Protection of Military Medical Personnel in Armed Conflicts

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Medical personnel are entitled to protection in armed conflicts under international law. However, that protection will be lost unless such personnel strictly comply with the requirements set out in the relevant conventions. The authors examine the protection regime available to medical personnel including the regime applicable to hospital ships and medical aircraft. The authors argue that any permanent military medical personnel who engage in hostile acts without being correctly re-assigned permanently from their medical role could be liable for their conduct under the criminal law because they do not possess combatant immunity. The difficulty in re-assigning personnel from medical to non-medical roles and vice versa is examined against the background of the concept of civilians directly participating in hostilities. The authors examine the interpretive guidance issued by the International Committee of the Red Cross and the significant criticism of that guidance.

MILITARY medical personnel, facilities, equipment, medical aircraft and hospital ships are entitled to general protection under the Geneva Conventions,[1] including the Additional Protocols,[2] and under customary

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This paper was written in a personal capacity and does not necessarily represent the views of the Australian Department of Defence or the Australian Defence Force. The authors are grateful to a number of their colleagues in the Australian Defence Force that have provided helpful comments on earlier drafts of this paper. All errors remain those of the authors.

1. *Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field* (opened for signature 12 Aug 1949, 75 UNTS 31, entered into force 21 Oct 1950) ('Geneva Convention I'), art 19 (protection for fixed establishments and mobile medical units), arts 24 & 25 (medical personnel); *Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea* (opened for signature 12 Aug 1949, 75 UNTS 85 entered into force 21 October 1950) ('Geneva Convention II'), art 36 (medical personnel of hospital ships).
2. *Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts* (opened for signature 8 Jun 1977, 1125 UNTS 3; entered into force 7 Dec 1978) ('Additional Protocol I'), art 12 (medical units), art 21 (medical vehicles); *Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to*

international law.[3] In general, this means that medical personnel 'must not knowingly be attacked, fired upon, or unnecessarily prevented from discharging their proper functions'.[4] The protection under customary international law is applicable in both international and non-international armed conflicts.[5] However, medical personnel and medical units and vehicles lose their protection if they engage in acts outside their humanitarian function that are harmful to the enemy or acts that are hostile acts.[6]

The permissible actions of military medical personnel in armed conflicts are considered in this paper together with the issue of whether military commanders can, or should, order permanent military medical personnel within their command to carry out non-medical duties and relinquish their protective identification brassards. There are a number of serious consequences that could flow from such conduct, including reduced protection for military medical personnel generally; possible acts of perfidy; and the possibility of criminal sanctions for permanent military medical personnel if they participate in hostilities without combatant immunity. The issue of military medical personnel participating in acts harmful to the enemy is related to the concept of civilians directly participating in hostilities because the result is that both lose their protected status if they engage in such activities. It is therefore useful when examining the protection of medical personnel to also examine the regime applicable to civilians. In 2009, the International Committee of the Red Cross (ICRC) issued an *Interpretive Guidance on the Notion of Direct Participation in Hostilities under International Humanitarian Law.*[7] The ICRC interpretive guidance has sparked a debate on the correct test that should be applied to determining whether or not a civilian is directly participating in hostilities.[8] The interpretive guidance will be examined to the extent that it

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the Protection of Victims of Non-International Armed Conflicts (opened for signature 8 Jun 1977, 1125 UNTS 3; entered into force 7 Dec 1978) ('Additional Protocol II'), art 9 (medical personnel), art 11 (medical units and transports); *Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Adoption of an Additional Distinctive Emblem* (opened for signature 8 Dec 2005, 2404 UNTS 261; entered into force 14 Jan 2007) ('Additional Protocol III').

3. J-M Henckaerts & L Doswald-Beck, *Customary International Humanitarian Law* (Cambridge: CUP, 2005) vol 1, 79–104: rule 25 (medical personnel); rule 28 (medical units); rule 29 (medical transports). Civilian medical personnel are also protected: see *1949 Geneva Convention IV Relative to the Protection of Civilian Persons in Time of War,* art 20; Additional Protocol I, above n 2, art 15.
4. Henckaerts & Doswald-Beck, ibid 83–4, where the authors cite the *Military Manual* (UK) and the *Field Manual* (US).
5. Ibid 79.
6. Geneva Convention I, above n 1, art 21 (fixed establishments and mobile medical units); Additional Protocol II, above n 2, art 11(2) (medical units and transports). Under customary international law, see Henckaerts & Doswald-Beck, ibid 79–104, rule 25 (medical personnel), rule 28 (medical units), rule 29 (medical transports).
7. *Interpretive Guidance on the Notion of Direct Participation in Hostilities under International Humanitarian Law* (vol 90, no 872, Dec 2008; adopted by Assembly of ICRC 26 Feb 2009).
8. See MN Schmitt, 'The Interpretive Guidance on the Notion of Direct Participation in Hostilities: A Critical Analysis' (2010) 1 *Harvard National Security Journal* 5; MN Schmitt, 'Deconstructing

assists in understanding when medical personnel may lose their protective status. It must be noted that the interpretive guidance is not legally binding and has not received total acceptance. Also, it does not provide a guide to medical personnel but it does highlight the issues that medical personnel will face if they participate in hostile acts.

This paper is divided into five parts. In Part I, a brief overview of the historical context behind the protection of military medical personnel will be provided. In Part II, the policy considerations that support the protection afforded to military medical personnel in armed conflicts will be examined. In Part III, the scope and application of that protection regime will be outlined with reference to both conventional international humanitarian law and customary international law. For completeness, the full protection regime will be outlined including the protection afforded to hospital ships and medical aircraft. However, the focus of the loss of protection discussed in subsequent parts of the paper will primarily be on the actions of individual medical personnel. In Part IV, the circumstances where the general protection is lost are examined. Finally, in Part V, the legal consequences that could arise when permanent military medical personnel are used in non-medical roles, where they lose their protected status, and where combatants are temporarily assigned to a medical unit, will be examined by reference to a number of practical scenarios. The central issue in the practical scenarios relates to the problems associated with re-assigning combatants as protected medical personnel and vice versa.

The authors conclude that military commanders should not order permanent military medical personnel to participate in hostilities even for short periods of time. To do so would create an unacceptable risk to the entire system of protection. The consequences to the individual military medical personnel, including possible criminal sanctions, are serious and would place medical personnel in an untenable position. It is also concluded that combatants should not wear the protective symbols available to temporary military medical personnel unless they strictly comply with the criteria for temporary medical personnel set out in Geneva Convention I and Additional Protocol I.

