direct attack, relates to general protection – i.e., what is the legal difference between the protection against attack under special protection and under general protection (as civilian objects)? The first point to be noted is that special protection does not technically derogate from general protection.[43] Both military and civilian medical units are at once civilian objects under the definition of Article 52 of AP I, and specially protected objects under the relevant provisions of IHL. There are two layers of protection which add up one to the other; if one protection disappears for some reason, e.g. because a medical unit has become a military objective, which eliminates the general protection, there remains the layer of the special protection, with its own requirements for the loss of immunity against attack (to be explained below). Conversely, if a medical object loses its special protection because it is used for AHTTE, it may remain a civilian object and entitled to the general protection against attack unless the usage for AHTTE converts it into a military objective. We are thus not in a configuration of *lex specialis derogat legi generali*; it would rather be *lex specialis "completat" legi generali*.

The second point to be noted is that special protection is somewhat more stringent than general protection. For the loss of the latter, a military contribution and a military advantage in destruction or neutralization (objects) or a direct participation in hostilities (persons) are sufficient; for the loss of the former, in principle, an advance warning must be issued, with a reasonable time limit provided for the warning to be observed whenever possible, and an ascertainment that the warning was not heeded made, before an attack against the medical services that have become military objectives are carried out. Notice that the latter *must* have become military objectives under Article 52(2) of AP I in order to allow an attack – it is not sufficient that they commit any type of AHTTE. For an attack, the legal standard to be applied comes from the regime of general protection and not from the one of special protection. If AHTTE are committed, a series of responses may be carried out, such as capture of a medical unit having indulged in such acts; but if an attack is to be performed, the object to be attacked must in any case be a military objective. This is so because Article 52(2) of AP I indicates in an exhaustive manner when an object can be attacked. To

41 A. Breitegger, above note 7, p. 108.

42 J. K. Kleffner, above note 38, pp. 53–58. Kleffner affirms that the category of protected persons must be treated the same under the rules governing precautions and those governing proportionality, as both are interrelated and anchored to the fundamental principles underlying targeting law.

43 Yoram Dinstein, *The Conduct of Hostilities under the Law of International Armed Conflict*, 3rd ed., Cambridge University Press, Cambridge, 2016, pp. 187, 201; Nils Melzer, *International Humanitarian Law: A Comprehensive Introduction*, ICRC, Geneva, 2016, pp. 135, 145.

these conditions under general protection, the ones under special protection (warning, etc.) must be added. For the moment, we may thus conclude that the rules granting special protection result in a higher threshold for the loss of protection against attack with regard to persons and objects under special protection in comparison with those just under general protection. We may now turn to a closer analysis of the conditions for the loss of special protection.

Loss of special protection

The special protection granted to medical services is "fundamental but not absolute".[44] IHL takes into account the fact that parties to a conflict may be tempted to abuse their special status in order to commit AHTTE.[45] By way of illustration, "[d]uring the Second World War, members of the medical personnel in occupied territories sometimes concealed combatants in hospitals and helped them carry out military missions, such as intelligence activities and sabotage".[46] These conducts may lead to a loss of special protection of these medical personnel and these hospitals. Such loss is considered an "exception",[47] which is linked to the medical services' definitional requirement that they are "*exclusively* assigned to medical duties [in order] to be accorded respect and protection".[48] What are the exact conditions for such a loss of special protection?

First condition: AHTTE outside of humanitarian function

The first condition is that medical services commit AHTTE[49] outside their humanitarian function.[50] For IAC, Article 21 of GC I provides for the loss of protection for military medical establishments and units, Article 19(1) of GC IV for civilian hospitals, Article 13(1) of AP I for civilian medical units, and Article 21 of AP I for civilian medical vehicles.[51] The phrase "humanitarian function" adopted in the Additional Protocols replaces "humanitarian duties" in the Geneva Conventions.[52] For NIAC, Article 11(2) of Additional Protocol II (AP II)

44 Elżbieta Mikos-Skuza, "Hospitals", in A. Clapham, P. Gaeta and M. Sassòli (eds), above note 10, p. 218.
45 *Ibid.*
46 Jean Pictet, "The Medical Profession and International Humanitarian Law", *International Review of the Red Cross*, Vol. 25, No. 247, 1985, pp. 198–199. For recent examples, see Leonard S. Rubenstein and Melanie D. Bittle, "Responsibility for Protection of Medical Workers and Facilities in Armed Conflict", *The Lancet*, Vol. 375, 2010, pp. 334–336. In this latter article, an analysis is provided concerning attacks on wounded and sick individuals, attacks on medical personnel, medical facilities or medical transports, and improper use of medical facilities or emblems. The article covers reported incidents in armed conflicts in El Salvador, the Philippines, the former Yugoslavia, Rwanda and the Occupied Palestinian Territory, among others, between 1989 and 2008.
47 ICRC Customary Law Study, above note 2, commentaries on Rule 25, p. 84, Rule 28, p. 97, Rule 29, p. 102.
48 *Ibid.*, commentary on Rule 25, p. 84.
49 The notion of AHTTE needs refined legal analysis, which will be presented below in a separate section.
50 ICRC Customary Law Study, above note 2, Rules 25, 28–29; ICRC Commentary on GC I, above note 4, Art. 21, para. 1844.
51 Cf. GC II, Art. 34(1), for hospital ships.

provides for the loss of protection for medical units and transports. Here the phrase AHTTE is replaced with "hostile acts". The meaning of the two phrases "AHTTE" and "hostile acts" is essentially the same.[53] The loss of special protection pertaining to medical personnel is nowhere expressly stated in IHL. The rules specifically applicable to the discontinuance of special protection pertaining to medical units are "applied by analogy to medical personnel".[54]

The provisions, both in treaty law and customary law, that govern the consequences of the commission of AHTTE by medical units and transports, and by analogy medical personnel, refer only to "loss of protection", not "loss of special protection". At first reading, a question arises as to what this loss really entails. Does it mean that these medical services lose their entitlement of being granted some treatment by the adverse party – the obligation to protect, but not respect (partial loss of special protection), or the obligation to protect and respect (full loss of special protection)? Does it lead to a loss of protection against direct attack? To consider that the loss is limited to the obligation to protect is too narrow an interpretation. This would not be feasible in practice, as "it is frequently impossible to clearly separate the obligation to 'respect' from the obligation to 'protect'".[55] To consider that the loss automatically results in the loss of protection against direct attack is, on the other hand, too wide an interpretation. AHTTE come in a wide range of different forms, and not all of them would be sufficiently grave for such a loss.[56] Even when the special protection is lost, it should be recalled that civilian medical personnel and medical objects retain their general protection unless engagement of AHTTE converts the person or object into a military objective. Thus, an interpretation that the loss of special protection automatically transforms the medical services in question into lawful targets is not sound. Summing up the foregoing, the loss should be interpreted as a loss of "special protection", encompassing both the obligation to protect and respect, with a remark that it does not inevitably extend into a loss of protection against direct attack.

The separate notion of "outside their humanitarian function" is not defined under IHL,[57] but it does not give rise to particular problems of interpretation, as the functions of medical services are clearly defined.[58] It is simply a negative definition of the medical services' function enumerated under IHL. The conduct of medical

52 ICRC Commentary on AP II, above note 4, Art. 11, para. 4724. This change is a matter of drafting.
53 *Ibid.*, paras 4720–4721. The ICRC Commentary explains that the term "hostile acts" was adopted for a NIAC context "to eliminate any possibility of an interpretation which would give any sort of recognition to the insurgent party".
54 ICRC Customary Law Study, above note 2, commentary on Rule 25, p. 85.
55 ICRC Commentary on GC I, above note 4, Art. 24, para. 1985.
56 Examples of conducts that constitute AHTTE will be discussed in the next section.
57 ICRC Commentary on GC I, above note 4, Art. 21, para. 1840.
58 Medical personnel, units and transports must be assigned, by a party to the conflict, exclusively to the medical purposes exhaustively defined by IHL – i.e., the search for, collection, transportation, diagnosis or treatment of the wounded, sick and shipwrecked, or for the prevention of disease. AP I, Art. 8; ICRC Customary Law Study, above note 2, commentaries on Rule 25, p. 81, Rule 28, p. 95, Rule 29, p. 100. See also M. Sassòli, above note 10, p. 52.

