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The protection of medical personnel under the Additional Protocols: the notion of 'acts harmful to the enemy' and debates on incidental harm to military medical personnel

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This presentation will be divided in three parts. It will begin with some remarks on the rules protecting the medical mission, the rules governing the conduct of hostilities and their interplay. It will then turn to the conditions under which wounded and sick and medical personnel and objects lose their protection, and it will close with a discussion on the relevance of incidental harm to such persons and objects.

- *Interplay between the rules protecting the medical mission and the rules governing the conduct of hostilities*

The development and clarification of the rules protecting the medical mission and of the rules governing the conduct of hostilities are among the most important features of the 1977 Additional Protocols. These two bodies of rules overlap and complement each other to protect wounded and sick[1] and medical personnel and objects against the effects of hostilities.

The rules affording protection to wounded and sick persons, and to medical personnel and objects are at the origin of the development of modern IHL.[2] Today they regulate multiple issues[3] such as the definition of wounded and sick, medical personnel and objects;[4] the right to use the Red Cross, Red Crescent and Red Crystal emblems;[5] the status and treatment of

*The views expressed in this presentation are those of the author alone and do not necessarily reflect the views of the ICRC. The author would like to thank Alexander Breitegger, Lindsey Cameron and Bruno Demeyere for their useful comments on earlier drafts of this presentation.
[1] The same holds true for shipwrecked even though the presentation will refer to wounded and sick only.
[2] Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, Geneva, 22 August 1864 (1864 Geneva Convention).
[3] Among many others, see Jan Kleffner, 'Advances in the protection of medical personnel, facilities and transports under the Additional Protocols and interpretative challenges on the fundamental obligations to respect and protect' and 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* (2013), 95 (889), 83-127.
[4] Art. 8 of the 1977 First Additional Protocol (AP I).
[5] Arts 38-44 of the 1949 First Geneva Convention (GC I); Arts 41 - 45 of the 1949 Second Geneva Convention (GC II), Arts 18 and 20 to 22 of the 1949 Fourth Geneva Convention (GC IV); Art. 18 AP I; Art. 12 of the 1977 Second Additional Protocol (AP II).

medical personnel upon capture;[6] and the obligation of medical personnel to treat wounded and sick impartially and solely according to medical needs.[7] At the heart of the protection afforded to wounded and sick persons and medical personnel and objects is the obligation to respect and protect them.[8] A vital component of this obligation is the prohibition to attack them.

The rules governing the conduct of hostilities are often referred to as affording general protection, to distinguish them from the rules specifically protecting the medical mission described above.

The rules governing the conduct of hostilities also afford protection against attack to wounded and sick and to medical personnel and objects. Their central feature is the principle of distinction. Parties to the conflict must at all times distinguish between civilians and civilian object on the one hand, and military objectives on the other. Attacks may only be directed against the later, and never against civilians and civilian objects.[9]

Wounded and sick persons, medical personnel and medical objects may be civilians or civilian objects, and protected as such under the principle of distinction and the other rules governing the conduct of hostilities. Furthermore, military medical personnel are not combatants,[10] and the principle of distinction therefore prohibits attacking them.[11] Finally, the prohibition to attack persons 'hors de combat' extends notably to all defenceless wounded and sick, in particular military ones, who may therefore not or no longer be attacked.[12]

Turning to objects, military objectives are limited to those objects which by their nature, location, purpose or use make an effective contribution to military action and whose total or partial destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage.[13] While the view has been expressed that a military medical unit 'prima facie meets [this] test',[14] it is submitted here on the contrary that military medical objects do not meet the definition of military objective (at least as long as they are not use

[6] Arts 28 - 32 GC I; Art. 37 GC II.
[7] Art. 12 GC I; Art. 12 GC II; Arts 9 and 10 AP I; Arts 7 and 9 AP II; ICRC, *Customary International Humanitarian Law, Vol. I: Rules*, Jean-Marie Henckaerts and Louise Doswald-Beck (eds), Cambridge University Press, Cambridge, 2005 (hereinafter ICRC Customary IHL Study), Rule 110; ; 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 edition, 2016*, (hereinafter ICRC 2016 Commentary), para. 765 on common Article 3.
[8] See in particular Arts 12, 19, 20, 24, 35 and 36 GC I; Arts 12, 22, 23 and 36 GC II; Arts 16, 18 and 20 to 22 GC IV; Arts 10, 12, 15, and 21 to 27 AP I; Art. 7, 9 and 11 AP II; Rules 25 to 30 ICRC Customary IHL Study.
[9] Arts 48, 51 and 52 AP I and Art. 13 AP II, Rules 1 and 7 Customary IHL Study.
[10] Art. 43(2) AP I; Rule 3 ICRC Customary IHL Study.
[11] Art. 48 AP I ('*the Parties to the conflict ... shall direct their operations only against military objectives*') and Rule 1 ICRC Customary IHL Study ('*Attacks may only be directed against combatants.*').
[12] Art. 41 AP I; Rule 47 ICRC Customary IHL Study.
[13] Art. 52(2) AP I; Rule 8 ICRC Customary IHL Study.
[14] Ian Henderson, *The Contemporary Law of Targeting: Military Objectives, Proportionality and Precautions in Attack under Additional Protocol I*, Martinus Nijhoff Publishers, Leiden, 2009, p. 195.

to commit acts harmful to the enemy outside of their humanitarian function, see below). Military medical units and transports must be assigned exclusively to the medical purposes exhaustively defined by IHL, i.e. search for, collection, transport, treatment of the wounded and sick, and the prevention of disease.[15] In the exact same way as civilian medical units and transports, they must be used to provide care impartially and solely according to medical needs, whether the wounded and sick are civilians or military, friend or foe.[16] Ensuring care for all military wounded and sick, including for those of the enemy wounded on the battlefield, and not only for a party's own military wounded and sick personnel, has been at the heart of the specific protection since the adoption of the very first 1864 Geneva Convention.[17] While at that time, military medical facilities and transports may not have been afforded protection other than the specific protection, as the rules on the conduct of hostilities were not clearly codified then, this is no longer the case. Military medical objects no more fulfil the contemporary definition of military objective than civilian medical objects do. Indeed, the definition of military objective adopted in 1977 crystallizes a development towards a more restrictive concept than the limits previously set by IHL,[18] and has been said to require 'a direct nexus to military operations'.[19] In view of the fact that military medical objects must be assigned exclusively to specifically defined medical purposes, that they must be used to carry out these medical tasks impartially, including for the benefit of wounded and sick adversaries, that wounded and sick military personnel must refrain from any act of hostilities to avoid losing their specific protection, and that they may possibly never go back to the fight even after being discharged from the medical unit because of long-lasting physical or mental impairment, it is not tenable to argue that military medical objects offer an *effective* contribution to the military action of one party and that their destruction would offer a *definite* military advantage to the party that would carry out the attack. Any contribution that such objects may make to the future military potential of the enemy does not exhibit the close nexus between the object to be attacked and the actual fighting that the contemporary definition of military objective requires.[20] For the rules governing the

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[15] Art. 36 GC I; Art. 22 GC II; Art. 18 GC IV; Art. 8 AP I; Rules 28 and 29 ICRC Customary IHL Study; ICRC 2016 Commentary paras 1787 - 1788 on Art. 19 GC I and paras 2369-2380 on Art. 35 GC I.