Direct Participation in Hostilities: The Constitutive Elements' (2010) 42 *New York University Journal of International Law and Politics* 697; N Melzer, 'Keeping the Balance Between Military Necessity and Humanity: A Response to Four Critiques of the ICRC's Interpretive Guidance on the Notion of Direct Participation in Hostilities' (2010) 42 *New York University Journal of International Law and Politics* 831; B Boothby, '"And for Such Time As": The Time Dimension to Direct Participation in Hostilities' 42 *New York University Journal of International Law and Politics* 741; K Watkin, 'Opportunity Lost: Organized Armed Groups and the ICRC "Direct Participation in Hostilities" Interpretive Guidance' 42 *New York University Journal of International Law and Politics* 641; WH Parks, 'Part IX of the ICRC "Direct Participation in Hostilities" Study: No Mandate, No Expertise, and Legally Incorrect' 42 *New York University Journal of International Law and Politics* 769.

I. HISTORICAL CONTEXT

The protection of the wounded, and later the medical personnel caring for them, can be traced to as early as the middle of the 16th century.[9] By the 17th century there was considerable development of medical services with campaigning troops and 'arrangements were first made between commanders in the field which extended to such questions as the reciprocal care of the wounded'.[10] As early as 1689, a convention was signed between the Elector of Brandenburg and the Count of Asfield who commanded the French forces providing for 'mutual respect towards both hospitals and the wounded'.[11] The French established a permanent medical service by decree in 1708.[12] By 1759, an agreement was signed between the French and the British providing that medical personnel were not to be taken prisoner and 'if they should happen to be apprehended within the lines of the enemy, they were to be sent back immediately'.[13]

Although proposals were put forward as early as the 18th century for a general and international convention to protect the wounded,[14] it was not until the establishment of the International Committee of the Red Cross that an international convention was adopted.[15] The protection of medical personnel was included in the 1864 Geneva Convention[16] and was included in the subsequent Geneva Conventions of 1906 and 1929.[17] These conventions built upon the medical provisions included in the ad hoc agreements of the 17th and 18th centuries.[18]

9. See LC Green, 'The Relations between Human Rights Law and International Humanitarian Law: A Historical Overview' in SC Breau & A Jachec-Neale (eds), *Testing the Boundaries of International Humanitarian Law* (London: British Institute of International and Comparative Law, 2006) 65; G Butler & S Maccoby, *The Development of International Law* (London: Longmans Green, 1928) 149.
10. Butler & Maccoby, ibid 149.
11. Ibid.
12. LC Green, *Essays on the Modern Law of War* (New York: Transnational Publishers, 2nd edn, 1999). 490.
13. Butler & Maccoby, above n 9, 149–50.
14. Ibid 150–1.
15. Green, above n 9, 67.
16. A diplomatic conference was convened in Geneva in August 1864 where representatives of 12 States signed a brief international treaty containing only ten articles: see A Baccino-Astrada, *Manual on the Rights and Duties of Medical Personnel in Armed Conflicts* (Geneva: International Committee of the Red Cross, 1982) 17.
17. *Convention for the Amelioration of the Condition of the Wounded in Armies in the Field* (opened for signature 22 Aug 1864, 129 Consol TS 361; entered into force 21 Jun 1865) ('1864 Geneva Convention'), art 2; *Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field* (opened for signature 6 Jul 1906, 11 LNTS 440; entered into force 9 Aug 1907) ('1906 Geneva Convention'), arts 9–10; *Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field* (opened for signature 27 Jul 1929, 118 UNTS 303; entered into force 19 Jun 1931) ('1929 Geneva Convention'), arts 9–10.
18. Green, above n 9, 67.

II. POLICY CONSIDERATIONS

The protective regime is now included in the First, Second and Fourth Geneva Conventions of 1949 and the Additional Protocols of 1977. The scope of the protection granted to medical personnel was expanded in Additional Protocol I to cover civilian medical personnel in addition to military medical personnel in all circumstances.[19] The regime relating to hospital ships and medical aircraft, which is based primarily on the Geneva Conventions and the Additional Protocols and customary international law, is set out in the *San Remo Manual on International Law Applicable to Armed Conflicts at Sea*[20] and the recently issued *Manual on International Law Applicable to Air and Missile Warfare* ('Air Warfare Manual').[21]

The protection of military medical personnel must be understood within the broad context of international humanitarian law,[22] which divides persons into distinct categories that determine not only their status and treatment during the actual conduct of hostilities, but also their treatment in the event that they fall into the power of the adversary during the course of a conflict.[23] Such categorisation underlies the 'principle of distinction',[24] which has been declared by the International Court of Justice to be a 'cardinal' principle underpinning the law of armed conflict.[25]

The distinction between combatants and non-combatants is one such distinction designed to protect non-combatants from attack. The protection of medical personnel is not a personal privilege accorded to them, but is a natural consequence or 'subsidiary protection' granted to them to ensure that protection is given to the persons primarily concerned, namely, the wounded and sick.[26] In other words, the 'status of the medical profession during war has never been looked at

19. Additional Protocol I, above n 2, art 15.
20. L Doswald-Beck (ed), *San Remo Manual on International Law Applicable to Armed Conflicts at Sea* (Cambridge: CUP, 2005) ('San Remo Manual').
21. Program on Humanitarian Policy and Conflict Research at Harvard University, *Manual on International Law Applicable to Air and Missile Warfare* (Bern, 15 May 2009) ('Air Warfare Manual'). See also Program on Humanitarian Policy and Conflict Research at Harvard University, *Commentary on the HPCR Manual on International Law Applicable to Air and Missile Warfare*, Version 2.1, (Harvard University, 2010) ('Commentary on the Air Warfare Manual'). The manual was produced as part of a 6-year project involving a group of experts and is designed to be a restatement of existing international law applicable to air and missile warfare.
22. The terms 'international humanitarian law' and the 'law of armed conflict' are considered by the authors to be synonymous and will be used interchangeably in this paper.
23. See T Gill & E van Sliedregt, 'Guantanamo Bay: A Reflection on the Legal Status and Rights of Unlawful Enemy Combatants' (2005) 1 *Utrecht Law Review* 28, 28.
24. For a brief explanation of the three other main principles of the law of armed conflict (ie. 'military necessity', 'avoidance of unnecessary suffering' and 'proportionality'), see H Gulam, 'Medical Personnel and the Law of Armed Conflict' (2005) 6(1) *ADF Health* 30, 30.
25. *Nuclear Weapons Advisory Opinion* [1996] ICJ Rep 226, 257. See also D Stephens & MW Lewis, 'The Law of Armed Conflict: A Contemporary Critique' (2005) 6 *Melbourne Journal of International Law* 55, 77.
26. Henckaerts & Doswald-Beck, above n 3, 80 referring to Spain's *Law of Armed Conflict Manual* (1996).

independently, but has always been considered from a functional point of view, that is to say in regard to the need to protect the wounded'.[27]

It is therefore in the interests of each party to a conflict, and each combatant, to ensure that medical personnel are not targeted. Medical personnel, on either side of a conflict, may treat sick and injured combatants and civilians. If it was legally permissible to target and kill medical personnel, combatants would suffer through lack of available treatment – both when treated by their own medical personnel or the enemy's medical personnel after capture. Any action taken that reduces the protection afforded to medical personnel will result in a proximate detriment to all combatants. If a party to a conflict is unsure of the identity of medical personnel, or is unsure whether medical personnel are engaging in acts harmful to the enemy, that party is more likely to target and kill those personnel. Therefore, permitting commanders to adopt procedures, even if strictly legal, which would tend to confuse the enemy regarding medical personnel, must lessen that protection and be a detriment to the welfare of combatants generally.