services going beyond these duties may, depending on the circumstances, qualify as AHTTE outside their humanitarian function, which could entail a loss of special protection.[59] This understanding leads to an interpretation that "[e]ven if a particular type of conduct may appear to constitute an 'act harmful to the enemy', it will still not result in a loss of special protection where it remains within the humanitarian duties"[60] of the medical services. Obviously, the nursing of wounded and sick armed forces or combatants,[61] which "enables them to return to the battlefield",[62] is considered a humanitarian function, as is "assistance with the health planning aspects of the military operation and involvement in the transmission of the health details of enemy patients, even though in some circumstances this information may have military value".[63] Other factual scenarios of conduct that appears to be AHTTE but remains within the humanitarian function include "a mobile medical unit accidentally break[ing] down while it is being moved in accordance with its humanitarian function, and thereby obstruct [ing] a crossroads of military importance".[64] Similarly, "the presence or activities of a medical unit might interfere with tactical operations"[65] due to the unit's proximity to the battlefield, "its lights at night",[66] or the use of X-ray apparatus emitting radiation that could interfere with the military radio communications of the enemy.[67] These conducts are compatible with the medical services' humanitarian function and do not deprive them of their special protection.[68] However,

> from a practical perspective, once such an act is identified as being harmful to the adversary, reasonable action should be taken to remedy the issue as soon as possible so as to not unnecessarily jeopardise the safety of the wounded and sick being cared for by the medical units.[69]

AHTTE must be committed outside the medical services' humanitarian function, but this does not lead to a conclusion that only acts deliberately committed to harm the adversary constitute AHTTE. Acts which could accidentally have an unfavourable effect on the enemy are arguably included as well (to be explained below).

59 ICRC Commentary on GC I, above note 4, Art. 24, para. 1978; ICRC Commentary on AP I, above note 4, Art. 8, para. 353.
60 *Ibid.*, Art. 21, para. 1844.
61 GC I, Art. 22(5); GC IV, Art. 19(2); AP I, Art. 13(2)(d).
62 Y. Dinstein, above note 43, p. 224.
63 Cf. ICRC Commentary on GC II, above note 8, Art. 36, para. 2485. This arguably applies by analogous reasoning to the medical services on land.
64 ICRC Commentary on AP I, above note 4, Art. 13, para. 552.
65 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. 1: *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, ICRC, Geneva, 1952 (Pictet Commentary on GC I), Art. 21, p. 201.
66 *Ibid.*
67 *Ibid.*
68 Peter De Waard and John Tarrant, "Protection of Military Medical Personnel in Armed Conflicts", *University of Western Australia Law Review*, Vol. 35, 2010, p. 175.
69 *Ibid.*

Second condition: A warning and a time limit, the warning remaining unheeded

The second condition to be met in order for the special protection to cease is established in the same treaty law provisions stipulating the first condition. Special protection granted to the medical units "*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".[70] Thus, in the first place, a warning must be given.[71] The aggrieved party to the conflict must inform the medical service that

> the latter has committed, or is committing, an act harmful to it, or that there are reasonable grounds for suspicion that such acts have been or are being committed, and that it is in danger of being attacked or subjected to an enforcement measure if it does not put an end to the activity in question.[72]

The purpose of issuing a warning is to allow those engaging in AHTTE to terminate those acts or at least to evacuate the wounded or sick.[73] The underlying assumption is that medical services will normally not engage in harmful acts and that such acts, if committed, may have been caused either by mistake or negligence. In this regard, the warning requirement reflects the principle of necessity as *ultima ratio*: if no warning is given, it cannot be said that the attack was really necessary to curb the harmful acts; a request to that effect could indeed have been heeded. Conversely, the absence of a warning is an exception "in the extreme circumstances of an immediate threat to the lives of advancing combatants, where it is clear that a warning would not be complied with".[74] The provisions do "not specify what is meant by a 'due warning', including what form it must take".[75] Whatever the method selected, in order to achieve the purpose, the "warning should be clear and specific, and it should mention the harmful act in which the unit, establishment, or personnel is engaged".[76]

70 GC I, Art. 21 (emphasis added). The same requirement with slight modifications is provided in GC IV, Art. 19(1); AP I, Art. 13(1); AP II, Art. 11(2). Cf. GC II, Art. 34(1), for hospital ships.

71 The warning obligation examined here is more stringent than the one under general protection, set out in Article 57(2)(c) of AP I. In the context of special protection, there can be no attack without a prior warning, except in extreme situations where a warning is impossible - for example, when incoming fire requires an immediate response due to overriding military necessity. In the context of general protection, the warning shall as a principle take place unless the circumstances do not permit (e.g., because of mobile targets).

72 ICRC Commentary on GC II, above note 8, Art. 34, para. 2381. This arguably applies by analogous reasoning to medical services on land.

73 ICRC Commentary on GC I, above note 4, Art. 21, para. 1849.

74 *Ibid.* See also J. K. Kleffner, above note 14, p. 338. As an example of when fire could be returned immediately without issuance of a warning by the aggrieved party to the conflict, this article cites "a medical transport, which approaches a military checkpoint while firing upon those manning the checkpoint".

75 ICRC Commentary on GC I, above note 4, Art. 21, para. 1850.

76 T. Haeck, above note 10, p. 848. Haeck refers to the *Report of the United Nations Fact-Finding Mission on the Gaza Conflict*, UN Doc. A/HRC/12/48, 25 September 2009, paras 596–652. The Mission concluded that the attacks on Al-Quds Hospital (which belongs to the Palestinian Red Crescent Society) and Al-Wafa Hospital by the Israeli armed forces constituted a violation of Article 18 of GC IV, and that the absence of concrete warnings prior to these attacks was in violation of Article 19 of GC IV. *Ibid.*, para.

Then, in the second place, when possible, a reasonable time limit for ceasing the harmful acts must be indicated. Sometimes, however, no delay in the response is possible. The often-mentioned example is "a body of troops approaching a hospital" who are "met by heavy fire from every window";[77] "[i]n such a case, after the issuance of a warning, fire could be returned without delay".[78] When a reasonable time limit is appropriate, it "must be long enough to achieve the purpose of a warning":[79] that is, to allow those in charge of the medical services "enough time to reply to the accusations that have been made";[80] "depending on the circumstances, to change their approach, to explain themselves if a mistake has been made";[81] to cease the unlawful acts;[82] or to evacuate the wounded and sick.[83]

Lastly, the warning must have remained unheeded. When the medical services ignore the warning issued by the aggrieved party to the conflict – i.e., "where the act harmful to the enemy is not terminated"[84] – the relevant provisions relieve the obligation of the aggrieved party to respect and protect that specific medical service. Note again that the commission of AHTTE leads to the loss of special protection but conducting an attack against medical units or transports still requires the aggrieved party to satisfy Article 52(2) of AP I. Subsequent attacks or enforcement measures should be effective in inducing the adverse party to respect the law and should be proportionate to the committed AHTTE that the aggrieved party aims to stop. Such measures cannot be punitive in nature; they must be merely protective. The provisions do not specify "the measures that the aggrieved Party to the conflict is allowed to take if the warning remains unheeded";[85] neither is it clear whether the aggrieved party may take some measures short of an attack even if the warning has been heeded.[86] Measures short of an attack that could be taken by the aggrieved party to the conflict include search operations or capture for medical units and transports, and interrogation, arrest or detention for medical personnel.[87] Although IHL does not specifically prohibit such measures against

646: "It [the warning] was not specific and no indication was given about when the attack would take place or how much time there was to evacuate the hospital."

77 Pictet Commentary on GC I, above note 65, Art. 21, p. 202.

78 ICRC Commentary on GC I, above note 4, Art. 21, para. 1851.

79 *Ibid.*, para. 1852.

80 ICRC Commentary on AP I, above note 4, Art. 13, para. 556.

81 ICRC Commentary on AP II, above note 4, Art. 11, para. 4727.

82 ICRC Commentary on AP I, above note 4, Art. 13, para. 556; ICRC Commentary on AP II, above note 4, Art. 11, para. 4726.

83 ICRC Commentary on AP I, above note 4, Art. 13, para. 556; ICRC Commentary on AP II, above note 4, Art. 11, para. 4727.

