When do Medical and Religious Personnel Lose what Protection ?

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Résumé

Les membres du personnel religieux et sanitaire appartiennent à la catégorie de personnes bénéficiant d'une protection spéciale en droit international humanitaire (DIH) en raison de leur fonction. Cette protection n'est cependant pas absolue.

Les circonstances dans lesquelles les membres du personnel religieux et sanitaire peuvent perdre leur protection contre des attaques ne sont pas explicitement définies dans les Conventions de Genève (CG) et leurs Protocoles Additionnels (PA). Ces instruments fournissent cependant certaines indications : la première CG et le premier PA, qui s'appliquent tous deux en cas de conflit armé international, disposent que la protection due aux établissements et aux *unités sanitaires mobiles ne pourra cesser que « s'il en est fait usage pour commettre, en dehors de leur destination humanitaire, des actes nuisibles à l'ennemi ». Dans des situations de conflits armés non-internationaux, le deuxième PA prévoit, de façon similaire, que la protection due aux unités et moyens de transport sanitaires ne pourra cesser que s'ils sont utilisés pour commettre, « en dehors de leur fonction humanitaire, des actes hostiles ». Il est généralement admis que ces dispositions, bien que conçues par les traités afin de s'appliquer aux unités et moyens de transport, peuvent également être appliquées, mutatis mutandis, au personnel religieux et sanitaire.*

Si l'expression « en dehors de leur fonction humanitaire » ne pose pas de problèmes particuliers (*les devoirs du personnel sanitaire étant clairement défini dans les CG), la définition d'* « actes nuisibles à l'ennemi » *est loin d'être évidente. Selon le Comité international de la Croix-Rouge, les actes nuisibles à l'ennemi sont ceux « ayant pour but ou pour effet, en favorisant ou en entravant des opérations militaires, de nuire à la Partie adverse ». Plus concrètement, il peut s'agir d'abriter dans un hôpital des combattants valides ou d'utiliser du personnel médical pour entraver une attaque de l'ennemi. Bien que la plupart des auteurs considèrent que la notion d' « actes nuisibles à l'ennemi » est plus large que celle de « participation directe aux hostilités », les deux expressions ont pour moi la même signification. La différence de terminologie résulte uniquement du fait que l'expression « actes nuisibles à l'ennemi » a été élaborée afin de s'appliquer aux unités et moyens de transport tandis que celle de « participation directe aux hostilités » se réfère aux personnes.*

Il est important de souligner que seuls les actes nuisibles à l'ennemi commis par des membres du personnel sanitaire en dehors de leur mission humanitaire peuvent entraîner une perte de protection. Les soins aux blessés et malades, la prévention de maladies ou le présence sur le champ de bataille afin de recueillir les blessés et malades n'entraîneront jamais une perte de protection, même si les bénéficiaires sont des soldats et si ces actes renforcent la capacité militaire d'une des parties au conflit. En outre, les membres du personnel sanitaire peuvent réaliser un grand nombre d'actes en dehors de leur mission humanitaire, tels que la distribution de nourriture ou le construction d'un pont pour la population civile, sans pour autant que cela entraîne une perte de protection contre des attaques en droit international humanitaire.

Pendant combien de temps les membres du personnel religieux et médical perdent-ils leur protection lorsqu'ils commettent des actes nuisibles à l'ennemi en dehors de leur mission humanitaire ? Cette question est particulièrement complexe en ce qui concerne le personnel médical militaire. Dans l'affaire Galic, le Tribunal pénal international pour l'ex-Yougoslavie a souligné qu'un hôpital cesse d'être protégé pendant le temps où il est utilisé pour commettre des actes nuisibles à l'ennemi. La protection est rétablie dès que l'hôpital n'est plus utilisé à cette fin. Au contraire, les membres du personnel sanitaire militaire qui participent directement aux hostilités ne regagnent pas la protection qui leur est conférée une fois leur participation aux hostilités terminée. La question qui se pose dès lors est celle de leur statut et de leur traitement lorsqu'ils tombent entre les mains de l'ennemi.
La position logique serait de considérer qu'ils demeurent membres du personnel médical. Cependant, dès lors que les membres du personnel sanitaire doivent être immédiatement rendus à la partie au conflit dont ils relèvent, à moins que leur rétention soit nécessaire *afin de soigner les blessés et malades, cette option n'est pas réaliste. En tout état de cause, ils pourront être punis pour leur participation dès lors qu'ils ne sont pas des combattants. Une alternative serait de considérer qu'en participant directement aux hostilités, les membres du personnel sanitaire militaire – en tant que membres des forces armées – perdent de manière permanente leur statut de personnel sanitaire et deviennent ainsi des combattants. Ils pourraient dès lors être détenus en tant que prisonniers de guerre jusqu'à la fin des hostilités, mais ne pourraient pas être punis pour avoir commis des actes nuisibles à l'ennemi. Une troisième et dernière possibilité serait de considérer comme des civils les membres du personnel sanitaire militaire ayant perdu leur protection en tant que personnel sanitaire. Cette interprétation présente l'avantage d'exiger une évaluation au cas par cas de la possibilité de détention pour raisons impératives de sécurité.*