Protection is granted to military medical personnel because there is an obvious benefit in lessening the suffering of those hors de combat. But the protection of military medical personnel is granted on the basis that they will not participate in hostilities. The quid pro quo for the protection is that medical personnel do not take a direct part in hostilities at all. Protection is only given to them when they are exclusively carrying out their humanitarian tasks.[28]

The protection afforded to military medical personnel means that, although they are members of the armed forces, they are considered to be non-combatants. Therefore, unlike their non-medical colleagues within the armed forces, they may not be the subject of attack by the adversary. Importantly, as non-combatants, they do not enjoy 'combatant immunity', also referred to as 'combatant privilege'. Article 43(2) of Additional Protocol I only extends combatant immunity to members of the armed forces of a party to a conflict other than medical personnel and chaplains. This issue will be explored further in Part V, below.

III. THE PROTECTION REGIME

1. Defining and classifying military medical personnel

The term 'military medical personnel' refers to medical personnel who are members of the armed forces of a party to an armed conflict.[29] Additional Protocol I made a number of modifications to the protection of medical personnel as laid down in the Geneva Conventions. Additional Protocol I defines medical personnel as:

27. Green, above n 12, 492.
28. Henckaerts & Doswald-Beck, above n 3, 81.
29. Ibid.

> [T]hose persons *assigned*, by a Party to the conflict, *exclusively* to the medical purposes enumerated under sub-paragraph (e) [namely the search for, collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or for the prevention of disease] or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either *permanent* or *temporary*.[30]

An important distinction between permanent and temporary medical personnel is made in both Geneva Convention I and Additional Protocol I. Additional Protocol I defines permanent medical personnel as 'those *assigned exclusively* to medical purposes for an *indeterminate period*.[31] Temporary medical personnel, units and transports are defined in Additional Protocol I as 'those *devoted exclusively* to medical purposes for *limited periods during the whole of such periods*'.[32] Because temporary medical personnel are combatants they have a right to participate in hostilities except when exclusively undertaking medical duties on a temporary basis.

The term 'medical personnel' is not limited to those persons who give direct care to the wounded and sick such as the doctors, surgeons, dentists, chemists, orderlies, nurses, and stretcher bearers. The definition of medical personnel also includes administrative staff that indirectly care for the wounded and sick by forming an integral part of the medical units and ensuring that they function properly.[33] Therefore, the scope of those involved in the administration of medical units should be interpreted widely to not only include administrators, but to also include persons such as hospital cooks and cleaners.[34] Similarly, persons involved in the operation or administration of medical transports may be defined to include not just the drivers and pilots of medical transports, but also, co-pilots, navigators, crew of medical ships, mechanics, aircraft technicians, ship maintainers and persons who plan the employment of medical transports.[35]

(a) The requirement of exclusivity

The requirement for all medical personnel (both temporary and permanent) to be exclusively assigned or devoted to medical tasks means that they may not spend any time on other activities relating to the armed conflict if they are to maintain their protective status.[36] This is a necessary precaution to prevent abuses of the emblem for commercial or, most importantly, military purposes.[37] The requirement of exclusivity will be examined further in Part V.

30. Additional Protocol I, above n 2, art 8(c) (emphasis added).
31. Ibid, art 8(k) (emphasis added).
32. Ibid (emphasis added).
33. See Y Sandoz, C Swinarski & B Zimmermann (eds), *Commentary on the Additional Protocols*, (Geneva: Martinus Nijhoff Publishers, 1987) [352].
34. Ibid.
35. Ibid.
36. Ibid [353].
37. Ibid.

(b) Permanent medical personnel

To be classified as permanent, medical personnel, units and transports must be 'assigned exclusively for an indeterminate period'.[38] The ICRC Commentary to Article 8(k) of Additional Protocol I suggests that it is appropriate to note the explanation given by the Drafting Committee of Committee II for using the word 'assign' when the personnel, units and medical transports are permanent and the word 'devote' when they are temporary:[39]

> These different words have been chosen in order to make it clear, that the protection of permanent units or personnel starts at the time of the order, assignment or similar act creating the unit or giving a medical task to the personnel. The protection of temporary units or personnel, however, commences only when they have in fact ceased to do other than medical work.

The exact meaning of the expression 'for an indeterminate period' was not discussed in depth by the 1974-77 Diplomatic Conference. However, the ICRC Commentary suggests that the meaning of the expression is clear and that it 'covers persons or objects which can be expected to be assigned definitively to medical purposes'.[40] Thus, if a party to a conflict assigns a person to their medical category, for example, as a doctor or a nurse, that person would be trained so that he or she could be deployed on operations in his or her medical capacity. It would still be possible, although highly unlikely, that as a result of a lack of combatants, a party to a conflict might change the assignment of some of its medical officers and transfer them to active combat duty. However, this would only occur due to unforeseeable circumstances and in very rare circumstances.[41] The critical point is that if 'at the outset, the idea is to make the assignment of personnel, units or transports to medical personnel definitive (ie, without imposing any time limit), they are permanent'.[42]

(c) Temporary medical personnel

The concept of temporary assignment to medical duties, on the other hand, is more problematic. The protection of temporary medical personnel only begins when such persons have in fact ceased to perform non-medical tasks.[43] This raises the

38. Ibid [391].
39. Ibid [392].
40. Ibid [394].
41. If a party to a conflict reassigned permanent medical personnel to active combat duties the party would need to comply with any domestic regulations and policies applicable to any such reassignment. This is important to ensure that the relevant personnel are formally assigned to a combat position and are able to participate in hostilities with combatant immunity. Accordingly, reassignment of permanent medical personnel to combat duties is unlikely during a conflict because of the delay inherent in complying with formal requirements of reassignment. It is more likely that a party to a conflict would deploy more combatants and scale back its operations until those additional combatants were deployed to the conflict.
42. See Sandoz, Swinarski & Zimmermann, above n 33, [394].
43. Ibid [395].

issue of the minimum time that must be observed for the assignment to medical purposes to be considered exclusive.[44] The ICRC Commentary suggests that:

> There is no doubt that by putting the emphasis on the exclusive character of use, a choice has been made in the Protocol for a certain guarantee. No time limit was fixed, but common sense dictates that to the greatest possible extent, there should be no change in the assignment of medical personnel or medical objects during an operation...If the medical assignment is too short and changes too often, this could only serve to introduce a generally harmful mistrust regarding the protection of medical personnel and medical objects.[45]