84 ICRC Commentary on GC I, above note 4, Art. 21, para. 1853.

85 Cf. ICRC Commentary on GC II, above note 8, Art. 34, para. 2383.

86 Cf. Article 34 of GC II, for example, which allows the capture of a hospital ship having indulged in hostile acts, even if the warning has been heeded; but the ship cannot be attacked in such a case. For further details, see ICRC Commentary on GC II, above note 8, Art. 34, para. 2384; Louise Doswald-Beck (ed.), *San Remo Manual on International Law Applicable to Armed Conflicts at Sea*, Cambridge University Press, Cambridge, 1995, paras 49–50.

87 See ICRC, *Promoting Military Operational Practice that Ensures Safe Access to and Delivery of Health Care*, ICRC, Geneva, 2014, pp. 25–27.

these medical services, whenever feasible, the way that these operations are conducted should be closely regulated, and practical measures should be developed to minimize the negative effects of health-care delivery in armed conflicts.[88]

Summing up, AHTTE may have legal consequences even if the warning has been heeded,[89] which constitutes in part a sanction of their hostile attitude. But an attack is excluded in such cases, since the latter can only be protective in nature and no necessity exists any more in this regard once the warning has been heeded. Notice also that when medical units and transports have ceased their AHTTE, they automatically also lose their status as a military objective under Article 52 of AP I.[90] This is so because if there are no AHTTE, there is *a fortiori* no contribution to military operations, which is a definitional element of the military objective.

What if the warning is partially heeded? The attack should then be proportionate to the committed AHTTE, taking into consideration the concrete context of circumstances, including the (partial) response of the medical services and the conditions of the wounded and sick. In other words, the question here is one of full context viewed in the light of the principles of necessity and proportionality.

For NIAC, the *San Remo Manual on the Law of Non-International Armed Conflict* confirms: "An opportunity must be given to the other side to abide by the rules, and an attack can only be made if it is clear that the warning has been ignored."[91] The question has arisen as to whether the warning requirement also exists under customary international law for NIACs. Strictly speaking, for the International Committee of the Red Cross's (ICRC) Customary Law Study, the warning procedural requirements are not obligatory in a NIAC for States that

88 *Ibid.*

89 The assertion that proportionate enforcement measures are allowed by the aggrieved party to the conflict even when warnings are heeded by the medical service engaging in AHTTE, outside its humanitarian function, is a logical conclusion. Consider an ambulance transporting wounded and sick combatants while simultaneously collecting intelligence near a military checkpoint. The aggrieved party to the conflict issues the legally required warning informing the ambulance that if it does not cease this harmful act immediately, it will be stopped and searched. The ambulance hastily returns to its depot. The following week, the ambulance returns and restarts the same act. Several issues arise. First, can the ambulance get away with its harmful act committed on the first day, as it had heeded the subsequent warning issued by the aggrieved party? The law arguably does not allow such a manoeuvre, especially if the harmful act was of significant gravity – for instance, if the intelligence collected was crucial to launching an important military operation against the aggrieved party. Second, when the ambulance starts to collect intelligence again the following week, is the aggrieved party obliged to issue another warning? If so, and if the ambulance heeds the warning a second time, is the aggrieved party still obliged to grant special protection to it? If not, is the aggrieved party allowed to immediately take an enforcement measure against the ambulance without giving an opportunity for the safe evacuation of the wounded and sick occupants inside it? Does last week's warning remain valid? What if a similar incident occurs the next month, or the next year? Battalions rotate, as do medical personnel, and the circumstances of war are fluid. Should no consequence be attached to these abuses? Not only is this interpretation unreasonable, but a lot of uncertainty would arise in its practical application.

90 For a nuanced analysis of a medical object used for AHTTE in relation to the definition of military objective in Article 52(2) of AP I, see the next section.

91 Michael N. Schmitt, Charles H.B. Garraway and Yoram Dinstein (eds), *The San Remo Manual on the Law of Non-International Armed Conflict: With Commentary*, International Institute of Humanitarian Law, Sanremo, 2006, Chap. 4.2.1.

have not ratified AP II.[92] It should be recalled, however, that this study "did not distinguish between the two categories of non-international armed conflict [AP II and Article 3 common to the four Geneva Conventions] because it was found that States did not make such a distinction in practice".[93] Some warning obligation could perhaps be implied in common Article 3, which reflects customary law, though that is uncertain. The question as to the reach of customary international law on this issue consequently remains debatable.

Finally, the jurisprudence of the International Criminal Tribunal for the former Yugoslavia (ICTY) in the *Galić* case[94] sheds some light on the warning obligation. In this case, the lawfulness of shell attacks by a belligerent directed against a hospital was discussed.[95] The hospital, while still treating the wounded and sick, had become a "military base"[96] from which weapons were being fired by the adverse belligerent against this belligerent.[97] The Appeals Chamber asserted that a hospital becomes a legitimate target when used for hostile or harmful acts unrelated to its humanitarian function.[98] However,

> relying on relevant provisions of AP I (Article 13(1)) and AP II (Article 11(2)), the Appeals Chamber qualified the loss of protection by requiring that an advance warning be given of an attack. In its view, the lack of a due warning, including a reasonable time period for compliance, would render any subsequent attack unlawful, despite the fact that the protected object constituted a military objective.[99]

The notion of "acts harmful to the enemy"

Negotiating history

The concept of AHTTE – though differently worded – was introduced for the first time in treaty law in Article 7 of the 1906 Geneva Convention, specifying that the

92 ICRC Customary Law Study, above note 2, Rules 25, 28–29. See, for example, Luisa Vierucci, "The Protection of Wounded and Sick in IAC and NIAC", in Carl Marchand and Gian L. Beruto (eds), *The Distinction between International and Non-International Armed Conflicts: Challenges for IHL? 38th Round Table on Current Issues of International Humanitarian Law (Sanremo, 3rd–5th September 2015)*, Franco Angeli, Milan, 2016, p. 213: the fact that, by and large, a warning has not been given before attacking medical facilities in Syria might not only be indicative of lack of existence of the relevant IHL rule in NIAC but also calls into question the respect for the principle of precaution in general, since the obligation to give a warning is one of the corollaries of this principle.

93 Jelena Pejic, "The Protective Scope of Common Article 3: More Than Meets the Eye", *International Review of the Red Cross*, Vol. 93, No. 881, 2011, p. 191.

94 ICTY, *Prosecutor v Stanislav Galić*, Case No. IT-98-29-A, Judgment (Appeals Chamber), 30 November 2006.

95 *Ibid*., paras 336–352.

96 *Ibid*., para. 337.

97 *Ibid*., paras 338–339.

98 *Ibid*., para. 340.

99 Iain Bonomy, *Principles of Distinction and Protection at the ICTY*, FICHL Occasional Paper Series, No. 3, 2013, p. 21. See also ICTY, *Galić*, above note 94, para. 344.

protection of sanitary formations and establishments ceases if they are used to commit "acts injurious to the enemy".[100] Still in 1949, AHTTE was not defined in any meaningful sense. As was stated at the 1949 Diplomatic Conference:

> The term *acts harmful* to the enemy is perhaps not very elegant. We endeavoured to find a better wording; but we returned to the traditional expression …. The expression is, perhaps, somewhat elastic, but it seems to us clear. It covers not only acts of warfare proper but any activity characterizing combatant action.[101]

The ICRC's alternative wording, expressing the same idea for AHTTE in preparation for the Diplomatic Conference, was "acts the purpose or effect of which is to harm the adverse Party, by facilitating or impeding military operations".[102] Jean Pictet in 1985 wrote that "[s]uch acts [AHTTE] have the aim or effect, by favouring or impeding military operations, of being detrimental to one of the belligerents".[103] In the context of Article 13(1) of AP I, the ICRC Commentary explains that "the definition of *harmful* is very broad. It refers not only to direct harm inflicted on the enemy, for example, by firing at him, but also to any attempts at deliberately hindering his military operations in any way whatsoever".[104]