[16] See note 7 above. See also *The Joint Service Manual of the Law of Armed Conflict*, JSP 383, Ministry of Defense, U.K., 2004 (U.K. 2004 military manual), para. 7.3.2: "*Paragraph 7.3 [on Protection and Care of the Wounded and Sick] applies to all wounded and sick, whether United Kingdom, allied or enemy, military or civilian. (…) It is forbidden, for example, to give the treatment of United Kingdom and allied wounded priority over the treatment of wounded enemy personnel.*"

[17] Art 6(1) of the 1864 Geneva Convention: "*Wounded or sick combatants, to whatever nation they may belong, shall be collected and cared for*".

[18] See e.g. Hays Parks' criticism of the restrictive character of this definition in W. H. Parks, 'Air War and the Law of War', *32 The Air Force Law Review 1* (1990), pp. 138-144.

[19] Michael N. Schmitt (speaking of 'military advantage' in the second prong of the definition of military objective), 'Targeting in operational law' in Terry D. Gill and Dieter Fleck, *The Handbook of the international law of military operations,* (Oxford, OUP, 2015), p. 279, para. 4. Similarly, Yoram Dinstein requires "*a proximate nexus to 'war-fighting'*" (*The Conduct of Hostilities under the Law of International Armed Conflict*, 2016 (3rd Ed.), Cambridge, Cambridge University Press, para. 293, p. 109).

[20] See also Laurent Gisel, 'Can the incidental killing of military doctors never be excessive?', *International review of the Red Cross*, (2013), 95 (889), 215-230, at pp 219f.

conduct of hostilities, military medical objects such as military hospitals and military ambulances are therefore civilian objects.[21]

Considering hospitals that are not used to commit acts harmful to the enemy outside of their humanitarian function to be military objectives would constitute a significant departure from the very notion of the medical mission under IHL. Moreover, it would be counterproductive to their protection and could even be taken by malicious actors as an encouragement to target them.

The rules protecting the medical mission and the rules governing the conduct of hostilities therefore largely overlap with regard to the protection of wounded and sick, medical personnel and medical objects against attack.

Some of their other provisions differ, however. For example, a warning is required in all circumstances before a specifically protected medical personnel or object may be targeted, and this is true even - or rather especially - when this person or object has become a lawful target.[22] This is not the case for a non-medical civilian taking a direct part in hostilities, or a non-medical object normally dedicated to a civilian purpose but used as a military objective. Both may be attacked without warning to end such participation or use.[23] It is therefore important to underline that the provisions complement each other. When the protection does not exactly overlap, person or objects may be targeted only when they are protected neither by the specific protection nor by the general protection.

- *Conditions under which wounded and sick and medical personnel and objects lose their protection*

Let us now turn to the loss of protection of medical personnel and objects, focusing first on the loss of specific protection, and then on the loss of general protection.

Turning to objects first, the Conventions and Protocols provide that medical objects lose their specific protection when they are used to commit, outside their humanitarian function,

[21] ICRC 2016 Commentary on Art. 19 GC I, para. 1794. Under IHL, civilian objects are all objects that are not military objectives, see Art. 52(1) and Rule 9 ICRC Customary IHL Study. Several military manuals include 'hospitals' in general (and not only 'civilian hospitals') among the examples of civilian objects: *Law of Armed Conflict, Manual,* Joint Service Regulation (ZDv) 15/2, Federal Ministry of Defense, Germany, May 2013, para. 408 ("*hospitals and places where the sick and wounded are collected*"); Côte d'Ivoire, *Droit de la guerre, Manuel d'instruction, Livre III, Tome 1: Instruction de l'élève officier d'active de 1ère année, Manuel de l'élève*, Ministère de la Défense, Forces Armées Nationales, November 2007, pp. 32–33 (as quoted in ICRC Customary IHL Study, practice related to Rule 9); U.K. 2004 military manual, para. 15.16.1 (which mentions "*hospitals, and medical establishments and units*" among objects which are not military objectives; see also para. 5.24.2 which mentions hospitals when discussing civilian objects); in the same vein, the U.S. Chairman of the Joint Chiefs of Staff Instruction, *No-Strike and the Collateral Damage Estimation Methodology*, CJCSI 3160.01, 13 February 2009 includes "*Medical facilities (both civilian and military)*" among "*Objects defined by the Law of War (LOW) as functionally civilian or noncombatant in nature*" (Enclosure B, p. B-1, para.(1) and 2(a)(4)).

[22] Art. 21 GC I; Art. 34 GC II; Art. 19 GC IV; Art. 13 AP I; Art. 11 AP II.

[23] An effective advance warning will nevertheless be required under Art. 57(2)(c) AP I if the attack may affect the civilian population, unless circumstances do not permit, but that type of warning has another purpose.

acts harmful to the enemy. The ICRC had suggested a more precise definition in 1949, namely 'acts the purpose or effect of which is to harm the adverse Party, by facilitating or impeding military operations'.[24] This definition was not included in the law, but Art. 23 of the 1977 First Additional Protocol (AP I) gives one example of an act harmful to the enemy for some categories of medical ships and craft, that is 'the clear refusal to obey a command' to stop, move off or take a certain course. Examples found in the literature include firing at the enemy for reasons other than self-defence; installing a military position on a medical post; sheltering able-bodied combatants; turning a medical unit into a weapons or ammunition depot, or an observation post; using the medical unit to shield a military objective from enemy operations; using medical transport for the deployment of combatants or weapons or for collecting intelligence.[25]

Conversely, the Four Geneva Conventions of 1949 and AP I list a number of situations or acts that may not be considered acts harmful to the enemy.[26] This includes:

- The equipment of medical personnel with light individual weapons for self-defence purposes;
- The presence of sentries or escort;
- The presence of small arms and ammunitions taken from the wounded and sick;
- The fact that civilian medical units also treat wounded and sick combatants or conversely that military medical units also treat wounded and sick civilians.

Art. 22 of the 1949 First Geneva Convention (GC I) on military medical units adds the presence of the veterinary services, maybe a bit of an anachronism today, while Art. 35 of the 1949 Second Geneva Convention (GC II) on hospital ships adds two other situations to the list:

- The presence of means to facilitate navigation and communication;
- The transport of medical personnel and equipment. This last point is today valid more generally, as it is included in the definition of medical transportations and transports given in Art. 8 AP I.