The ICRC Commentary points out that it is also important not to be too dogmatic in this field as the contributory role of temporary medical personnel, sometimes for a very short period of time, may constitute a considerable source of aid.[46]

2. Protection of hospital ships

Geneva Convention II which is concerned with the treatment of persons at sea has specific provisions dealing with the protection of medical personnel. Article 36 provides that medical personnel of hospital ships and their crews 'shall be respected and protected; they may not be captured during the time they are in the service of the hospital ship, whether or not there are wounded and sick on board'.[47] The reason for the protection of the crew is explained in the San Remo Manual.[48] The protection 'is to ensure that the hospital ship is always operational, which would not be the case if it were deprived of its crew'.[49] To provide for their own protection hospital ships may be equipped with purely deflective means of defence, such as chaff and flares.[50]

3. Protection of medical aircraft

The Air Warfare Manual provides a restatement of the law in relation to air warfare and provides a restatement of the specific protection afforded to medical aircraft. Rule 1(u) defines medical aircraft as any aircraft permanently or temporarily assigned 'exclusively to aerial transportation or treatment of wounded, sick, or shipwrecked persons, and/or the transport of medical personnel and medical equipment or supplies'.[51]

The provisions applicable to the protection of medical aircraft differ depending on where the aircraft is located. Rule 77 provides that in and over areas controlled

44. Ibid.
45. Ibid.
46. Ibid [396].
47. Geneva Convention II, above n 1, art 36.
48. San Remo Manual, above n 20.
49. Ibid 225.
50. Ibid, Rule 170.
51. Air Warfare Manual, above n 21, 4–5.

by friendly forces the specific protection of medical aircraft is not dependant on the consent of the enemy.[52] By contrast under Rule 78(a), medical aircraft in and over areas controlled by the enemy, as well as in and over those parts of the contact zone which are physically controlled by friendly forces or the physical control of which is not clearly established, are only fully protected by virtue of the prior consent of the enemy.[53] The contact zone 'means any area on land where the forward elements of opposing forces are in contact with each other, especially where they are exposed to direct fire from the ground'.[54] The Commentary on the Air Warfare Manual emphasises that 'medical aircraft operating in and over these areas without consent do not lose their specific protection, but rather risk being shot down if they are not identified as medical aircraft'.[55] Pursuant to rule 78(b) the consent of the enemy has to be sought in advance.[56]

The Air Warfare Manual also provides for a mechanism for aircraft to be inspected. Pursuant to Rule 80(a), a medical aircraft flying over an area covered by Rule 78(a) may be ordered to land.[57] The Commentary on the Air Warfare Manual observes that an order to land must be obeyed otherwise 'it can result in the medical aircraft being forced to land and, as a last resort, being attacked'.[58] When an aircraft is forced to land, if the aircraft is found to be engaged in activities consistent with its medical status, then, pursuant to Rule 80(b) it must be allowed to continue with its flight.[59] However, if it is engaged in activities inconsistent with its medical activities then the aircraft may be seized pursuant to Rule 80(c).[60] Pursuant to Rule 80(d) any permanent military aircraft seized by the enemy may only be used thereafter as a medical aircraft.[61] But if a temporary medical aircraft is seized then it may be used by the enemy for other purposes provided that any distinctive emblems are removed.[62]

Pursuant to Rule 81 a medical aircraft must not 'possess or employ equipment to collect or transmit intelligence harmful to the enemy'.[63] However, medical aircraft are permitted by Rule 82 to be equipped with deflective means of defence such as chaff or flares and to carry light individual weapons necessary to protect the aircraft, the medical personnel and the wounded, sick or shipwrecked on board.[64]

52. Ibid 29.
53. Ibid.
54. Commentary on the Air Warfare Manual, above n 21, 189.
55. Ibid.
56. Air Warfare Manual, above n 21, 29.
57. Ibid 30.
58. Commentary on the Air Warfare Manual, above n 21, 191.
59. Air Warfare Manual, above n 21, 30.
60. Ibid.
61. Ibid.
62. Commentary on the Air Warfare Manual, above n 21, 194.
63. Air Warfare Manual, above n 21, 30.
64. Ibid 30–1.

4. Identification

For the system of protection of medical personnel to function effectively, the relevant persons need to be easily identifiable. The entitlement that medical personnel, units and transports have to protected status in an armed conflict is directly linked with their right to display an internationally recognised distinctive emblem which makes it clear that they treat the sick and injured and take no direct part in hostilities.[65] Since the adoption of the Additional Protocols in 1977, special emphasis has been given to the visibility of the protective emblem. The distinction which was made in the Geneva Conventions between the identification of permanent and temporary medical personnel has been superseded and all medical personnel entitled to protection must now be identifiable as easily as possible. [66] In addition, such personnel must be supplied with identity cards or documentation meeting specified requirements. For permanent military personnel, the identity card must include the person's name and date of birth, their rank and service number and the capacity that entitles them to protection.[67] The identity card must include a photograph of the person and be embossed with the stamp of the military authority.[68] For temporary military medical personnel, it is a requirement that they carry identity documents specifying 'what special training they have received, the temporary character of the duties they are engaged upon, and their authority for wearing the armlet'.[69] This is a critical requirement. If a combatant wearing a distinctive protective armlet or brassard does so without the appropriate documentation, they could be liable for misuse of the protective emblem.[70]

Identification of medical units and medical transports is also critical to avoid being targeted by aircraft. Rule 72(b) of the Air Warfare Manual provides that as far as possible such units and transports ought to use a distinctive emblem 'made of materials which make it recognisable by technical means of detection used in air or missile operations'.[71] The Commentary on the Air Warfare Manual suggests that the distinctive emblem could be made of 'adhesive tapes with a high thermal

65. The four signs currently recognised in the Geneva Conventions and Additional Protocols are the red cross; the red crescent; the red lion and sun; and the red crystal all displayed on a white background. See Geneva Convention I, above n 1, art 38; Additional Protocol III, above n 2, art 2. Chaplains attached to the armed forces are also protected from attack and are entitled to wear the distinctive emblem: see Geneva Convention I, arts 24 & 40.
66. Under art 41 of Geneva Convention I, above n 1, temporary medical personnel were only entitled to wear a miniature version of the protective emblem compared to the full size version worn by permanent medical personnel under art 40. Art 4 of Annex I to Additional Protocol I, above n 2, requires that the distinctive emblem used 'shall be as large as appropriate under the circumstances'.
67. Geneva Convention I, ibid, art 40.
68. Ibid.
69. Ibid, art 41.
70. Ibid, arts 53 and 54.
71. Air Warfare Manual, above n 21, 27.

reflection coefficient [that] can make the distinctive emblem visible to thermal imaging cameras'.[72]