Conducts amounting to AHTTE

Examples of AHTTE leading to the loss of special protection for medical units include "firing at the enemy for reasons other than individual self-defence",[105] "installing a firing position in a medical post",[106] "the use of a hospital as a shelter for able-bodied combatants or fugitives, as an arms or ammunition dump, or as a military observation post",[107] the use of a hospital "as a centre for liaison with fighting troops"[108] and "the placing of a medical unit in proximity to a military objective with the intention of shielding it from the enemy's military operations".[109] This last act is specifically prohibited under Article 12(4) of AP I. Examples of AHTTE leading to the loss of special protection for medical transports include "the use of the vehicle as a mobile military command post or as a base from which to launch an attack"[110] and "the transport of healthy troops, arms or munitions".[111] Moreover, prohibited acts of medical aircraft

100 ICRC Commentary on GC I, above note 4, Art. 21, para. 1838.
101 *Final Record of the Diplomatic Conference of Geneva of 1949*, Vol. II-A, pp. 818–819.
102 Pictet Commentary on GC I, above note 65, Art. 21, p. 200.
103 J. Pictet, above note 46, p. 204.
104 ICRC Commentary on AP I, above note 4, Art. 13, para. 551.
105 ICRC Commentary on GC I, above note 4, Art. 21, para. 1842.
106 *Ibid.*
107 Pictet Commentary on GC I, above note 65, Art. 21, pp. 200–201.
108 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. 4: *Geneva Convention relative to the Protection of Civilian Persons in Time of War*, ICRC, Geneva, 1958, Art. 19, p. 154.
109 ICRC Commentary on GC I, above note 4, Art. 21, para. 1842.
110 *Ibid.*, Art. 35, para. 2389.
111 ICRC Customary Law Study, above note 2, commentary on Rule 29, p. 102.

under Article 28(1)–(2) of AP I apply not only to medical aircraft but also, by analogy, to any persons and objects enjoying special protection.[112] Although the phrase "acts harmful to the enemy" is not explicitly used, these are analogous forms of abuse[113] with regard to the medical aircraft's protected status.[114] Thus, they can be applied by analogous reasoning to the medical services on land. The analogous application of this rule to medical units and transports is that these services will lose their special protection if they are used "to attempt to acquire *any* military advantage over an adverse party", "to attempt to render military objectives immune from attack", "to collect or transmit intelligence data" or "to carry any persons or cargo not related to medical function".[115] Finally, examples of AHTTE leading to the loss of special protection for medical personnel include when such personnel "take up arms for offensive or for non-recognized defensive purposes",[116] "[assist] in the operation of a weapon system or in the planning of a military operation, or [transmit] intelligence of military value",[117] or "help able-bodied combatants of their State to hide for a while in a hospital".[118]

Some recent examples of AHTTE can be found in the ICRC's *Health Care in Danger* report,[119] which identifies the fact that "[h]ealth-care facilities were occupied and subject to misuse"[120] as one of its most important findings. Misuse includes "any use for purposes other than the exclusive function of providing health care".[121] This is a broader definition than AHTTE, as not every misuse is militarily harmful. The ICRC report documents misuse in several forms, including military occupation and/or military bases established in such facilities, services used by a belligerent for shelter from the adverse belligerent's attacks (mainly in a context identified as one of active fighting), installation of weapons, and launching of attacks.[122] These conducts transform these health-care facilities

112 ICRC Commentary on AP I, above note 4, Art. 28, para. 1052. See also Vaios Koutroulis, "Loss of Protection of Medical Personnel in Armed Conflict", in Odile Vandenbossche, Ware Vercamer and Arthur Fallas (eds), "Report of the Flanders Fields Conference of Military Law and the Law of War", *The Military Law and the Law of War Review*, Vol. 55, No. 2, 2016–17, p. 230.

113 *Ibid.*, para. 1058.

114 *Ibid.*, para. 1046.

115 Vaios Koutroulis, "Loss of Protection of Medical Personnel in Armed Conflict", unpublished presentation delivered at the Flanders Fields Conference of Military Law and the Law of War, International Society for Military Law and the Law of War, Ypres, 12–15 October 2014, slide 10 (emphasis added), available at: https://tinyurl.com/y9c9xf3w.

116 ICRC Commentary on GC I, above note 4, Art. 24, para. 2005. Medical personnel may be equipped with light individual weapons in line with Articles 22(1) of GC I and 13(2)(a) of AP I, and are entitled to use these against unlawful violence either for their own defence or for that of the wounded and sick in their charge. These conducts do not constitute AHTTE and consequently do not forfeit their special protection.

117 *Ibid.*, para. 2000.

118 *Ibid.*

119 ICRC, *Health Care in Danger: Violent Incidents Affecting the Delivery of Health Care, January 2012 to December 2014*, ICRC, Geneva, 2015. This report provides an analysis regarding 2,398 incidents of violence against health care in eleven countries in the context of armed conflicts and other emergencies during the indicated three years.

120 *Ibid.*, p. 1.

121 *Ibid.*, p. 13, fn. 27.

122 *Ibid.*, p. 13.

into "objects serving military purposes"[123] and can thus be considered as AHTTE. Other forms of misuse have also been documented, including military personnel camping in the facility for a limited time, guarding the facility in order to conduct interrogations and identify opposition fighters, and keeping hostages and exercising ill-treatment.[124] For these conducts, further facts must be contextually assessed to establish whether the relevant conduct amounts to AHTTE.

Another more complicated question relates to when the wounded and sick are interrogated or tortured inside medical units. Would these conducts qualify as AHTTE, and if so, what would be the legal consequences? During the Iraq War in 2003, the US military commanders were advised that "the questioning of Iraqi detainees and EPWs [enemy prisoners of war] beyond the legally required identification information on board U.S. hospital ships during armed conflict might strip the ship of its protected status under GWS-Sea [Geneva Convention II], article 22".[125] The ICRC Commentary on Article 34 of Geneva Convention II (GC II) takes the position that "the interrogation of enemy prisoners of war on board hospital ships, when the said interrogation seeks to acquire information beyond what they are required to disclose on the basis of Article 17 of the Third [Geneva] Convention",[126] would qualify as AHTTE. This interpretation would apply by analogy to medical units on land. In the same vein, when the wounded and sick are subjected to prohibited torture and cruel, inhuman or degrading treatment inside medical facilities, this would arguably qualify as AHTTE as well. In these mistreatment cases, proportionate enforcement measures to respond to the harmful acts against the medical service in question, such as armed entry, inspection or capture, could be made. Whether these harmful conducts would justify a direct attack against the medical facility would then be subject to the rules on the conduct of hostilities. In most cases, these rules, together with the overarching obligation to protect and respect the wounded and sick, would render such an attack unlawful.

As evinced in the aforementioned examples, "[t]he notion of acts harmful to the enemy, despite the plural form, presumably applies to a singular act".[127] There is indeed no reason to exclude single acts from the purview of the exception, all the more since a single AHTTE can be of significant gravity. AHTTE is restricted to specific "conducts" – i.e., "a person's behaviour in a particular place or in a particular situation"[128] – and in principle, specific conducts relevant to AHTTE should not be blurred with other conducts that are not. Otherwise, this could inherently enlarge the scope of the loss of special protection to medical persons or objects that have not been used to commit AHTTE. Furthermore, AHTTE

123 ICRC, above note 87, p. 47.
124 ICRC, above note 119, p. 13.
125 Gregory P. Noone *et al.*, "Prisoners of War in the 21st Century: Issues in Modern Warfare", *Naval Law Review*, Vol. 50, 2004, p. 39.
126 ICRC Commentary on GC II, above note 8, Art. 34, para. 2375.
127 Stuart Casey-Maslen, "The Status, Rights, and Obligations of Medical and Religious Personnel", in A. Clapham, P. Gaeta and M. Sassòli (eds), above note 10, p. 816.
128 Albert S. Hornby (ed.), *Oxford Advanced Learner's Dictionary of Current English*, 7th ed., Oxford University Press, Oxford, 2005, p. 316.

supposes "use for military purposes". The idea that hospitals lose protection when being used for military purposes can be traced back to Article 27 of the 1907 Hague Convention IV.[129] The law does not elaborate on the degree of use, the frequency or the gravity; any use of the medical services by a party to the conflict for military purposes may be considered an act harmful to the enemy,[130] and a threshold for severity, including volume, duration or intensity, is not required. Neither does the use necessarily need to be continuous or regular; it could be singular, sporadic or irregular. Even indirect, accidental or attempted[131] use is arguably included.[132] Conversely, there are also conducts that do not constitute AHTTE. Examples of such acts are codified in Article 22 of GC I for military medical units and establishments, Article 19(2) of GC IV for civilian hospitals, and Article 13(2) of AP I for civilian medical units.[133] Article 13(2) of AP I reads:

> The following shall not be considered as acts harmful to the enemy:
>
> a) that the personnel of the unit are equipped with light individual weapons for their own defence or for that of the wounded and sick in their charge;
> b) that the unit is guarded by a picket or by sentries or by an escort;
> c) that small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service, are found in the units;
> d) that members of the armed forces or other combatants are in the unit for medical reasons.