The International Committee of the Red Cross (ICRC) considers that violence against health-care workers is 'one of the most crucial yet overlooked humanitarian issues today'.[1] Since 2009, it has run a global campaign aiming, *inter alia*, at improving the protection of and respect for medical personnel in situations of armed conflict and other situations of violence.[2] However, although the ICRC Campaign did indeed further highlight the lack of respect for such personnel, one should refrain from concluding that the relevant protective rules are systematically violated: in reality, the law is complied with most of the time but understandably such respect does not make it into the headlines.

International Humanitarian Law (IHL) provides a solid legal framework protecting medical and religious personnel in all circumstances.[3] Thanks to Additional Protocol I, the protection regime is now the same for military and civilian medical personnel.[4] Contrary to what was upheld in a recent US court decision,[5] such protection does not depend on the personnel carrying a card and other identification, but only on their temporary or permanent assignment, by a party to the conflict, to medical tasks. Such protection is however not unlimited, and may cease if personnel commit, 'outside their humanitarian duties, acts harmful to the enemy'.[6] While the expression 'outside their humanitarian duties' does not give rise to particular problems (as the functions of medical personnel are clearly defined in the Geneva Conventions), the definition of 'acts harmful to the enemy' remains a critical issue. Does the phrase bear the same meaning as 'any act of hostility'? As 'direct participation in hostilities'? Or does it describe a third category of acts? Furthermore, what does 'loss of protection' mean? Does it imply that such medical personnel become lawful targets of attack? For how long? If such personnel fall into the hands of the enemy, what is their status, and how should they be treated? This presentation aims at providing some elements of answer to these controversial questions.

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1 Health Care in Danger Campaign, ICRC website:< http://www.icrc.org/eng/what-we-do/safeguarding-health-care/index.jsp?cpn=hcid>

2 Ibid.

3 See Article 24, Geneva Convention I.

4 Articles 8 (c) and 15, Additional Protocol I.

5 *Al Warafi v. Obama*, US Court of Appeals, No. 11-5276, 24 May 2013: The Court held: 'In the end, the question of whether Al Warafi has met his burden of establishing his status as permanent medical personnel entitled to protection under the First Geneva Convention is one of fact, or at least a mixed question of fact and law. Although the district court believed – and we agree – that military personnel without appropriate display of emblems can never so establish, it also found facts – *e.g.*, the prior combat deployment – inconsistent with that role.' (pp. 7-8).

6 Article 21, Geneva Convention I. See also Article 13, Additional Protocol I.

1. Loss of Protection of Medical and Religious Personnel

The circumstances under which medical and religious personnel may lose their protection against attack are not explicitly defined in the Geneva Conventions of 1949 and their Additional Protocols of 1977. However, these instruments provide some guidance: the First Geneva Convention, and Additional Protocol I, which both apply to international armed conflicts, indicate that the protection of medical *units* and *establishments* may cease if 'they are used to commit, outside their humanitarian duties, acts harmful to the enemy'.[7] They also mention several types of acts which cannot be considered as depriving such units of their protected status.[8] With regard to non-international armed conflict (NIAC), Additional Protocol II similarly envisages that medical units and transports will lose their protection against attacks if they commit 'hostile acts, outside their humanitarian function'.[9] The variation in the terminology used in Protocols I and II denotes reluctance by States to refer to an 'enemy' in NIACs, but the meaning is in my view the same.

It has generally been accepted that such provisions, used by the treaties for *units* and *establishments*, may also be applied, *mutatis mutandis*, to medical and religious *personnel*. Indeed, personnel are an essential part of units. Nevertheless, this does not entirely solve the problem: a difficult – and recurring – question is whether the expression 'acts harmful to the enemy', when applied to personnel, should be understood as bearing the same meaning as 'direct participation in hostilities'. The ICRC explains that the terms 'acts harmful to the enemy' refer to 'acts the purpose or effect of which is to harm the adverse party by facilitating or impeding military operations.'[10] Most authors consider that the concept of 'acts harmful to the enemy' is larger than 'direct participation in hostilities':[11] for instance, they may include sheltering able-bodied combatants or situating medical personnel as an obstacle to an attack.

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7 Ibid.