Rule 75 of the Air Warfare Manual provides that medical aircraft are entitled to specific protection.[73] To assist in being afforded protection, rule 76(b) provides that medical aircraft ought to use additional means of identification where appropriate. Such additional means include a flashing blue light not used by other aircraft and a radio message preceded by a distinctive priority signal earmarked for all medical transports.[74] The Commentary on the Air Warfare Manual envisages that in the future 'an automatic radio identification system will be developed using a transponder with digital selective calling techniques, and a Secondary Surveillance Radar (SSR) system identifying and following the course of medical aircraft'.[75]

5. Entitlement of medical personnel to carry arms

Medical personnel are permitted to carry arms to be used only in limited circumstances. In many modern armed conflicts, a state of internal disorder may exist, which, apart from the conflict itself, may engender acts of violence. It is therefore essential to defend the wounded and sick against such acts. Also, although wounded soldiers are considered hors de combat, they may not necessarily be totally incapacitated and it is important to maintain order within medical facilities. Accordingly, it is permissible for medical personnel to be armed with light weapons for the purposes of self-defence and the maintenance of order. Geneva Convention I and Additional Protocol I both provide that medical personnel do not lose their protective status by virtue of being armed for the purpose of their own self-defence or the defence of the wounded and sick.[76]

6. The consequences of categorisation of medical personnel upon capture

In the event of capture during an international armed conflict, the adversary is entitled to treat military medical personnel differently depending on their category. Geneva Conventions I and III provide that permanent military medical personnel are not prisoners of war.[77] Geneva Convention I provides that permanent medical personnel who fall into the hands of the adversary shall be 'retained only in so far as the state of health, the spiritual needs and the number of prisoners of

72. Commentary on the Air Warfare Manual, above n 21, 176.
73. Air Warfare Manual, above n 21, 28.
74. Commentary on the Air Warfare Manual, above n 21, 186.
75. Ibid.
76. Geneva Convention I above n 1, art 22(1); Additional Protocol I, above n 2, art 13(2)(a).
77. Geneva Convention I, ibid, art 28; *Geneva Convention (III) relative to the Treatment of Prisoners of War* (opened for signature 12 Aug 1949, 75 UNTS 135, entered into force 21 Oct 1950) ('Geneva Convention III'), art 33.

war require'.[78] But 'they are only retained as an exceptional measure'.[79] Geneva Convention II provides that medical and hospital personnel of hospital ships and their crew 'may not be captured during the time they are in the service of the hospital ship, whether or not there are wounded and sick on board'.[80]

Military medical personnel thus retained are not prisoners of war but classified as 'retained persons' and are subject to the privileges afforded to those with prisoner of war status;[81] that is, a detaining power can 'apply to retained medical personnel only those provisions of the Prisoners of War Convention that are manifestly to their advantage'.[82] Permanent military medical personnel 'shall continue to carry out, in accordance with their professional ethics, their medical and spiritual duties on behalf of prisoners of war, preferably those of the armed forces to which they themselves belong'.[83]

Importantly, permanent military medical personnel will be subject to the internal discipline of a prisoner of war camp; however, they cannot be lawfully directed to perform work outside their medical duties.[84]

On the other hand, temporary military medical personnel will be prisoners of war in the event that they are captured by the adversary during an international armed conflict. Geneva Convention I provides that auxiliary medical personnel who 'have fallen into the hands of the enemy, shall be prisoners of war, but shall be employed on their medical duties in so far as the need arises'.[85]

This has important practical consequences. During detention, unlike their permanent medical colleagues, temporary medical personnel have no right to be employed by the adversary in their medical capacity. Whilst the law seems to strongly suggest that temporary medical personnel be used for medical duties if there is a need, their use is within the adversary party's complete discretion.

More importantly, temporary medical personnel are not entitled to repatriation like their permanent medical colleagues. It is interesting to note that the retention of medical personnel (and chaplains) who fall into enemy hands was one of the most important issues that the Diplomatic Conference had to settle when dealing with Geneva Convention I.[86] Prior to Geneva Convention I, temporary medical

78. Geneva Convention I, ibid, art 28.
79. JS Pictet (ed), 'Commentary to Article 28', *Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field* (Geneva: ICRC, 1952) 245.
80. Geneva Convention II, above n 1, art 36.
81. Geneva Convention I, above n 1, art 28.
82. Pictet, above n 79, 243.
83. Geneva Convention I, above n 1, art 28.
84. Geneva Convention III, above n 77, art 33(c).
85. Geneva Convention I, above n 1, art 29.
86. See Pictet, above n 79, 235.

personnel were entitled to repatriation.[87] The ICRC Commentary on Article 29 of Geneva Convention I provides an explanation as to why there was a change in approach.

> [Temporary] personnel are as much 'combatant' as medical, and their repatriation would help to increase the military potential of the home country. Besides, since their medical functions are subsidiary only, the necessary instruction can quickly be given to other troops who can be detailed to replace those captured.[88]

Other justifications discussed in the ICRC Commentary on Article 29 of Geneva Convention I for the different treatment of temporary medical personnel focus on the potential for abuse by belligerents (for example, the potential to train a large number of fighting troops as stretcher bearers in order to furnish them with a claim to repatriation upon capture) and the difficulty in commanders establishing, with any degree of certainty, whether or not particular soldiers were engaged in medical work at the time of their capture.[89]

IV: LOSS OF PROTECTION OF MEDICAL PERSONNEL

1. Acts harmful to the enemy

As outlined earlier, the protection regime afforded to medical personnel forms an integral part of the protection afforded to the sick and wounded (who are the primary people requiring protection). Specific protection for military medical personnel is therefore only appropriate where medical personnel are exclusively assigned to the care of the wounded and sick.

Geneva Convention I and Additional Protocol I, which apply to international armed conflicts, provide that medical units and transports will lose their protection if they are used to commit, 'outside their humanitarian function, *acts harmful to the enemy*'.[90] Additional Protocol II, which applies to internal armed conflicts, provides for the loss of protection where they are used to commit '*hostile acts*, outside their humanitarian function'.[91] Although there is a slight variation in the terminology used, the meaning is essentially the same.[92] These provisions apply expressly to medical units and transports rather than directly to medical personnel. However, under customary international law, the rule that medical personnel lose their protection can be applied by analogy with the treaty provisions.[93] It is

87. See 1929 Geneva Convention, above n 17, art 12.
88. Pictet, above n 79, 258.
89. Ibid 258–9.
90. See Geneva Convention I, above n 1, art 21; Additional Protocol I, above n 2, art 13 (emphasis added). Geneva Convention I, art 21, refers to 'humanitarian duties' as opposed to 'humanitarian function', which appears in Additional Protocol I, art 13.
91. See Additional Protocol II, above n 2, art 11 (emphasis added).
92. Sandoz, Swinarski & Zimmermann, above n 33, [4720]–[4721]. See also Henckaerts & Doswald-Beck, above n 3, 84–5.
93. Henckaerts & Doswald-Beck, ibid 85.

therefore important to note that if one or more members of a medical unit engage in hostile acts, then the entire medical unit or establishment is at risk of losing its protection.[94] There is no requirement that all members of the unit engage in hostile acts.