This list is not exhaustive.[134] The analogous application of this rule to medical personnel implies that

> it is not to be considered a hostile act if medical personnel are escorted by military personnel or such personnel are present or if the medical personnel are in possession of small arms and ammunition taken from their patients and not yet handed over to the proper service.[135]

The list mentioned above is not applicable to NIAC and AP II, but it can serve as a basis for interpretation of the law[136] and also for the determination of customary international law. Let us look more closely at these conducts not constituting AHTTE.

129 Hague Convention (IV) respecting the Laws and Customs of War on Land and its Annex: Regulations Concerning the Laws and Customs of War on Land, 205 CTS 227, 18 October 1907 (entered into force 26 January 1910).
130 Cf. ICRC Commentary on GC I, above note 4, Art. 21, para. 1842.
131 AP I, Art. 28(1). It is also recalled that the ICRC's alternative wording, expressing the same idea for AHTTE in preparation for the 1949 Conference, was "acts the purpose *or* effect of which is to harm the adverse Party, by facilitating or impeding military operations" (emphasis added).
132 The warning requirement is precisely for this reason: to alert medical personnel, hospital administrators, etc. to unintentional AHTTE that could strip them from protection from direct attack.
133 Cf. GC II, Art. 35, for hospital ships.
134 ICRC Commentary on GC I, above note 4, Art. 22, para. 1860.
135 ICRC Customary Law Study, above note 2, commentary on Rule 25, p. 85.
136 ICRC Commentary on AP II, above note 4, Art. 11, para. 4723.

Articles 13(2)(a) of AP I and 22(1) of GC I regulate that medical personnel may be armed and that they may, in case of need, use these arms to defend either themselves or the wounded and sick in their charge against unlawful violence.[137] This would not constitute AHTTE. Article 22(1) of GC I does not specify the type of arms that medical personnel could lawfully use,[138] but Article 13(2)(a) of AP I limits it to "light individual weapons".[139] "Any use going beyond these permitted purposes, even with 'light individual weapons'",[140] or when medical personnel are equipped with "any weapons heavier than those stipulated",[141] would constitute AHTTE. Examples of AHTTE by medical personnel include using light individual "weapons in combat against enemy forces acting in conformity with the law of war, notably to resist capture",[142] "carrying weapons which are portable by one individual yet which go beyond the purpose of self-defence, such as a man-portable missile or an anti-tank missile",[143] and installing "heavy weapons, such as 'crew-served' machine guns (requiring a team of at least two people to operate them)",[144] on a medical unit. The main interpretational point – as manifested in practice – is that the allowed weapons are essentially handguns.[145] In an interpretation given by some States during the negotiations for the Additional Protocols at the Diplomatic Conference of 1974–77, fragmentation grenades, weapons which cannot fully be handled or fired by a single individual and those intended for non-human targets were excluded.[146]

This provision is based on the experience that in situations of armed conflict, the ordinary police enforcement mechanisms have often crumbled, and that concomitantly, criminality spreads. A medical unit contains materials which can be economically valuable (the coronavirus crisis of 2020 shows how medical material can be sold on black markets).[147] A medical post must consequently be guarded, and to be efficient, the guards must be armed. However, their armed opposition must be directed only against the criminal elements, not against the military forces of the enemy. The medical unit may not be defended against

137 For the scope of defence, see ICRC Commentary on GC I, above note 4, Art. 22, paras 1866–1867; M. Sassòli, above note 10, p. 54; A. Breitegger, above note 7, p. 112.
138 ICRC Commentary on GC I, above note 4, Art. 22, para. 1864; ICRC Commentary on AP I, above note 4, Art. 13, para. 562.
139 ICRC Commentary on AP I, above note 4, Art. 13, para. 563.
140 ICRC Commentary on GC I, above note 4, Art. 22, para. 1865.
141 *Ibid*., para. 1864.
142 ICRC Customary Law Study, above note 2, commentary on Rule 25, p. 85.
143 ICRC Commentary on GC I, above note 4, Art. 22, para. 1864.
144 *Ibid*., para. 1868.
145 Michael Bothe, Karl J. Partsch and Waldemar A. Solf (eds), *New Rules for Victims of Armed Conflicts: Commentary on the Two 1977 Protocols Additional to the Geneva Conventions of 1949*, 2nd ed., Martinus Nijhoff, Leiden and Boston, MA, 2013, AP I, Art. 13, p. 131, and Art. 65, p. 459.
146 *Ibid*., pp. 460–461. See also ICRC Commentary on AP I, above note 4, Art. 13, para. 563.
147 See, for example, Maria Caspani, "U.S. COVID-19 Cases Rocket Past 100,000 as Doctors Look for Black Market Medical Supplies", *National Post*, 28 March 2020, available at: https://nationalpost.com/news/world/u-s-coronavirus-cases-surpass-100000-as-doctors-cope-with-medical-shortages; "Black Market for Coronavirus Test Kits Flourishes in Climate of Mistrust, Stigma in Nigeria", *News 24*, 23 April 2020, available at: www.news24.com/Africa/News/black-market-for-coronavirus-test-kits-flourishes-in-climate-of-mistrust-stigma-in-nigeria-20200423.

the enemy belligerent; that would amount to AHTTE.[148] In view of this finality, the "necessity" requirement explains why only handguns are allowed, as only those guns are *necessary* to oppose crime; heavier weapons would have a belligerent function and are thus not *necessary* for the type of allowed defence. However, the question could arise as to whether such heavier weapons could be exceptionally conceded if the marauders display a level or organization and force which requires more than handguns to defend against them. In the absence of a permission under the applicable IHL provisions, the commander of the unit will have to seek an agreement with the enemy forces on this point.

It has been rightly said that arming of medical personnel, especially if civilian (as under Article 13 of AP I), is not without problems.[149] Such personnel could be mistaken as combatants or as abusing their civilian function. In view of the necessities of defence against crime, however, this shortcoming cannot be wholly avoided. For this reason, it is all the more important that the weapons carried be of a type (i.e., handguns) that immediately allows others to grasp their true purpose.

Articles 13(2)(b) of AP I and 22(2) of GC I regulate that when medical units are under armed protection by guards,[150] "specifically to the defence of the wounded and sick contained therein",[151] this does not constitute AHTTE. Guards include both "medical and non-medical personnel".[152] Under exceptional cases,[153] "non-medical members of the armed forces"[154] and "civilian uniformed police force"[155] are also envisaged. Guards are subject to the same conditions as armed medical personnel regarding the type and use of weapons permitted: "only the same type of weapons, notably 'light-individual weapons', may be carried and, where necessary, used for defensive purposes only".[156]

Articles 13(2)(c) of AP I, 22(3) of GC I and 19(2) of GC IV stipulate that the temporary presence of small arms and ammunition found inside the medical unit, which have been taken from the wounded and sick and have not yet been handed over to the proper service ("i.e. authorities outside the medical establishment or unit"[157]), would not constitute AHTTE. The understanding of the arms concerned relates to "portable weapons"[158] and is broader than the "*individual*

148 ICRC Commentary on GC I, above note 4, Art. 22, para. 1867; ICRC Commentary on AP I, above note 4, Art. 13, para. 561.

149 M. Bothe, K. J. Partsch and W. A. Solf (eds), above note 145, AP I, Art. 13, p. 131. An analogous problem arises with the armament of civil defence personnel: *ibid.*, Art. 65, pp. 460–461. See also ICRC Commentary on AP I, above note 4, Art. 13, para. 560.

150 Article 22(2) of GC I includes the expression "in the absence of armed orderlies". This does not mean that the simultaneous presence of armed orderlies and military guards is prohibited. See Pictet Commentary on GC I, above note 65, Art. 22, pp. 203–204.