These examples are illustrative and not limitative. To give an example of a situation that is not expressly mentioned in the Conventions or the Protocols, if able-bodied combatants are in a hospital to visit wounded and sick relatives, the hospital is not used to commit an act harmful to the enemy outside its humanitarian function. Provided that such visits do not amount to able-bodied combatants using the hospital as shelter, they may not affect the protection afforded to the hospital. [27]

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[24] ICRC 2016 Commentary on Art. 21 GC I, para. 1840.

[25] See notably ICRC 2016 Commentary on Art. 21 GC I, para. 1842 and Nils Melzer (coordinated by Etienne Kuster), *International Humanitarian Law, a comprehensive Introduction,* ICRC, Geneva, 2016, p. 146.

[26] Arts 22 GC I, 34 GC II, 19 GC IV and Art. 13 AP I.

[27] U.K. 2004 military manual, para. 7.18, includes visits to the wounded and sick among the medical reasons for which combatants may be in medical units under Art. 13(2)(d) AP I. See also United States, Department of Defense, *Law of War Manual* (U.S. DoD Law of War Manual), June 2015 (updated December 2016), para. 7.10.3.6.

A few of issues have raised controversies in the literature or in operations, notably the means of defence available to medical units, the interrogation of wounded and sick, and the transmission of information concerning the wounded and sick.

As mentioned, the presence of sentries or escorts or the fact that medical personnel themselves would carry light individual weapons is not an act harmful to the enemy, and therefore does not deprive the medical personnel, unit or transport of their specific protection. The limitation to individual weapons stems from various grounds: while military units may not be attacked, depending on the circumstances they may be captured by the enemy; medical personnel, sentries or escorts are therefore not authorized to defend against a lawful attempt to capture a medical unit;[28] instead, medical personnel and sentries may use their weapons only in self-defence against illegal attacks; medical personnel may also have to maintain order within the medical unit. The assumption of the law is that light individual weapons will be sufficient to discharge these tasks. Furthermore, protecting the hospital with heavy weapons would entail two risks: first, that the party doing so ends up using the weapons beyond self-defence purposes; and second that the presence of heavy weapons raises the suspicions of the enemy on the real function of the hospital or of the weapons stationed there. This would put the wounded and sick and medical personnel or unit at greater risk of attack.[29] While the relevant articles in the Conventions and Protocol do not discuss the type of weapons that sentries might carry, the ICRC 2016 Commentary states that they may only carry the same weapons as medical personnel, namely light individual weapons.[30] Indeed, the reasons for which sentries are entitled to use their weapons without causing the medical unit to lose its protection against attack are the same as those for which the medical personnel themselves could use a weapon. To be noted that when such sentries are part of the armed forces, they do not become medical personnel. However, in practice they enjoy immunity from attack, as the medical unit that they guard remains protected.[31]

On this basis, how to deal with a situation where a belligerent genuinely concludes that a medical unit faces a threat requiring heavy weapons to defend against? To station such heavy weapons outside the medical unit would ensure that the unit does not lose its specific

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[28] See e.g. *Law of Armed Conflict, Manual,* Joint Service Regulation (ZDv) 15/2, Federal Ministry of Defense, Germany, May 2013, para. 617; U.K. 2004 military manual, para. 7.16; U.S. DoD Law of War Manual (updated December 2016), para. 7.10.1.3; Tom Haeck, 'Loss of protection', in Andrew Clapham, Paola Gaeta, Marco Sassòli (eds), *The Geneva Conventions, A commentary*, 2015, Oxford, Oxford University Press, p. 846, para. 25.
[29] ICRC 2016 Commentary on Art. 22 GC I, para. 1873.
[30] ICRC 2016 Commentary on Art. 22 GC I, para. 1874. The U.S. DoD Law of War Manual (updated December 2016) states that GC I "*does not specifically restrict the weapons that medical units or facilities may have. Military medical units and facilities may be armed to the extent necessary to enable them to defend themselves or their patients against unlawful attacks*" but that "*medical units or establishments should not be armed such that they would appear to an enemy military force to present an offensive threat*". It explains that "*U.S. military medical and religious personnel have generally not been authorized to carry or employ crew-served weapons, hand grenades, grenade launchers, antitank weapons, or Claymore munitions*" (para. 7.10.3.4).
[31] 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, p. 204, on Art. 22 GC I.

protection. They should actually be placed as far as possible from the medical unit as military requirements allow, to avoid the risk that the medical unit would suffer from incidental harm when combatants use such heavy weapons in hostilities.[32]

Let me turn to the second question, namely interrogation. May the party to the conflict that controls the hospital collect information from the patients? Information of a medical nature, obviously it may. Also, patients must be asked about their identity as soon as possible, to inform the families notably in case of the death of the patient. This is foreseen in detail in the Geneva Conventions,[33] and should be considered as appropriate information to be collected from patients in any hospital in an armed conflict. Wounded and sick people who come back from the battlefield may however also hold important up-to-date military information about the enemy tactical situation or operations. Such military intelligence is key to the efficient conduct of the fight. While the interrogation for military purposes of a single wounded or sick person is unlikely to cause a whole medical unit to lose its specific protection, it seems reasonable to consider that a medical unit in which such information would be systematically collected from the wounded and sick is in fact being used to commit acts harmful to the enemy outside of its humanitarian function. The United States is said to have refrained from interrogating wounded enemy fighters on hospital ships during the 2003 war in Iraq for this very reason.[34]

The situation is similar for the transmission of information: the information that parties must collect must also be transmitted, as soon as possible,[35] and such transmission, required by the law, may obviously not be considered an act harmful to the enemy. Information on the number of wounded and sick and type of injuries is necessary in particular to allow a proper planning of their evacuation and of the logistics that re-supplying the medical unit entails, while the identity of the wounded and sick is necessary for tracing purposes, but no information of military nature may be transmitted.

Very importantly however, the use of a medical object for acts harmful to the enemy outside of the humanitarian function of the object does not immediately cause the loss of the specific protection. As noted above, a warning must be given in all cases, setting whenever appropriate a reasonable time-limit.[36]

Let us now turn to the question of whether the loss of the specific protection of a medical unit necessarily entails the loss of its general protection as well. Under the rules governing the conduct of hostilities, attacks may only be directed at military objectives. Assuming that an act harmful to the enemy is understood as had been suggested by the ICRC in 1949 namely as 'facilitating or impeding military operations', the medical object used in such a

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[32] See Art. 19(2) GC I; Art. 18(5) GC IV; Arts 12(4) and 58 AP I.
[33] Art. 16 GC I; Arts 17, 120 and 122 GC III.
[34] Gregory P. Noone and al., 'Prisoners of war in the 21st century: issues in modern warfare', *50 Naval Law Review* (2004), pp 1 - 69, at pp 39-40.
[35] See note 33 above.
[36] See note 22 above and text in relation to it.

way will in many cases also fulfil the definition of military objective.[37] There may be exceptions however. For example, as noted above, a medical ship not obeying a clear command to stop, move off or take a certain course may lose its specific protection; however, as recalled by the San Remo Manual on Naval Warfare, if hospital ships and other vessels exempt from attack lose their specific protection, they may be attacked only if, among other conditions "*the circumstances of non-compliance are sufficiently grave that the hospital ship has become, or may be reasonably assumed to be, a military objective*".[38] Not obeying a clear command to stop, move off or take a certain course is not necessarily sufficient, in and of itself, to fulfil the definition of military objective. In many cases however, the same act will simultaneously entail the loss of specific and general protection - with the important caveat that the loss of specific protection requires a warning to be given.