8 Article. 22, Geneva Convention I; Article 13, Additional Protocol I; Article 11, Additional Protocol II. See also ICRC, CIHL 25

9 Article 11, Additional Protocol II

10 See Yves Sandoz, Christophe Swinarski & Bruno Zimmermann (eds.), *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949,* (Geneva and The Hague: ICRC, 1987), at paragraph 550.

11 See for instance Michael Bothe, Karl Josef Partsch and Waldemar A. Solf, *New Rules for Victims of Armed Conflicts. Commentary on the Two 1977 Protocols Additional to the Geneva Conventions of 1949,* The Hague, Martinus Nijhoff, 1982, p. 411; Robert W. Gehring, "Loss of Civilian Protections under the Fourth Geneva Convention and Protocol I", 90 in: *Military Law Review* 49 (1980); Nils Melzer, *Targeted Killings in International Law,* Oxford: Oxford University Press, 2008, p. 329 (the first two references however technically deal with the interpretation of the same terms concerning civil defence (see Article 65 (1) Additional Protocol I)

In my opinion however, the two expressions should be equated; it is true that the above-mentioned examples of acts harmful to the enemy do not constitute direct participation in hostilities, but this simply stems from the fact that the expression 'acts harmful to the enemy' was elaborated for medical units and establishments, while 'direct participation in hostilities' refers to persons. A hospital can obviously not directly participate in hostilities, but it can be used to commit acts harmful to the enemy if it shelters able-bodied combatants. Although I must admit that this remains subject to controversy, my opinion is that this does not apply to medical personnel: if the latter shelter an able-bodied combatant, this cannot be considered as an act harmful to the enemy entailing a loss of protection. Admittedly, my interpretation will raise controversy. For instance, driving an ammunition truck from a port to a place where the ammunition will be stocked does not constitute direct participation in hostilities,[12] while most would argue that, if committed by medical personnel, this is an act harmful to the enemy.

Here it is important to clarify that a wide range of acts may be carried out by medical personnel outside their humanitarian function, such as the distribution of food or the construction of a bridge for the civilian population, without entailing a loss of protection against *attacks* under International Humanitarian Law. Geneva Convention I and Additional Protocol I cite only some examples of acts which do not entail a loss of protection, because they would otherwise be controversial.[13] Both provide in particular that medical units do not lose their protected status by virtue of their personnel being armed for the purpose of their own defence or the defence of the wounded and sick. In this context, it is important to interpret, in a very restrictive way, the concept of self-defence of non-combatants (and here, it should be reminded that even military medical personnel are not combatants), in an armed conflict. First, medical personnel may only act in self-defence against attacks, i.e. acts of violence, not against attempts by the enemy to gain control over them, their units or the wounded and sick, which are not prohibited by International Humanitarian Law. Second, they must take into account the risk of generating a distorted perception when they start to use force against enemy armed forces, even if it is in self-defence. In addition, not all attacks may give rise to self-defence: in my view an unlawful attack triggering the right to self-defence is only one which has an unlawful target. On the contrary, medical personnel may not react to attacks which are unlawful because they violate the principle of proportionality, the obligation to take all feasible precautionary measures, or because they use – against combatants – unlawful weapons. Medical personnel would not be able to evaluate the legality of such an attack. This being said, one could wonder whether medical personnel may defend other people as well as themselves, their

12 See ICRC, *Interpretive Guidance to the Notion of Direct Participation in Hostilities Under International Humanitarian Law*, Geneva, ICRC, 2009, p. 56

13 Article 22, Geneva Convention I; Article 13, Additional Protocol I.

fellow personnel and the wounded and sick against an unlawful attack. Under the wording of the provisions, it is clear that they may defend other medical personnel and the wounded and sick under their care; in my opinion, this should be extended to defending a civilian targeted by an unlawful attack, even though this is not provided for in the Conventions. One should also add that the question of self-defence is one of the differences between medical and religious personnel: military religious personnel may not defend those in their spiritual charge, as it is not unlawful to attack them.

Finally, it should be stressed that IHL explicitly clarifies that only acts harmful to the enemy committed by medical personnel 'outside their humanitarian duties' can lead to loss of protection. Care for the wounded, sick, prevention of diseases, or presence on a battlefield to collect the wounded and sick never leads to loss of protection, even if the beneficiaries are soldiers and the medical acts therefore enhance the military capacity of those who fight for one party to the conflict.

As a preliminary conclusion, I would say that medical personnel lose their protection only when they directly participate in hostilities, in a manner which is outside their humanitarian function.