151 ICRC Commentary on GC I, above note 4, Art. 22, para. 1870.

152 *Ibid.*

153 *Ibid.*, para. 1872; ICRC Commentary on AP I, above note 4, Art. 13, para. 566.

154 *Ibid.*, para. 1871.

155 ICRC Commentary on AP I, above note 4, Art. 13, para. 566.

156 ICRC Commentary on GC I, above note 4, Art. 22, para. 1874.

157 *Ibid.*, para. 1876.

158 *Ibid.*, para. 1877. Article 22(3) of GC I does not define the term "small arms". The equally authentic French text, however, adopts the term "armes portatives" (portable weapons).

portable weapons"[159] authorized for medical personnel.[160] "[S]ome weapons which are slightly heavier than those which are authorized for medical personnel could be involved, such as, for example, small machine guns, provided that they are portable, even if this should require two or three soldiers."[161] Conversely, "to store arms or ammunition (other than the temporary storage of arms and ammunition taken from the wounded and sick and not yet handed over to the competent authority)"[162] in medical units constitutes AHTTE. Moreover, "the presence of any weapons other than portable weapons inside a medical establishment or unit could not be justified even on a temporary basis".[163]

Articles 13(2)(d) of AP I and 19(2) of GC IV stipulate that the presence of armed forces or other combatants inside the medical unit for medical reasons would not constitute AHTTE. Arguably, a temporary presence of combatants or other military objectives inside the medical unit for non-medical reasons does not automatically constitute AHTTE either.[164] It cannot be assumed that these persons or objects are using the medical unit for military purposes – e.g., being combatants directing missions from the unit – without ascertaining further facts. The combatants could, however, be attacked as lawful targets, but then all precautions would have to be taken not to interfere with the medical unit. This will in most cases mean that the adverse belligerent will have to wait until these persons have left the unit, since otherwise the collateral damage would be excessive with regard to the military advantage anticipated (AP I, Article 51(5)(b)).

AHTTE versus perfidy

AHTTE may qualify as perfidy, codified in Article 37(1) of AP I, if done in order to kill, injure or capture an enemy combatant.[165] Consider an ambulance approaching a military checkpoint of the adverse party. The soldiers manning the checkpoint approach it to facilitate its passage, but are fired upon by combatants hiding inside it. This conduct qualifies not only as perfidy but also as AHTTE. Certain forms of AHTTE consequently overlap with perfidy – that is, abuse of the medical services' special protection in order to gain some military advantage or to deny the adversary such an advantage. The two concepts have similar characteristics: both are deceits characterized by an action contrary to the principle of good

159 *Ibid.*
160 *Ibid.*
161 *Ibid.*
162 ICRC, above note 87, p. 28, fn. 18.
163 ICRC Commentary on GC I, above note 4, Art. 22, para. 1877.
164 See, for example, US Department of Defense, *Law of War Manual*, June 2015 (updated December 2016), para. 7.10.3.6.
165 ICRC Commentary on GC I, above note 4, Art. 21, para. 1842. The commission of AHTTE while displaying the distinctive emblems of the Geneva Conventions is specifically prohibited under AP I, Art. 38(1); AP II, Art. 12; Protocol Additional (III) to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem, 2404 UNTS 261, 8 December 2005 (entered into force 14 January 2007), Art. 6(1); and customary IHL (ICRC Customary Law Study, above note 2, Rule 59).

faith,[166] the gist of which consists of a belligerent using obligations under IHL for hostile purposes,[167] and both undermine compliance with the law.[168] The difference is that AHTTE do not have to result in the death, injury or capture of an enemy combatant.

AHTTE versus acts of hostility

AHTTE are broader than an "act of hostility" as codified in Article 8(a) of AP I. Harmful acts are acts causing or likely to cause harm, while hostilities refer to acts of warfare – i.e., to military operations. The legal understanding of "harmful", as previously discussed, "refers not only to direct harm inflicted on the enemy, … but also to any attempts at deliberately hindering his military operations in any way whatsoever".[169] "[T]he concept of 'hostilities' refers to the (collective) resort by the parties to the conflict to means and methods of injuring the enemy."[170] Although the term "act of hostility" does not have a clear definition under IHL, it must be understood by analogy to the term "hostile act" in Articles 41(2)(c) and 42(2) of AP I, with guidance from Article 51(3) of AP I[171] – i.e., "[h]ostile acts should be understood to be acts which by their nature and purpose are intended to cause actual harm to the personnel and equipment of the armed forces".[172] This is manifestly a narrower notion than the one on harmfulness, which encompasses indirect effects on military operations of the adverse party.

AHTTE versus direct participation in hostilities

For the same reason, AHTTE is also a broader concept than that of "direct participation in hostilities" (DPH) contained in Article 51(3) of AP I and Article 13(3) of AP II.[173] Acts of DPH are precisely linked to "hostilities" and not to "harm". There are, however, some broad interpretations of DPH – such as by the United States – that end up making the concept of AHTTE a narrower one than DPH. This is particularly true when a hostile intent of an organization, without actual conduct to carry it out, is taken to allow an attack on an individual

166 On the role of the principle of good faith in IHL, in particular with reference to the prohibition of perfidy, see Robert Kolb, *Good Faith in International Law*, Hart Publishing, Oxford and Portland, OR, 2017, pp. 251–254.

167 *Ibid.*, pp. 252–253.

168 *Ibid.* See also R. Kolb, above note 38, p. 41: "no belligerent would be imprudent enough to implement IHL obligations, if there must be a constant and well-founded fear that these obligations are used for hostile purposes".

169 ICRC Commentary on AP I, above note 4, Art. 13, para. 551.

170 ICRC and Nils Melzer, "Interpretive Guidance on the Notion of Direct Participation in Hostilities under International Humanitarian Law", *International Review of the Red Cross*, Vol. 90, No. 872, 2008, p. 1013.

171 J. K. Kleffner, above note 14, p. 324.

172 ICRC Commentary on AP I, above note 4, Art. 51(3), para. 1942.

173 Some, including the ICRC, perceive that the notion of AHTTE is broader than that of DPH. See ICRC, above note 5, p. 33; ICRC Commentary on GC I, above note 4, Art. 24, para. 2003: "In terms of acts covered, the scope of application of the notion of 'acts harmful to the enemy' is broader than that of 'direct participation in hostilities'." For the same line of argument, see Nils Melzer, *Targeted Killing in International Law*, Oxford University Press, Oxford, 2008, p. 329.

member of that organization, to whom the overall hostile intent is imputed.[174] Apart from these peculiar interpretations, it can be said that (1) the required "threshold of harm" for AHTTE is lower than that of DPH, the latter supposing "hostilities"; (2) "direct causation" – i.e., a direct link between AHTTE and the performance of concrete military operations – is not required; and (3) "belligerent nexus" is a prerequisite for both notions, whereby the AHTTE must be specifically designed in support of a party to a conflict *or* to the detriment of another. This implies that if civilian medical personnel directly participate in hostilities, this would automatically amount to AHTTE. Conversely, if civilian medical personnel commit AHTTE that do not amount to DPH, these persons may lose their special protection; however, they do not lose their general protection, "unless and for such time as they take a direct part in hostilities".[175] In other words, a civilian's commission of AHTTE does not automatically render the person liable to direct attack. "This would only be the case if these acts equally qualify as acts of 'direct participation in hostilities'."[176]

AHTTE versus military objective

The next question relates to when AHTTE would turn a medical object into a military objective under Article 52(2) of AP I. As is known, the test on whether an object is a military objective depends on two contextual cumulative elements, namely a military contribution and a military advantage. "Contribution" means that an object renders services and has usefulness to the concrete conduct of military operations. The link between the contribution and the military operations must be direct.[177] Moreover, the contribution must be effective, which implies that it must be real and discernible.[178] It must be recalled that AHTTE encompass both direct and indirect interferences with military operations;[179] a direct link of AHTTE with the performance of concrete military operations is not required. This implies that a medical object used to commit AHTTE does not automatically become an object that makes an effective contribution to military action. When it does, AHTTE could extend to its "location, purpose or use" but not to its "nature" aspect under Article 52(2) of AP I, as a medical object does not acquire an intrinsic military character.