The situation is similar for medical personnel, though with slight differences. The Geneva Conventions and the Additional Protocols do not include rules on the loss of the specific protection of medical personnel. However, the ICRC Customary IHL Study concluded that military medical personnel, like objects, lose their specific protection if they commit, outside their humanitarian function, acts harmful to the enemy.[39] For example, it is generally considered that taking a direct part in hostilities constitutes an act harmful to the enemy. Conversely, it is often noted that acts harmful to the enemy include *indirectly* interfering with enemy military operations,[40] and would therefore be a broader notion than direct participation in hostilities.[41] In any case, civilian medical personnel remain protected against attack unless and for such times as they take a direct part in hostilities, because they are civilians - a loss of specific protection due to the commission of acts harmful to the enemy that *indirectly* interfere with enemy military operations does not entail a loss of the general protection. Such civilian medical personnel may not be attacked, but the belligerents are no longer obliged not to unduly interfere with the exercise of the medical function that such personnel may still carry out, and, depending on the specific circumstances and act committed, this medical personnel may be interned or prosecuted under domestic law for the commission of the harmful act outside of his or her medical function. While the situation is less clear for military medical personnel, it has been advocated that the loss of specific protection should similarly be limited to acts that amount to direct participation in hostilities, because this notion would be a more relevant criteria for persons than the notion of acts harmful to the enemy, which had been developed for objects.[42]

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[37] ICRC 2016 Commentary on Art. 21 GC I, para. 1847.

[38] San Remo Manual on International Law Applicable to Armed Conflicts at Sea, 12 June 1994, paragraphs 51(c) and 52(c).

[39] ICRC Customary IHL Study, Rule 25.

[40] ICRC 2016 Commentary on Art. 21 GC I, para. 1841.

[41] ICRC 2016 Commentary on Art. 24 GC I, para. 2003; M. Bothe, K. Partsch and W. Solf, *New Rules for Victims of Armed Conflicts,* Martinus Nijhoff Publishers, Leiden Boston 2013 (2e ed), p. 411, para.2.10.2 (on Art. 57(3) AP I); Haeck, note 28 above, p. 842, para. 11.

[42] Marco Sassòli, 'When do medical and religious personnel lose what protection?' in *Vulnerabilities in Armed Conflicts: Selected Issues*, 14th Bruges Colloquium 17-18 October 2013, proceedings, pp 50-57, at p. 54.

- *Relevance of incidental harm to wounded and sick combatants and military medical personnel and objects*

Let me now turn to the last part of my presentation, the relevance of incidental harm to wounded and sick combatants, and military medical personnel and objects.

This issue is relevant when a medical unit or transport has lost its specific protection, because wounded and sick patients and medical personnel in this medical unit may still be protected. It is also relevant more generally when the target is a separate military objective, the attack of which is expected to cause incidental harm to specifically protected persons and objects.

To illustrate the first situation, let us take the scenario of a military observation and transmission post located on the roof of a hospital building in a manner turning the building into a military objective; let us further assume that the military post is not removed following a warning that had set an appropriate time-frame. The fact that the building becomes a lawful target does not affect the protection afforded to the wounded and sick and the medical personnel in that building. They all remain specifically protected persons, and - as will be discussed below - all feasible precautions must be taken in the choice of means and methods of warfare to avoid or at least minimize incidentally harming them, and such harm may not be excessive in relation to the concrete and direct military advantage anticipated. Provided it is 'feasible' as understood in IHL, it might require directing the attack on the roof-top only, without damaging the rest of the hospital building, or even capturing the hospital rather than attacking it.

The title of the presentation mentions incidental harm to military medical personnel, but let us address more generally incidental harm to wounded and sick and medical personnel and objects other than civilians. Indeed, wounded and sick civilians and civilian medical personnel and objects undoubtedly enjoy the general protection afforded to all civilians by the principles of proportionality and precautions, precisely because they are civilians.[43] Whether the same is true for wounded and sick combatants and military medical personnel and objects is less evident at first sight. Indeed, the rules on proportionality and precautions in the First 1977 Additional Protocol explicitly speak of incidental loss of *civilian* life, injury to *civilian* and damage to *civilian* objects.

This debate has taken more prominence since the publication of the United States Department of Defense Law of War Manual in June 2015. The Manual held the view that the respect and protection due to wounded and sick combatants and military medical personnel and units does not require to consider expected incidental harm to these persons and objects when assessing proportionality, because they are deemed to have accepted the risk of incidental harm due to their proximity to military objectives, and such harm therefore

[43] Arts 51 and 57 AP I.

gives no just cause for complaint.[44] Discussing incidental harm to several categories of persons, mainly civilians, that the Manual had excluded on this or similar[45] ground, Hathaway and Lederman argued that such ground was 'indefensible', and amounted to making 'proportionality … meaningless'.[46]

In December 2016, the manual was amended.[47] The updated manual notably recognized the relevance of incidental harm to categories of civilians originally excluded from the proportionality analysis on the ground of their 'assumption of risk'[48] - a radical change to be commended. It also highlighted repeatedly the obligation to reduce incidental harm to wounded and sick combatants and military medical personnel and objects as part of the required precautions, a welcome clarification.[49] It however retained the view that military medical personnel and objects have 'accepted the risk' of incidental harm, and continued to reject the relevance of incidental harm to such persons and objects for the principle of proportionality.[50] One of the manual's new paragraphs explained that "*The exclusion of*

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[44] U.S. DoD Law of War Manual, June 2015, in particular paras 7.3.3.1, 7.8.2.1, 7.10.1.1, 17.14.1.2, 17.15.1.2 and 17.15.2.2.

[45] In particular according to para. 5.12.3.2 of the U.S. DoD Law of War Manual, June 2015, certain individuals who may be employed in or on military objectives are "*deemed to have assumed the risk of incidental harm from military operations*".

[46] Oona Hathaway, 'The Law of War Manual's Threat to the Principle of Proportionality', 23 June 2016, at https://www.justsecurity.org/31631/lowm-threat-principle-proportionality/ and Marty Lederman, 'Troubling proportionality and rule-of-distinction provisions in the Law of War Manual' 27 June 2016, at https://www.justsecurity.org/31661/law-war-manual-distinction-proportionality/.