The critical issue is what amounts to 'acts harmful to the enemy'. The 1929 and 1949 Diplomatic Conferences did not consider it necessary to define this expression as its meaning was believed to be self-evident and it was considered that this term should remain very general.[95] Whilst the Geneva Conventions and Additional Protocols do not define 'acts harmful to the enemy', they do indicate several types of acts which do not deprive medical units or establishments of their protective status. Even though these provisions specifically apply to medical units and establishments, it is accepted State practice that those rules can be applied, by analogy, to medical personnel.[96] Article 22 of Geneva Convention I provides that military medical units, establishments and personnel will not be deprived of their protected status where:

(1) the personnel of the unit or establishment are armed, and that they use the arms in their own defence, or in that of the wounded and sick in their charge;

(2) in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort;

(3) small arms and ammunition taken from the wounded and sick and not yet handed to the proper service, are found in the unit or establishment;

(4) personnel and material of the veterinary service are found in the unit or establishment, without forming an integral part thereof;[97] and

(5) the humanitarian activities of medical units and establishments or of their personnel extend to the care of civilian wounded or sick.

In addition to this express provision, some examples of acts harmful to the enemy are given in the ICRC Commentary on Article 21 of Geneva Convention I. The commentary suggests that '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' or 'the deliberate siting of a medical unit in a position where it would impede an enemy attack',[98] would all be 'acts harmful to the enemy'. The definition of 'harmful' is therefore very broad and refers not only to direct harm

94. Geneva Convention I, above n 1, art 21.
95. Pictet, above n 79, 200.
96. Henckaerts & Doswald-Beck, above n 3, 85.
97. This particular condition is of less importance today than in the past due to the fact that military units are now largely mechanised. However, the possibility that veterinary personnel and material may be found within a medical unit should not be discounted because of the use of military working dogs in armed conflicts.
98. Pictet, above n 79, 200–1.

inflicted on the adversary but also to any attempts at deliberately hindering their military operations in any way whatsoever.

The application of the principle of self defence from the point of view of medical personnel is quite different from the application of the same principle to combatants in an armed conflict. For example, where the adverse party is advancing on a position that houses a medical establishment, medical personnel would not be entitled to resist the military advance by using arms. To do so, would result in a loss of their neutrality in the conflict, and hence their right to protection. The only time that medical personnel would be justified in using force in such a scenario would be if the adversary were to deliberately attempt to kill the wounded, the sick or members of the medical unit. This can provide some practical difficulties because an adversary's intention will not always be immediately evident. The presumption would have to be that the adversary will comply with international law with respect to the treatment of medical personnel and their patients, unless reliable intelligence suggested otherwise.

2. Direct participation in hostilities

The notion of 'direct participation in hostilities' is assuming growing importance in early 21st century warfare, especially with regards to the trend of military forces using civilian contractors to carry out combatant roles in support of their force in contemporary conflicts.[99] The issue is also significant in the context of civilian engagement in hostilities often in support of non-state actors. In general, taking a 'direct part in hostilities, in violation of the principle of strict neutrality and outside the humanitarian function of medical personnel, is considered an act harmful to the enemy'.[100] In general terms, this means that 'if medical teams are incorporated into combat units and their medical personnel bear arms and take a direct part in hostilities, they are not entitled to protection'.[101] However, neither the mere caring for the wounded and sick, nor the sole wearing of military uniforms or bearing the insignia of armed forces, can be considered as sufficient to be directly participating in hostilities.[102]

The ICRC has recently provided some interpretive guidance on the notion of direct participation by civilians in hostilities under international humanitarian law.[103]

99. On the topic of 'direct participation of hostilities' and its relationship to phrases such as 'acts harmful to the enemy' and 'hostile acts', see generally JR Heaton, 'Civilians at War: Re-examining the Status of Civilians Accompanying the Armed Forces' (2005) 57 *Air Force Law Review* 155; M Schmitt, '"Direct Participation in Hostilities" and 21st Century Armed Conflict' in H Fischer (ed), *Crisis Management and Humanitarian Protection* (Verlag: Berliner-Wissenschafts, 2004) 505–29; M Schmitt, 'Humanitarian Law and Direct Participation in Hostilities by Private Contractors or Civilian Employees' (2005) 5 *Chicago Journal of International Law* 511; PW Singer 'Outsourcing War' (2005) 84 *Foreign Affairs* 119; Gill & van Sliedregt, above n 23.
100. Henckaerts and Doswald-Beck, above n 3, 85.
101. Ibid.
102. Ibid.
103. ICRC, above n 7.

It must be noted that this interpretative guidance may not reflect State practice. Although the guidance is specifically in reference to civilians participating in hostilities, it is also useful in determining when medical personnel might lose their protective status. According to the ICRC, in order to qualify as direct participation in hostilities, a specific act must meet the following cumulative criteria:

(1) The act must be likely to adversely affect the military operations or military capacity of a party to an armed conflict or, alternatively, to inflict death, injury, or destruction on persons or objects protected against direct attack (threshold of harm); and

(2) There must be a direct causal link between the act and the harm likely to result either from that act, or from a coordinated military operation of which that act constitutes an integral part (direct causation); and

(3) The act must be specifically designed to directly cause the required threshold of harm in support of a party to the conflict and to the detriment of another (belligerent nexus).[104]

Some aspects of this guidance are relevant to the issue of medical personnel engaging in acts that may potentially be hostile acts but it must be stressed that the view of the ICRC is only an interpretive guidance and not of a legally binding nature.[105] In fact, the guidance has been greeted with some strong criticism. For example, Schmitt suggests that 'States involved in 21st century warfare are unlikely to view the document favourably, let alone use it to provide direction to their forces in the field'.[106] Schmitt suggests that in finding the correct balance between military necessity and humanity the interpretive guidance skews the balance too far in favour of humanity.[107] The guidance is 'certainly not a restatement of existing law'.[108]

Regardless of the position taken on the correctness or otherwise of the ICRC guidance, it is useful in highlighting the issues that face medical personnel who may be ordered to take part in activities outside their medical functions. The main aspects of direct participation in hostilities by civilians that are relevant to the discussion in this paper are the issues of when participation in hostilities commences and ceases; the functions that amount to direct participation; and the concept of the revolving door of protection.