As to the second element, the effectiveness of the contribution, would the medical object's destruction, capture or neutralization offer a definite military advantage for the attacking side? "[A]n 'advantage' may be defined as everything which facilitates the military operations."[180] It must be "military", must be

174 US Department of Defense, above note 164, para. 5.8.3.3: "demonstrated hostile intent may also constitute taking a direct part in hostilities".
175 AP I, Art. 51(3); AP II, Art. 13(3); ICRC Customary Law Study, above note 2, Rule 6.
176 ICRC, above note 5, p. 33.
177 R. Kolb, above note 38, pp. 160–162.
178 Agnieszka Jachec-Neale, *The Concept of Military Objectives in International Law and Targeting Practice*, Routledge, London and New York, 2015, p. 83.
179 ICRC Commentary on GC I, above note 4, Art. 21, para. 1841.
180 R. Kolb, above note 38, p. 162.

"definite", and must exist "in the circumstances ruling at the time".[181] The answer is clearly in the negative. Not all objects, including medical objects used to commit AHTTE and/or effectively contributing to military action, would yield a definite military advantage when attacked. "[A] much wider pool of objects [may] be effectively contributing to the defender's military action, but only some of them might offer a real military advantage in concrete circumstances."[182] Thus, the overall conclusion of the ICRC seems correct:

> It is submitted that not all forms of 'acts harmful to the enemy' would make an effective contribution to military action and an attack directed against them would not, in the circumstances ruling at the time, offer a definite military advantage. The failure to fulfil either of these requirements implies that such medical objects may not be considered to have become military objectives.[183]

Conversely, certain AHTTE may lead an object to become a military objective when the two-pronged test under Article 52(2) of AP I is satisfied, e.g. when the location is used to fire on opposing troops. It must be recalled again that committing AHTTE leads to the loss of special protection under the relevant provisions, which includes immunity from attack, but that conducting an attack still requires the attacking party to satisfy Article 52(2).

AHTTE in case of doubt

Based on "humanitarian considerations",[184] "in case of doubt as to whether a particular type of conduct amounts to an 'act harmful to the enemy', it should not be considered as such".[185] This interpretation is in line with the gist of the rules expressed in Articles 50(1) and 52(3) of AP I, with their legal presumptions of the civilian character of a person and of an object under the rules governing the conduct of hostilities. Although similar provisions are not found in AP II for NIAC, "[o]ne cannot automatically attack anyone who might appear dubious".[186] These legal presumptions are in favour of the protection of the person and object in question, which leads to the protection of the wounded and sick – the ultimate aim of special protection under IHL.

Consequences of the loss of special protection

The main consequences of the loss of special protection are that the enemy is no longer obliged to refrain from interfering with the work of the medical services or

181 *Ibid.*
182 A. Jachec-Neale, above note 178, p. 116.
183 ICRC, above note 5, p. 33.
184 ICRC Commentary on GC I, above note 4, Art. 21, para.1844; see also Art. 24, para. 1998.
185 *Ibid.*
186 ICRC Customary Law Study, above note 2, commentary on Rule 6, p. 24: "In the case of non-international armed conflicts, the issue of doubt has hardly been addressed in State practice, even though a clear rule on this subject would be desirable."

to take positive measures to assist it in its work,[187] after fulfilment of the warning requirements. Further, if the warning, time limit and non-heeding are fulfilled, the service can be attacked. But there remain open questions, such as: when a person commits AHTTE inside a medical unit, should the response be given to the person only, or can the entire unit be attacked? If only a part of the unit is abused, can the whole unit be attacked? Does the abusive act affect the entire unit's protected status? And to what extent can medical personnel be attacked?

For *military* medical personnel, the commission of AHTTE does not change their status as medical personnel, just as DPH does not change the status of civilian into combatant.[188] The only consequence is the loss of special protection (because of AHTTE and the fulfilment of the warning-prong requirements).[189] In this case, the concerned medical personnel, normally protected against attack, will be liable to attack, exactly like civilians under the DPH doctrine.[190] It must also be recalled that military medical personnel, either generally or once having lost their special protection, can be targeted at all times,[191] and are not subjected to a contextual two-pronged test as are objects under Article 52(2) of AP I. If *civilian* medical personnel engage in AHTTE, these persons analogously remain civilians. They cannot, however, be attacked all the time, since they enjoy general protection under Articles 48 and 51 of AP I, as well as related customary international law; it is only if the AHTTE amount to DPH (i.e., are not merely "harmful" but also "hostile" in the sense discussed above), or if medical personnel engage in DPH in addition to AHTTE, that an attack on them becomes lawful under IHL. Conducts to be discussed under AHTTE in this context include the collecting and communicating of intelligence related or unrelated to combat operations, the shielding of able-bodied combatants, or firing on adverse forces.

In order to determine the loss of special protection of *medical objects*, both military and civilian, so that they can be attacked, two tests need to be satisfied: an AHTTE test together with the two additional requirements for the loss of special protection (warning, unheeded), and a military objective test under Article 52(2) of AP I for the loss of general protection against direct attacks. In contrast to medical personnel, where the difference in the respective legal status of military medical personnel and civilian medical personnel leads to an additional DPH test

187 ICRC Commentary on GC I, above note 4, Art. 21, para. 1854, Art. 24, para. 2008.

188 For a detailed analysis, see P. De Waard and J. Tarrant, above note 68, pp. 175–182.

189 For an alternative view, see V. Koutroulis, above note 112, p. 231; M. Sassòli, above note 10, pp. 53–55. Sassòli asserts that the loss of special protection for both *military* medical personnel and *civilian* medical personnel should be limited to acts that amount to DPH, instead of AHTTE, as the latter is a relevant criterion developed for objects while the former is for persons.

190 Nonetheless, questions do arise as to whether an attack against a member of military medical personnel who has committed a single, low-level harmful act that does not amount to a hostile act (e.g., sending one email containing low-quality intelligence unrelated to combat operations) would indeed be necessary.

191 If a temporal loss rather than a permanent loss of special protection is justified, where the special protection is regained, the person is no longer liable to attack. For the temporal end of the loss of special protection with regard to military medical personnel, see ICRC Commentary on GC I, above note 4, Art. 24, para. 2009. For a similar discussion on civil defence personnel in the context of Article 65 of AP I, see M. Bothe, K. J. Partsch and W. A. Solf (eds), above note 145, AP I, Art. 65, pp. 458–459.

for civilian medical personnel in order to assess their loss of protection against direct attack, both military and civilian medical objects have the same civilian status under the rules governing the conduct of hostilities,[192] and thereby undergo the same two tests (loss of special protection and loss of general protection).

An important question is to what extent single acts or localized action within a medical unit may turn the whole unit into a military objective liable to direct attack. The US Department of Defense *Law of War Manual* states that "a single enemy rifleman firing from a hospital window would warrant a response against the rifleman only, rather than the destruction of the hospital".[193] The legal reasoning has not been made explicit, although mention is made that "[s]uch use of force in self-defense against medical units or facilities must be proportionate".[194] Is this because the United States, in this specific case, considers that the military objective test has been narrowed down to the individual and not to the entire unit, as the conduct of the rifleman was not sufficient to transform the unit into a military objective? Or that the military objective test was satisfied for the unit, but the proportionality test was not automatically fulfilled by the same token?

In general terms, it must be said that a medical service cannot be automatically considered as a single military objective. If the military aim of neutralizing the AHTTE can be obtained by attacks on single parts of it, this narrower course must be chosen. This solution flows from the fact that the proportionality principle applies to all protected persons and objects, as well as from the fact that Article 57 of AP I requires precautionary measures in all types of situations.[195] This nuanced position finds some support in the jurisprudence of the aforementioned ICTY *Galić* case, which discussed the lawfulness of direct attacks against Koševo Hospital in Sarajevo by a party to the conflict: the Sarajevo Romanija Corps (SRK), a branch of the Army of Republika Srpska.[196] The hospital had become a dual-use object, an object serving at once civilian and military purposes. While the wounded and sick were being treated, it had also become a "military base"[197] of the opposing party to the conflict, the Army of Bosnia and Herzegovina (ABiH). Weapons were being fired from its grounds by

192 See above note 26.

193 US Department of Defense, above note 164, para. 7.10.3.2.

194 *Ibid.* The Manual stipulates that the proportionality principle creates obligations to "take feasible precautions in planning and conducting attacks to reduce the risk of harm to civilians *and other persons and objects protected from being made the object of attack*" (emphasis added): *ibid.*, paras 2.4.1.2, 5.11. It further underlines that "the requirement to take feasible precautions in planning and conducting attacks and the prohibition on attacks expected to cause excessive incidental harm are fundamentally connected and mutually reinforcing obligations": *ibid.*, para. 5.10.5. It rejects, however, that the proportionality requirement applies to military medical personnel and objects, or to military wounded and sick, as they are deemed to have accepted the risk of incidental harm due to their proximity to military objectives: *ibid.*, paras 4.10.1, 5.10.1.2, 7.3.3.1, 7.8.2.1, 7.10.1.1, 17.14.1.2, 17.15.1.2, 17.15.2.2. For a detailed analysis on the Manual's approach on this matter, see J. K. Kleffner, above note 38, pp. 52–55.