[47] For a discussion of this amendment, including on the issues discussed in this presentation, see e.g. Geoffrey S. Corn, 'Initial Observations on the Law of War Manual Revision: "Three ups/Three downs", 14 December 2016, at https://www.justsecurity.org/35531/initial-observations-law-war-manual-revision-three-upsthree-downs/ and Marty Lederman, 'Thoughts on Distinction and Proportionality in the December 2016 Revision to the Law of War Manual', 19 December 2016, at https://www.justsecurity.org/35617/thoughts-distinction-proportionality-december-2016-revision-law-war-manual/.

[48] Compare in particular U.S. DoD Law of War Manual, June 2015, para. 5.12.3.2 "*Harm to certain persons who may be employed in or on military objectives would be understood not to prohibit attacks under the proportionality rule. These categories include (…) civilian workers who place themselves in or on a military objective, knowing that it is susceptible to attack, such as workers in munitions factories. These persons are deemed to have assumed the risk of incidental harm from military operations*" with U.S. DoD Law of War Manual, updated December 2016, para. 5.12.3.3 *"Provided such workers [civilian workers who support military operations in or on military objectives] are not taking a direct part in hostilities, those determining whether a planned attack would be excessive must consider such workers, and feasible precautions must be taken to reduce the risk of harm to them*".

[49] U.S. DoD Law of War Manual, updated December 2016, in particular paras 5.10, 5.10.1.2, 5.11, 7.3.3.1, 7.8.2.1, 7.10.1.1, 7.12.2.5, 17.14.1.2, 17.15.1.2 and 17.15.2.2. This obligation was already mentioned in the first sentence of para. 5.11 of the June 2015 manual. The importance of underlining the requirement to reduce incidental harm to wounded and sick combatants and military medical personnel and objects cannot be overemphasized. It is also telling, because Art. 57(2)(a)(ii) AP I speaks of avoiding or reducing incidental harm to civilians and civilian objects with the very same words used in the rule of proportionality in Arts 51 and 57 AP I.

[50] U.S. DoD Law of War Manual, updated December 2016, paras 5.10.1.2, 7.3.3.1, 7.8.2.1, 7.10.1.1, 17.14.1.2, 17.15.1.2 and 17.15.2.2. In the June 2015 manual, these paragraphs of chapters 7 and 17 expressly stated that incidental harm to such person and objects needed not be considered when assessing proportionality. In the December 2016 updated manual, these paragraphs mention that such incidental harm "*does not serve to exempt nearby military objectives from attack*". However, para. 5.10.1.2 clarified that the December 2016 updated Manual continued to exclude such persons and object from the scope of the principle of proportionality.

protected military personnel and military medical facilities from this prohibition [proportionality] *reflects such factors as, among others, the general impracticality of prohibiting attacks on this basis during combat operations*. *For example, the expected incidental harm to a sick-bay on a warship would not serve to exempt that warship from being made the object of attack*.[51]

Along an apparently similar line, Corn and Culliver held the view that extending the principle of proportionality to wounded and sick combatants and military medical personnel would be inconsistent with the nature of combat operations.[52] They suggested however that the Martens Clause would nevertheless require to consider incidental harm to specifically protected persons and objects other than civilians when operationally feasible.[53]

Without downplaying the challenges of assessing proportionality during combat operations, it is only a narrow aspect of the issue which should not obscure the broader perspective. Furthermore, the law already takes operational reality into consideration.

First, it is only a narrow aspect of the issue. The scenario that Corn and Culliver use to illustrate their argument relates to combatants who become wounded during the initial stages of an operation,[54] and the U.S. DoD Law of War Manual might have the same concern in mind when stating that prohibiting attacks on the basis of the rule of proportionality would be impractical during combat operations. However, this has no bearing on the feasibility to assess incidental harm to persons and objects that are already specifically protected at the time of the planning of and decision upon the attack, such as fixed or mobile medical units, including medical personnel and wounded and sick present therein. In the view of the ICRC, such incidental harm can and must be considered, irrespective of whether the concerned persons or objects are civilians or belong to the armed forces. The specific challenges raised by the scenario discussed by Corn and Culliver do not justify to wholly reject the relevance of incidental harm to wounded and sick combatants and military medical personnel and object for the principle of proportionality.

Second, the law already takes into account operational requirements. While it is important to recall that the prohibition of disproportionate attack is absolute, the precautions required to assess whether incidental harm would be excessive are qualified by what is 'feasible'.[55] What precautions are feasible depends on the circumstances at the time, including

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[51] U.S. DoD Law of War Manual (updated December 2016), para. 5.10.1.2.

[52] Geoffrey S. Corn and Andrew Culliver, 'Wounded Combatants, Military Medical Personnel, and the Dilemma of Collateral Risk' (December 13, 2016), at http://dx.doi.org/10.2139/ssrn.2884854 p. 10; see also Geoffrey Corn, 'Transatlantic Workshop on International Law and Armed Conflict: Wounded and Sick, Proportionality, and Armaments', 10 October 2017, at https://www.lawfareblog.com/transatlantic-workshop-international-law-and-armed-conflict-wounded-and-sick-proportionality-and, and John Merriam, 'Must Military Medical and religious Personnel Be Accounted for in a Proportionality Analysis?' 8 June 2016, at https://www.justsecurity.org/31905/military-medical-religious-personnel-accounted-proportionality-analysis/.

[53] Corn and Culliver, *ibidem*, pp 14- 17.

[54] *Ibidem*, p. 10. See also the different hypothetical in Corn 2017, note 52 above.

[55] ICRC Customary IHL Study, Rule 18.

humanitarian and military considerations.[56] It goes without saying that the precautions that can be taken to refrain from disproportionate attacks by the ground commander in the middle of an on-going military operation are more limited than those that can be taken during the planning process for deliberate targeting.

It is also worth noting that under Art. 57(2)(b) AP I and customary IHL,[57] an attack must be cancelled or suspended if it becomes apparent that the attack may be expected to be disproportionate. This rule is undoubtedly relevant in a situation where civilians, whether medical personnel or not, would rush to treat or evacuate wounded combatants in the midst of a military engagement, for example in the immediate aftermath of a first salvo. This shows that the law already envisages how the rule of proportionality must be applied when the situation changes during the execution of an attack. The challenges of doing so should therefore not be deemed so insurmountable as to justify disregarding the relevance of incidental harm to specifically protected persons and objects other than civilians in such situation.