In relation to the duration of involvement in hostilities, the interpretative guidance has been criticised as taking a narrow view of when participation starts and ceases

104. Ibid 995–6.
105. Ibid 992. For further recent discussion on direct participation in hostilities, see R Lyall, 'Voluntary Human Shields, Direct Participation in Hostilities and the International Humanitarian Law Obligations of States' (2008) 9 *Melbourne Journal of International Law* 313.
106. Schmitt, 'Deconstructing Direct Participation in Hostilities', above n 8, 699.
107. Schmitt, 'The Interpretive Guidance on the Notion of Direct Participation in Hostilities', above n 8, 6.
108. Watkin, above n 8, 693.

thereby providing more protection to civilians participating in hostilities than is appropriate.[109] In the context of medical personnel the same issue will arise. If permanent medical personnel are ordered to take part in acts harmful to the enemy, some criteria will be needed to determine when such acts commence and cease. Any doubt as to when such acts do commence and cease will create doubt as to when such personnel enjoy protection from attack and when they do not.

On the issue of what amounts to direct participation in hostilities there is disagreement as to what acts are to be included within the threshold of harm element of the interpretive guidance. A significant area of disagreement relates to activities amounting to logistical support.[110] Again, this same issue is likely to arise in the context of military medical personnel. Given that such personnel are not likely to have received significant combat training they are therefore more likely to be ordered to engage in logistical functions if indeed they are ordered to engage in any functions outside their medical duties.

The revolving door concept that arises in the context of civilians participating in hostilities is also directly relevant in the context of medical personnel. When applied to civilians the concept of a revolving door of protection allows a civilian to participate in discrete acts in a conflict and yet benefit from protection as a civilian when not engaged in these discrete acts. The concept has been criticised by Watkin in the context of the ICRC interpretive guidance on the basis that 'the law begins to be undermined by suggesting an opponent can repeatedly avail themselves of such protection'.[111] Boothby argues that 'the correct position at customary law is that civilians who directly participate lose their protected status for the approximate period of that participation, there being no revolving door of protection'.[112] Again the issue of the revolving door of protection is relevant to medical personnel. If no such revolving door of protection exists then such personnel will lose their protection from attack for much longer periods if they engage in a number of discrete acts that are harmful to the enemy.

The concept of direct participation of civilians in hostilities does highlight a number of issues that are relevant to medical personnel who may be ordered to engage in acts outside their medical function. The ICRC interpretive guidance, although not of direct application in this context, does nevertheless highlight some issues that are relevant to medical personnel. The criticism of the interpretive guidance also highlights the lack of clarity in this area of the law which in turn highlights the care needed to be exercised by military commanders and medical personnel alike when any decision is being considered to use medical personnel in activities outside of their medical function.

109. Ibid 660.
110. Ibid 683–4.
111. Ibid 689.
112. Boothby, above n 8, 767.

3. Acts inconsistent with humanitarian function

A further requirement for an action by medical personnel to be prohibited is that the action which is harmful to the enemy must be committed outside their humanitarian function.[113] This is a significant requirement because it assists in distinguishing between those acts that are committed without the intention of being harmful but which could accidentally have an unfavourable effect on the enemy, and those acts which are deliberately committed in order to harm the enemy. There are a number of practical scenarios where this could occur and a number of examples were discussed by the Diplomatic Conferences in 1949 and 1974–77. For example, a mobile medical unit might accidentally break down while it is being moved in accordance with its humanitarian function and obstruct a crossroad of military importance; radiation emitted by an x-ray apparatus could interfere with the transmission or reception of wireless messages at a military location, or with the working of a radar unit; or the lights of a medical unit at night could interfere with the tactical operations of the adversary.[114]

These examples would technically be permitted because they do not constitute acts outside the humanitarian function of the medical units. 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.

V. LEGAL CONSEQUENCES OF REASSIGNMENT OF PERSONNEL

It is possible that permanent military medical personnel may be reassigned to non-medical duties or that combatants will be assigned to medical tasks for short periods of time. Different factors are relevant in these two circumstances in determining the legal consequences that will follow from a reassignment of personnel.

1. Use of permanent medical personnel for non-medical duties

There may be circumstances where a military commander finds that he or she has insufficient combatants to undertake particular tasks commonly performed by combatants. For example, a commander may have insufficient combatants to guard the perimeter of a military establishment within an area of operations. The military establishment may include a medical unit but also a number of military objectives such as military aircraft, fuel depots and combat troops. The commander may consider it desirable to use permanent military medical personnel for piquet duty. However, a commander in such circumstances would need to take extreme care because the ability to use permanent military medical personnel in

113. Henckaerts & Doswald-Beck, above n 3, 79.
114. Pictet, above n 79, 201.

such circumstances is significantly limited. Permanent medical personnel can only be utilised for duties such as piquet duty provided it can be demonstrated that the use of such personnel was lawful or the personnel could be formally reassigned as non-medical personnel.

If the piquet duty was restricted to keeping a watch only over the medical establishment, and the medical personnel and patients within it, there would be no issue with using permanent military medical personnel for this duty because this would form part of their broad medical function; that is, the use of permanent medical personnel for piquet duty directly related to a medical facility would be lawful. Permanent medical personnel are entitled to wear their red-cross brassards and retain their special identity cards whilst carrying out such duties. Further, they are entitled to arm themselves with light individual weapons for this purpose and to resist an advance by the adversary if they had reasonable grounds to believe that the adversary was deliberately attempting to kill the wounded, the sick or members of the medical unit.

However, if the scope of the piquet duty went beyond defending the medical unit and its personnel and patients from attack, difficulties can arise. Where the perimeter being defended holds a number of military objectives within it, piquet duty of this nature is likely to constitute an act harmful to the enemy that is contrary to the medical unit's humanitarian function. Using unarmed medical personnel on piquet duty would make no difference to the nature of the task[115] because the early warning that a member of piquet duty provides may amount to hindering the adversary's operations. This would be an act harmful to the enemy that is inconsistent with a medical person's humanitarian function. Therefore, medical personnel participating in piquet duty would lose their protected status and would not be entitled to display their protective emblem or carry a special identity card.

Other scenarios can arise where the situation may not be clear. For example, medical personnel may accompany other forces into a combat zone to treat sick or injured combatants or to transit through the combat zone. If a unit containing some medical personnel comes under attack the ability of the medical personnel to participate in any counterattack or act of self-defence with their combatant colleagues will be less clear. Their combatant colleagues will be able to engage in the hostilities as combatants and use all force available to combatants whereas the medical personnel will only be able to engage in acts of self-defence. The close proximity of the medical personnel with their combatant colleagues while in contact with the enemy may lead to uncertainty as to the amount of force that can be used by the medical personnel. If they go beyond acting in self-defence and engage in acts harmful to the enemy, for example, by defending their combatant

115. Intelligence gathering and guarding activities whilst unarmed would, depending on the circumstances, most likely be considered –direct participation in hostilities: see ICRC, above n 7, 1023, 1032 & 1043.

colleagues who are not injured, they will lose their protection from attack and will not enjoy combatant immunity.