2. Consequences of a Loss of Protection

The consequences of the loss of protection constitute another controversial question. First, for how long do medical and religious personnel lose their protection if they commit acts harmful to the enemy? This is a tricky question especially for military medical personnel. In its *Galic* Judgment of 30 November 2006, the International Criminal Tribunal for the former Yugoslavia (ICTY) underlined that a hospital lost protection only while it was used for acts harmful to the enemy.[14] Protection is therefore regained as soon as the hospital is no longer so used, which is logical considering the definition of a military objective found in Article 52(2) of Additional Protocol I. Only a military advantage for the attacker 'in the circumstances ruling at the time' turns an object into a military objective. But this is applicable to hospitals, and not necessarily to persons: while the concept of military objectives is situation-dependent, the targetability of combatants depends on their status. The question is therefore whether military medical personnel, who are members of the armed forces, losing their specific protection: (1) automatically turn into combatants; (2) remain medical personnel regaining protection once they are no longer committing acts harmful to the enemy; or (3) turn into civilians as everyone who is neither a combatant nor medical personnel is a civilian.[15]

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14 ICTY, *The Prosecutor v. Stanilav Galic* (Appeal Judgement), IT-98-29-A, 30 November 2006, p. 346

15 Arts 50 (1) and 43 (2), Additional Protocol I.

A second question concerns the meaning of the loss of protection. Should one distinguish between the notions of 'respect' and 'protection'? Article 21 of the First Geneva Convention only mentions that '*protection* (…) shall not cease', which might be considered to imply that *respect* for medical personnel continues until they directly participate in the hostilities. If they commit acts harmful to the enemy that do not amount to direct participation in hostilities, they only lose the protection but not the respect. In my opinion however, 'protection' and 'respect' are the same concepts and, as mentioned above, military medical personnel may only be attacked if they directly participate in hostilities.

Here it should be noted that the question of the consequence of loss of protection is only relevant for military medical personnel. For civilian medical personnel, no legal problem arises: they may lose their protection as medical personnel, but they still remain civilians. Therefore, they may not be attacked except if and for such time as they directly participate in hostilities.

Another, but closely related question is to determine the status and treatment of military medical personnel who have committed acts harmful to the enemy once they fall into the power of the enemy.

From a logical point of view, one may argue that they remain medical personnel and hence still benefit from the retention regime. However, because medical personnel have to be sent back home immediately except if they are needed to treat the wounded and sick,[16] this option is not very realistic. In any case, as they are not combatants, they may be punished for their participation: either under the domestic law of the country for having committed acts harmful to the enemy,[17] or if their direct participation in hostilities as medical personnel constituted an act of perfidy, or, finally, if their participation may be regarded as a violation of Article 8(2)(b) (xxiii) of the Statute of the International Court of Justice, which prohibits '[u]tilising the presence of a civilian or other protected person to render certain points, areas or military forces immune from military operations'.

An alternative would be to consider that military medical personnel, being members of the armed forces, permanently lose their status as medical personnel by directly participating in hostilities and therefore become combatants.[18] This would be in line with Article 43 of Additional Protocol I, which states that all members of the armed forces except medical personnel are combatants: if they are no longer medical personnel, they have to be combatants. They

16 Arts 28 and 30, Geneva Convention I.

17 However, under Art. 16, Additional Protocol I, medical personnel may not be punished for medical acts, nor for refusing to provide information (except as required by the law of their own party).

18 See Melzer, op.cit. , p. 330

could therefore be detained as prisoners of war until the end of active hostilities, but could not be punished for having committed acts harmful to the enemy. However, an act harmful to the enemy committed by medical personnel will frequently be an act of perfidy and will thus be punishable as such (even combatants may be punished for perfidious acts). In addition, one could also argue that combatant immunity only applies for the time that a person is a combatant. In that sense, medical personnel who commit acts harmful to the enemy may still be punished for such acts because they were not yet combatants at the time the act was committed. This follows the same logic as that for civilians killing enemy soldiers before entering the army: they may be punished for acts committed before becoming combatants.

A third and final possibility would be to consider military medical personnel as civilians once they lost their specific protection as medical personnel. Article 4 of the fourth Geneva Convention states that persons not protected by the other Geneva Conventions (granted that they are in the power of a party to the conflict of which they are not nationals) are persons protected by the fourth Convention. This may be interpreted as meaning that military medical personnel indeed become protected persons: they are no longer protected by the first Geneva Convention (because they lost the protection of medical personnel), nor by the third Convention (because they are not combatants). This interpretation would have the advantage of requiring a case-by-case decision on whether the person may be detained – and therefore retained – for imperative security reasons.[19]

In conclusion, unresolved controversies continue to exist on when military medical personnel lose what kind of protection for what duration in international armed conflicts and what subsidiary protection they benefit from in such case. In practice, however, most medical personnel are civilians and/or affected by non-international armed conflicts. They are therefore not concerned by these controversies. In addition, most medical personnel are attacked under circumstances which cannot possibly be considered as evidencing the controversies mentioned in this contribution.

19 Articles 42 and 78, fourth Geneva Convention.