Let us recall that the obligation to search and collect wounded and sick apply 'at all times' and must be implemented 'without delay' and therefore also during an engagement, as soon as circumstances permit.[58] The application of the principles of proportionality and precautions with regard to the incidental harm to medical personnel, including military medical personnel, decreases the risks that such personnel face. It therefore enables the parties to the conflict to discharge their obligation to search and collect all wounded and sick as soon as possible. To disregard the relevance of incidental harm to military medical personnel would also discriminate against them compared to civilian medical personnel, while one of the advances of the 1977 Additional Protocols was precisely to ensure that all medical personnel and objects, whether civilian or military (and all wounded and sick, whether military or civilians) enjoy the same protection.[59]

Finally, the abovementioned sick-bay example given in the U.S. DoD Law of War Manual misses the point.[60] As explained in the commentary by Bothe, Parsch and Solf, targeting warships is not prohibited despite the presence of a sickbay because the incidental harm will normally not be excessive when attacking a warship.[61] This is precisely an application of the

[56] See the definition of feasible precautions e.g. in Art. 3(4) of the CCW Protocol on Prohibitions or Restrictions on the Use of Mines, Booby-Traps and Other Devices (Protocol II), 1980, and in the States practice referred to in ICRC Customary IHL Study, p. 54. Corn and Culliver actually use strikingly similar wording when concluding that, under the Marten Clause approach they suggest, the obligations to consider incidental harm to specifically protected military personnel and objects would arise '*only when doing so is assessed as feasible under the circumstances*' (Corn and Culliver, note 52 above, p. 16).

[57] Rule 19 ICRC Customary IHL Study.

[58] Art. 15 GC I; Rule 109 ICRC Customary IHL Study; ICRC 2016 Commentary on Art. 15 GC I, para. 1488.

[59] For more details, see Gisel, note 20 above, pp 224f.

[60] See text in relation to note 51 above.

[61] Discussing Art. 12(4) AP I, Bothe clarifies that: "*The problem of collateral damage is dealt with in more detail, with respect to the civilian population, in Arts. 51 et seq. It is significant that Art. 12, para. 4 states, with respect to medical units, two rules which are also found in Part IV, Section I of the Protocol. The first sentence of para. 4*

principle of proportionality, not an acknowledgement that such incidental harm would be irrelevant.

Turning to military practice, there should be little doubt that such incidental harm has been considered in proportionality assessment during armed conflicts. In particular, the 2009 U.S. Chairman of Joint Chiefs of Staff Instruction *No-Strike and the Collateral Damage Estimation Methodology*, defined collateral damage as harm to "*persons or objects that would not be lawful military targets in the circumstances ruling at the time*".[62] This includes protected persons and objects other than civilians, which must therefore be considered - and assuredly have been considered in practice.[63] While policies - and therefore also practices - might have considered incidental harm to non-combatants even beyond the requirements of IHL in specific instances,[64] the *Collateral Damage Estimation Methodology* Instruction dispels any doubt that its requirement in this regards would have been stated as a matter of policy only: "*the LOW [Law of War] also stipulates that anticipated civilian or noncombatant injury or loss of life and damage to civilian or noncombatant property incidental to attacks must not*

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is a corollary of Art. 51, para. 7. Protected objects and persons may not be used to "shield" military targets. The second sentence prescribes ("whenever possible") a precautionary measure which, for military medical units, is already provided for in Art. 19 of the First Convention and is a corollary of Art. 58, Protocol I. Article 12, para. 4 and Art. 19 of the First Convention show that, with respect to collateral damage, the rules which protect the civilian population against such damage constitute also, at least in principle, an adequate solution concerning the same problem as it arises in relation to medical units. Thus, the principle of proportionality applies in this case as well. The principle of proportionality is a general principle of the law of armed conflict which has found its expression in such provisions as the prohibition of "unnecessary" suffering (Art. 23 (c) of the Hague Regulations of 1907). It is not restricted to the question of the protection of the civilian population for which it has now been codified by Part IV of Protocol I. An obvious example that medical units cannot be exempted by law from suffering collateral damage is the existence of sickbays on men of war. If it were inadmissible to subject medical units to collateral damage, no attempt to sink a warship with a sickbay aboard would be permissible.

In applying the proportionality test to the protection of medical units against collateral damage, everything depends on the concrete situation. The yardstick of proportionality is the concrete and direct military advantage anticipated. If a medical unit operates near an important firing position (which it often has to do), the neutralization of this position constitutes a great advantage for the enemy and the enemy is consequently entitled to run the risk of causing a high degree of collateral damage within the medical unit as a result of the attack directed against the firing position. On the other hand, small and unimportant military objectives may not be attacked if this may be expected to cause important collateral damage within major medical units such as field hospitals." (Bothe, Partsch and Solf, note 41 above, p. 128, para. 2.2 on Art. 12 AP I).

[62] U.S. Chairman of the Joint Chiefs of Staff Instruction, *No-Strike and the Collateral Damage Estimation Methodology*, CJCSI 3160.01, 13 February 2009, Glossary, p. GL-4. Similiarly, the U.S. Joint Targeting, Joint Publication 3-60 (3 January 2013) defines collateral damage as '*[u]nintentional or incidental injury or damage to persons or objects that would not be lawful military targets in the circumstances ruling at the time*' (p. GL - 4 Terms and definitions).

[63] As noted by Lederman: "*It is hard to imagine that U.S. commanders very often, if ever, order a strike in which the expected harm to protected military personnel, such as medical personnel, and the sick and wounded, would be excessive in relation to the expected direct and concrete military advantage.*" (Lederman, note 47 above).

[64] The 22 May 2013 U.S Presidential Policy Guidance *Procedures for approving direct action against terrorist target locate outside the United States and Areas of Active Hostilities* required "*[n]ear certainty that non-combatants will not be injured or killed*" (sections 1.C(8), 1.E(2) and 5.A.2(2)), noting that "[*f]or purposes of this PPG, non-combatants are understood to be individuals who may not be made the object of attack under the law of armed conflict*" (p. 1).

be excessive in relation to the expected military advantage to be gained".[65] Similar views also appear - though not always consistently - in military manuals of Australia,[66] Canada,[67] the Netherlands,[68] New Zealand,[69] Philippines[70], Switzerland,[71] the United Kingdom,[72] and

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[65] U.S. Chairman of the Joint Chiefs of Staff Instruction, *No-Strike and the Collateral Damage Estimation Methodology*, CJCSI 3160.01, 13 February 2009, Enclosure D, p. D-1. It continues as follows: "*Failure to observe these obligations could result in disproportionate negative effects on civilians and noncombatants and be considered a LOW violation. Furthermore, U.S. leadership and military could be subject to global criticism, which could adversely impact military objectives, alliances, partnerships, or national goals. The U.S. government places a high value on preserving civilian and noncombatant lives. The U.S. military must emulate and represent these values through the conscientious use of force in the accomplishment of assigned military missions.*)." According to the CJCSI 3160.01 Instruction's Glossary: "*noncombatant. Military medical personnel, chaplains, and those out of combat, including prisoners of war and the wounded, sick, and shipwrecked*" (p. GL-7).

[66] *Law of Armed Conflict*, Australian Defence Doctrine Publication 06.4, Australian Defence Headquarters, 11 May 2006, includes non-combatants other than civilians when setting out the principle of proportionality (para. 2.8).

[67] *The Law of Armed Conflict at the Operational and Tactical Levels*, Office of the Judge Advocate General, Canada, 13 August 2001, para. 204.5: Deciding whether the principle of proportionality is being respected "*involves weighing the interests arising from the success of the operation on the one hand, against the possible harmful effects upon protected persons and objects on the other*. (emphasis added) However, most other statements of the principle of proportionality mention "*collateral civilian damage*", including para. 204.4 stating the principle of proportionality immediately before the paragraph quoted here.