195 See the above section entitled "Special Protection".

196 ICTY, *Galić*, above note 94, paras 336–352.

197 *Ibid.*, para. 337

the ABiH forces against the SRK forces.[198] The relevant factual findings made by the Trial Chamber, also confirmed by the Appeals Chamber, were that there were attacks from both sides: "the SRK was fired at from the hospital grounds, and … the SRK fired on the hospital grounds and building".[199] The Court noted that the hospital "was regularly targeted during the Indictment Period by the SRK",[200] that the "ABiH mortar fire originated from the hospital grounds or from its vicinity and that these actions may have provoked SRK counter-fire".[201] The Trial Chamber concluded that the SRK firing on the hospital buildings "was certainly not aimed at any possible military target".[202] This was subsequently dismissed by the Appeals Chamber as "partially incorrect":[203]

> the Trial Chamber erred in law in determining that fire on the hospital was "not aimed at any possible military target", because fire from the hospital turned it into a target. At the same time, however, military activity does not permanently turn a protected facility into a legitimate military target. It remains a legitimate military target only as long as it is reasonably necessary for the opposing side to respond to the military activity. Additionally, *an attack must be aimed at the military objects in or around the facility*, so only weaponry reasonably necessary for that purpose can be used.[204]

Conclusion

As a conclusion, some general recommendations can be presented. There are three points to be made.

First, *attacks against hospitals must be viewed only as a last resort*. This first recommendation subscribes to the one made as part of the ICRC's Health Care in Danger project:

> in consultations with military experts …, a recommendation was made, not necessarily based on legal considerations, that kinetic strikes against a medical facility that has lost protection should be considered a last resort, and that options other than launching a direct attack on such a facility should be contemplated.[205]

Factoring not only the direct effects of the attack but also the reasonably foreseeable long-term and cumulative effects into incidental harm under the proportionality

198 *Ibid.*, paras 338–339.
199 *Ibid.*, para. 338.
200 *Ibid.*, para. 340.
201 *Ibid.*
202 *Ibid.*
203 *Ibid.*
204 *Ibid.*, para. 346 (emphasis added).
205 ICRC, above note 5, p. 33. See also ICRC, above note 87, pp. 41–42, for a set of "[s]pecific measures to guide the planning and conduct of an attack on a health-care facility which has lost its protection".

calculus would in most cases outweigh the military advantage anticipated.[206] This would consequently render an attack against a dual-use hospital that has become a military objective unlawful. In practice, the gist of the initial response to AHTTE is don't attack, provide a warning, and provide a time frame. "[T]he only remedy, practically speaking, available to the aggrieved Party to the conflict would most likely be capture or another appropriate measure of enforcing compliance."[207]

Second, *the notion of military objective and the attack allowed must be framed narrowly in the present context*. When an attack against a hospital is deemed *prima facie* lawful, as long as the hospital is simultaneously and continuously being used for the care of the wounded and sick, it is recommended, to the extent feasible, that the attack is made in a limited form and narrowed down to the exact military objective, as defined under Article 52(2) of AP I or its customary law equivalent,[208] within the hospital, and not directed at its entirety. "Article 51(4)(a) of Additional Protocol I requires that the attack be directed at the 'specific' military objective."[209] As much as possible, weapons used for the attack should be those necessary and proportionate to the exact military objectives defined within the military component of the hospital, so as to incapacitate those, and should not be directed against the civilian component or against the entire building.[210]

Third, *a prior warning must be considered as a stringent requirement for "authorized" and "unauthorized" hospitals*.[211] The following practical example illuminates the significance of this last recommendation even in atypical situations.

Consider a civilian hospital destroyed and abandoned due to an armed conflict. It no longer functions as a hospital. The medical personnel have left, so have the wounded and sick under their care. The local residents have also fled the area. After many months, new residents arrive, and a non-State armed group takes position in the building, which was once a hospital. Before an adverse belligerent launches an attack against this building, when such an attack is deemed lawful, a warning would arguably still be necessary. It is possible that a

206 Henry Shue and David Wippman, "Limiting Attacks on Dual-Use Facilities Performing Indispensable Civilian Functions", in Henry Shue, *Fighting Hurt: Rule and Exception in Torture and War*, Oxford University Press, Oxford, 2016, pp. 306–309.

207 Cf. ICRC Commentary on GC II, above note 8, Art. 34, para. 2388.

208 ICRC Customary Law Study, above note 2, Rule 8.

209 Agnieszka Jachec-Neale, "How Can My Home, School or Church Ever Be a Military Objective? Loss of Protection by Use, Purpose or Location", in *Urban Warfare*, Proceedings of the 16th Bruges Colloquium, 15–16 October 2015, p. 19. Jachec-Neale maintains that a single multi-storey building used partially for military purposes can be considered in whole as a "specific" military objective within the meaning of Article 51(4)(a) of AP I, provided it fulfils the definition of a military objective under Article 52(2) of AP I. Conversely, a compound comprised of several independent buildings may not be qualified as such if the information reasonably available to the adverse belligerent at the moment of the attack indicates that only some of the independent buildings within the compound are used for military purposes. Determining such a compound as a single military objective in its entirety is incompatible with the definition under Article 52(2) and would likely constitute an indiscriminate attack under Article 51(5)(a) of AP I. *Ibid*., pp. 19–20.

210 ICTY, *Galić*, above note 94, para. 346.

211 An authorized hospital means one that is assigned to medical purposes by a party to the conflict. See the definition of medical units in the above section entitled "Special Protection".

civilian seeking medical care could mistakenly enter the structure, for instance, due to the left signboards indicating that the structure is a hospital. How could the adverse belligerent know that the new population is aware that the structure is not a hospital anymore? How could they assume that a civilian, seeking medical treatment, will not enter it?

When, in the extreme, a hospital becomes a military objective and is liable to direct attack, it is recommended that the "warning procedural requirements" under the relevant provisions governing the loss of special protection are expanded to hospitals that do not fall within the meaning of IHL. According to the ICRC's Customary Law Study, "a lot of practice does not expressly require medical units to be recognised and authorised by one of the parties".[212] Moreover, under the Rome Statute of the International Criminal Court, the war crime of "[i]ntentionally directing attacks against … *hospitals and places where the sick and wounded are collected*, provided they are not military objectives",[213] is not confined to the IHL definition of authorized medical units. These factors seem to indicate that States, upon recognition that a facility is being used to provide medical care to the wounded and sick, acknowledge the existence of special protection attached to it.[214] There is no difference between the protective status of the wounded and sick in "authorized" and "unauthorized" hospitals, and thus, it does not make much sense to deprive the latter of the opportunity of being evacuated. Finally, the principle of precaution requires belligerents to do everything feasible to verify that the objectives (persons and objects) are neither civilian nor enjoy special protection but are military objectives.[215] This further includes ascertaining whether the attack does not violate the principle of proportionality, to which the wounded and sick are also entitled.

212 ICRC Customary Law Study, above note 2, commentary on Rule 28, p. 95.

213 Rome Statute of the International Criminal Court, UN Doc. A/CONF.183/9, 17 July 1998 (entered into force 1 July 2002), Arts 8(2)(b)(ix), 8(2)(e)(iv) (emphasis added).

214 This wider interpretation of hospitals has history. In the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, 129 CTS 361, 22 August 1864 (entered into force 22 June 1865), Art. 5, it was codified that "[t]he presence of any wounded combatant receiving shelter and care in a house shall ensure its protection".

215 AP I, Art. 57(2)(a)(i).