[68] *The Humanitarian Law of War, A Manual*, Royal Army of the Netherlands, September 2005, paras 227 – 228 in Chapter 2 'General concepts and terms', Section 4 'Principles': "*0227. Proportionality There is a discordance between the principles of military necessity and of humane treatment. (…) The humane principle, however, places limits on this freedom of action, because unnecessary suffering must be avoided, and non-combatants respected. 0228. For this reason, it is inadmissible for weapons and methods of combat to go beyond this, e.g., to cause excessive suffering or excessive damage to non-military targets (collateral damage).*" (unofficial translation available at ICRC library) However, statements of the principle of proportionality in chapter 5 'Behaviour in battle' when discussing Arts 52 and 57 AP I focus on incidental civilian harm.

[69] *Interim Law of Armed Conflict Manual*, DM 112, New Zealand Defence Force, Headquarters, Directorate of Legal Services, Wellington, November 1992, para. 207: "*The principle of proportionality establishes a link between the concepts of military necessity and humanity. This means that the commander is not allowed to cause damage to non-combatants which is disproportionate to military need ...It involves weighing the interests arising from the success of the operation on the one hand, against the possible harmful effects upon protected persons and objects on the other*." (emphasis added)

[70] *Air Power Manual*, Philippine Air Force, Headquarters, Office of Special Studies, May 2000, paras. 1-6.4: '*The chief unifying principle always applies-that the importance of the military mission (military necessity) determines, as a matter of balanced judgment (proportionality), the extent of permissible collateral or incidental injury to [an] otherwise protected person or object*.' (emphasis added)

[71] Switzerland, *Bases légales du comportement à l'engagement (BCE)*, Règlement 51.007/IVf, Swiss Army, 1 July 2005, para. 163: "*Principle of proportionality… Military action is only permissible if the loss of human life and damage to civilian or specially protected objects are not excessive in relation to the concrete and direct military advantage anticipated*." In the same vein, para. 225 states with regard to indiscriminate attacks (of which proportionality is an example according to Art. 51(5) AP I): "*Prohibited methods of warfare… Indiscriminate attacks, i.e. attacks which cannot distinguish between protected persons/objects and military objectives.*" (as quoted in the practice related to Rules 14 and 25 of the ICRC Customary IHL Study)

[72] U.K. 2004 military manual, para. 13.5(g): "*For the purposes of this chapter [maritime warfare] certain terms are defined below (…) (g) 'collateral casualties' or 'collateral damage' means the loss of life of, or injury to, civilians or other protected persons, and damage to or the destruction of the natural environment or objects that are not in themselves military objectives*" and para. 13.32 (d) "*With respect to attacks, the following precautions shall be taken: (…) (d) an attack shall not be launched if it may be expected to cause collateral casualties or damage which would be excessive in relation to the concrete and direct military advantage anticipated from the attack as a whole; an attack shall be cancelled or suspended as soon as it becomes apparent that the collateral casualties or damage would be excessive.*" (emphasis added) The statement of the

the United States.[73] This is also the view, under customary law, of the San Remo Manual on Naval Warfare,[74] of the Committee Established to Review the NATO Bombing Campaign against the Federal Republic of Yugoslavia (with regard to persons),[75] and of the International Law Association Study Group on the conduct of hostilities.[76]

The ICRC believes that this is the better view.[77] It is submitted here that the relevance of incidental harm to protected persons other than civilians for the principles of proportionality and precautions has two mutually reinforcing sources: the rules affording specific protection to the medical mission and the rules governing the conduct of hostilities.

As recalled at the outset of this presentation, the obligation to respect and protect is at the core of the protection of the medical mission. The ICRC considers that the obligation to "respect" requires duties of abstention, such as not attacking the medical mission, whether directly, indiscriminately or in violation of the principle of proportionality.[78] A memorandum

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principle of proportionality in chapter 5 on *The Conduct of Hostilities* reproduces however the wording of the proportionality rule in AP I (see para. 5.33).

[73] *The Commander's Handbook On The Law Of Naval Operations*, U.S. Navy, NWP 1-14M, August 2017: para. 8.11.2 "*The legal requirement to attack only military objectives and to avoid excessive incidental injury/death and collateral damage to noncombatants, civilians, and civilian objects applies when identifying targets for physical attack/destruction as part of an offensive IO [information operation] plan"* and para. 8.11.4: "*In employing nonlethal means of OCO [offensive cyberspace operations] against a military objective, factors involved in weighing anticipated incidental injury/death to protected persons can include, depending on the target, indirect effects.* The general statement of the principle of proportionality in para. 5.3.3. also seems to imply that the relevant incidental harm is not limited solely to harm to civilians and damage to civilian objects: "*The principle of proportionality requires a commander to conduct a balancing test to determine if the expected incidental injury resulting from an attack, including harm to civilians and damage to civilian objects, would be excessive in relation to the concrete and direct military advantage anticipated to be gained from the attack*". (all emphasis added)

[74] The paragraph on 'Definitions' in the San Remo Manual on International Law Applicable to Armed Conflicts at Sea states that "*collateral casualties or collateral damage means the loss of life of, or injury to civilians or other protected persons, and damage to or the destruction of the natural environment or objects that are not in themselves military objectives"* (Louise Doswald-Beck (ed.), San Remo Manual on International Law Applicable to Armed Conflicts at Sea, International Institute of Humanitarian Law, Cambridge University Press, Cambridge, 1995, p. 9, para. 13(c) (emphasis added); see also 'Explanation', p. 87, para. 13.9).

[75] In its Final Report to the Prosecutor, the Committee Established to Review the NATO Bombing Campaign Against the Federal Republic of Yugoslavia mentioned "*injury to non-combatants*" (and not 'injury to civilians') when speaking of incidental harm under the principle of proportionality (paras. 49 and 50).

[76] The Final Report of the International Law Association Study Group on the conduct of hostilities concludes that "*While some members of the SG [Study Group] initially favored a literal reading of the proportionality rule, the SG agreed that incidental killings of or injury to protected persons other than civilians render the attack prohibited if it is excessive compared to the concrete and direct military advantage anticipated - whether one anchors this finding in the rules on the protection of medical mission (and in particular the obligation to protect and respect medical personnel including military medical personnel), in the rules on the conduct of hostilities, or in both."* (p. 27), at https://ila.vettoreweb.com/Storage/Download.aspx?DbStorageId=3763&StorageFileGuid=11a3fc7e-d69e-4e5a-b9dd-1761da33c8ab).

[77] See ICRC 2016 Commentary on GC I, paras 1353 - 1357 on Art. 12, para. 1797 on Art. 19 and para. 1987 on Art. 24; ICRC, *International humanitarian law and the challenges of contemporary armed conflicts*, Report, Geneva, October 2015, 32IC/15/11, pp 31-32, at https://www.icrc.org/en/download/file/15061/32ic-report-on-ihl-and-challenges-of-armed-conflicts.pdf.

[78] ICRC 2016 Commentary on GC I, para. 1357 on Art. 12, para. 1797 on Art. 19 and para. 1987 on Art. 24.

by the U.S. Secretary of Defense seems to go in this direction when requiring that *"[c]onsiderations of humanity, proportionality, and honor should guide combatants in all their interactions with the wounded and sick*" and placing this requirement under the overall obligation that "*[a]ll the wounded and sick, whether or not they have taken part in the armed conflict, shall be respected and protected".*[79]

Disregarding the relevance of incidental harm to specifically protected persons and objects would indeed be incoherent with the very concept of the specific protection, which implies a more stringent protection than the one generally guaranteed to civilians and civilian objects,[80] a view also expressed most recently by Boothby and Heintschel von Heinegg.[81] Military instructions on collateral harm and academic writings reflect such a more stringent protection.[82]

In any case, as noted above, medical units and transports, whether civilian or military, do not fulfil the definition of military objective.[83] Military medical units and transport are therefore civilian objects for the rules governing the conduct of hostilities, and protected by the principle of proportionality as expressed in Articles 51 and 57 AP I.

If incidental harm to military medical objects is relevant, the same must be true for incidental harm to persons discharging the same function (military medical personnel) and persons in favour of whom the specific protection has been established in the first place (the

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[79] Ash Carter, Secretary of Defense, Memorandum *Principles Related to the Protection of Medical Care Provided by Impartial Humanitarian Organizations During Armed Conflict*, 3 October 2016, para. II. The Memorandum states that *"the statement reflects legal principles related to the protection of the wounded and sick and of impartial humanitarian organizations during armed conflict. Where the principles were not already legally binding as a matter of treaty or custom, the statement conveys the United States' support for the recognition of the principles as customary international law*".

[80] For more details, see Gisel, note 20 above, pp 224-226.

[81] William H. Boothby and Wolff Heintschel von Heinegg, "*The law of war : a detailed assessment of the US Department of Defense law of war manual"* Cambridge, Cambridge University Press, 2018, p. 450: "*Curiously, paragraph 5.10.1.2 [of the U.S. DoD Law of War Manual] suggests that the prohibition on attacks expected to cause excessive incidental harm does not require consideration of military medical personnel, military wounded and sick and military medical facilities. This seems to be an illogical conclusion. Given that each of these categories of personnel and facility must be respected and protected, and indeed that they are entitled to protection, e.g. in the form of warnings, that goes beyond that to which civilians are entitled, it cannot be right that expected injury or, as the case may be, damage to them is simply ignored in applying the proportionality rule. The better view must be that because of their special protection, such persons and objects must be considered when an attack is being planned or decided upon.*"

[82] For example, the U.S. Chairman of the Joint Chiefs of Staff Instruction, *No-Strike and the Collateral Damage Estimation Methodology*, CJCSI 3160.01, 13 February 2009, includes military medical facilities among "*Category I Protected or Collateral Objects … [which] includes the most sensitive subset of objects defined by the LOW*" (Enclosure B, p. B-1, para. 2(a)(4)) which are as such, put on the no-strike lists (on which medical facilities, schools and interest sites, whether military or civilians, are the third to fifth entities by priority order, Enclosure A to Appendix C, p. C-A-1). Non-specifically protected civilian objects are part of Category II Protected or collateral objects, and do not necessarily appear on the no-strike list. For an example in the academic literature: when introducing the notion of specific protection (often referred to as the special protection), Boothby explains that "*The adjective 'special' implies that there is an identifiable feature to the protection that in some way exceeds that accorded to civilian objects in general*" (William. H. Boothby, *The Law of Targeting* (Oxford, OUP, 2012), p. 232).

[83] See above text in relation to notes 13 to 21.

wounded and sick). To consider otherwise would run counter to the general approach of the rules governing the conduct of hostilities, which protect persons at least as much as objects, and sometimes more.[84]

Finally, medical units and medical aircrafts, whether civilians or military, may not be used to shield or immune military objectives from attack.[85] In the same vein, the war crime of using human shields in the Rome Statute of the ICC is defined as: "*Utilizing the presence of a civilian or other protected person to render certain points, areas or military forces immune from military operations*". If incidental harm to protected persons or objects other than civilians was not relevant for the prohibition of disproportionate attacks, how could they render certain military objectives immune from military operations?[86]

Taking a step back, it is important to underline that IHL is fundamentally rooted in a balance between military necessity and humanity. Kleffner highlighted that to consider that the obligation to respect and protect the medical mission prohibits any incidental harm would overemphasize humanitarian considerations. Conversely, to consider that incidental harm to specifically protected persons other than civilians could never be excessive as a matter of law would overemphasize military considerations. Considering that incidental harm to protected persons and objects may render the attack illegal, but only when such harm is expected to be excessive, appears to strike the very balance that IHL requires.[87] Such an understanding was already expressed shortly after the adoption of the Additional Protocols in Bothe, Partsch and Solf *New Rules for Victims of Armed Conflicts*. As noted above, Bothe expressed it in his commentary on Art. 12 on the protection to medical units,[88] while Solf expressed it in his commentary on Art. 41 on the safeguard of an enemy hors de combat: '[t]he accidental killing or wounding of such persons [hors de combat personnel], due to their presence among, or in proximity to, combatants actually engaged, by fire directed against the latter, gives no just cause for complaint, *but any anticipated collateral casualties of hors de combat persons should not be excessive in relation to the military advantage anticipated*.'[89]

It is therefore submitted that disregarding the relevance of incidental harm to protected persons and objects other than civilians is not tenable as a matter of law. Both the rules affording protection to the medical mission and the rules governing the conduct of hostilities support this conclusion. Beyond the legal debate, it is important in practice in order to

[84] On examples in which the law protect persons more than objects, see e.g. Bothe, Partsch and Solf, note 41 above, p. 411, para. 2.10.2 (on Art. 57(3) AP I).
[85] Arts 12(4) and 28(1) AP I.
[86] For more details, see Gisel, note 20 above, p. 226.
[87] Jan Kleffner, 'Transatlantic Workshop on International Law and Armed Conflict: Wounded and Sick and the Proportionality Assessment', 12 October 2017, at http://intercrossblog.icrc.org/blog/transatlantic-workshop-on-international-law-and-armed-conflict-wounded-and-sick-and-the-proportionality-assessment.
[88] Bothe, Partsch and Solf, note 41 above, p. 128, para. 2.2 on Art. 12 AP I, quoted extensively in note 61 above.
[89] Bothe, Partsch and Solf, note 41 above, para. 2.2.1 on Article 41 AP I, p. 253 (emphasis added).

ensure the continued protection of all those providing emergency medical care close to the fighting in sometimes very difficult and dangerous situations.