As a combatant, a person is authorised to participate in hostilities and to perform belligerent acts such as killing or wounding enemy combatants. That is, combatants possess a 'legally sanctioned license to kill and engage in organised violent acts; non-combatants do not have the right to engage in hostilities'.[116] This 'is often referred to as "combatant" or "belligerent" privilege'.[117] The rationale behind the status of combatant and the notion of belligerent privilege is 'to ensure that hostilities are conducted solely between combatants and against military objectives, hence preserving the immunity of civilians and other non-combatants from attack and thereby preventing that civilians and civilian objects are harmed any more than is strictly necessary'.[118] As a result of having a right to participate in hostilities, 'combatants enjoy immunity upon capture from criminal prosecution for lawful acts of war, such as attacks against military objectives'.[119]

It could be argued that an order given to permanent medical personnel to conduct piquet duties, beyond the scope of protecting a medical establishment, would effectively amount to a reassignment of non-combatants to combatant roles. However, the better view is that if a person assigned permanently as a medical member of the armed forces was reassigned to a combatant role for only a short period of time, they remain a permanent medical member of the armed forces. It is important to be clear that protection from attack and combatant immunity are two very different concepts. It does not follow that because a person has lost protection from attack that their status changes from a non-combatant to a combatant.

Therefore, it cannot be assumed that because a person participates in hostilities, they immediately gain combatant immunity. This is clear from the treatment of civilians under international humanitarian law. Civilians can be targeted 'for such time as they take a direct part in hostilities'.[120] But their status does not change. They remain civilians and are only liable for attack 'as if they were combatants',[121] not because they have changed status to combatants. A civilian may become a combatant by becoming a member of the armed forces but not simply by participating in hostilities.

The same principle should be applicable to permanent medical personnel. There is no provision in international humanitarian law that provides that their status as a non-combatant changes because they participate in hostilities. As permanent

116. Gill & van Sliedregt, above n 23, 31.
117. Ibid.
118. Ibid.
119. J Pejic, '"Unlawful/Enemy Combatants:" Interpretations and Consequences' in MN Schmitt & J Pejic (eds), *International Law and Armed Conflict: Exploring the Faultlines* (Leiden: Martinus Nijhoff Publishers, 2007) 336.
120. Additional Protocol I above n 2, art 51(3); Additional Protocol II, above n 2, art 13(3).
121. N Melzer, *Targeted Killing in International Law* (Oxford: OUP, 2008) 329.

medical personnel, their status should only change when they are *permanently* reassigned from the medical category to a non-medical category. Assigning them to a non-medical task for a few hours or a few days is not sufficient for such purposes. Accordingly, permanent medical personnel engaging in hostilities for short periods of time are almost certainly doing so without combatant immunity. As Melzer suggests, the participation in hostilities by medical personnel 'must presumably have the same effect as it does in the case of civilians'.[122] The participation of permanent medical personnel in hostilities could therefore result in serious criminal sanctions. If, while on temporary piquet duty to protect a military establishment, they engage and kill enemy combatants, they could be convicted of murder.[123]

As outlined in Part III, permanent military medical personnel must be issued with an identity card which must include the person's name, date of birth, rank, service number and the capacity that entitles them to protection.[124] In addition, the identity card must include a photograph of the person and be embossed with the stamp of the military authority.[125] If a permanent military member is reassigned from exclusive medical tasks to non-medical tasks, they would not only need to be permanently assigned to their new category, it would also be important to withdraw and cancel their protective identity card.[126] This would provide transparency and ensure that the system is not being abused.

Even if a small number of permanent military medical personnel take part in hostilities without being formally reassigned, the entire medical unit or establishment is at risk of losing its protective status. Under Geneva Convention I, protection is lost if units or establishments engage in acts harmful to the enemy.[127] It is a requirement that due warning be given to the medical unit and a reasonable time to comply with the warning, before a unit can lawfully be targeted.[128] However, there is no express requirement as to how many members of a medical unit need to engage in acts harmful to the enemy before their action is considered to be actions of the unit. Given the serious consequences that result from medical personnel engaging in acts harmful to the enemy, this provides another compelling reason not to assign permanent military personnel to combat duties.

122. Ibid.
123. MJ Aukerman, 'War, Crime, or War Crime? Interrogating the Analogy Between War and Terror' in DK Linnan (ed), *Enemy Combatants, Terrorism, and Armed Conflict Law* (Connecticut: Praeger Security Int'l, 2008) 147.
124. Geneva Convention I, above n 1, art 40.
125. Ibid.
126. Geneva Convention I, ibid, art 40 provides that permanent military medical personnel cannot be deprived of their insignia or identity cards nor of their right to wear the armlet. Accordingly their identity card can only be withdrawn if they are permanently reassigned to combat duties in accordance with domestic regulations and policies.
127. Geneva Convention I, ibid, art 21.
128. Ibid.

As a matter of law, if medical personnel are to be deployed on an operation under the assumption that they will be reassigned to combatant duties (such as piquet duty) on a regular basis, those medical personnel could not possibly be characterised as permanent because their assignment is not definitively to medical purposes. Therefore, the use of medical personnel in such a way could only operate on the assumption that all medical personnel within the deployed force are temporary. Under such a system, protection of personnel would only commence when they have in fact ceased to do non-medical work. One of the consequences of using temporary medical personnel would be that they would be treated as prisoners of war upon capture and would not be entitled to care for the wounded and sick in detention.

As with the scenario above, common sense would dictate that there should be no change in the assignment of medical personnel during an operation.[129] The more often a commander reassigns his or her permanent medical personnel to combatant duties and vice versa, the more difficult it would be for the commander to fulfil the requirement of 'exclusivity' and the personnel concerned could be liable for criminal sanctions for participating in hostilities without combatant immunity. Regular re-assignment also serves to introduce a generally harmful mistrust regarding the protection of medical personnel and objects.

2. The temporary use of combatants in medical units

Combatants are lawfully entitled to participate in hostilities. Nevertheless, combatants can be temporarily assigned to protect medical units or to engage in medical duties. Whether they fall within the definition of temporary medical personnel in Additional Protocol I,[130] and thus benefit from temporary protection from attack, will depend on the precise nature of their activities.

For example, combatants may be used to protect or escort a medical unit if the unit does not have sufficient permanent personnel for such purposes.[131] In such circumstances the medical unit does not lose protection from attack.[132] The status of these combatants is that they will remain combatants and do not fall within the definition of medical personnel in Geneva Convention I or Additional Protocol I. To be eligible for protection as temporary medical personnel they need to engage in activities such as the search for, collection, transportation, diagnosis or

129. As outlined in Part III above, if a party to a conflict reassigned permanent medical personnel to active combat duties the party would need to comply with any domestic regulations and policies applicable to any such reassignment. It is unlikely that a field commander would have discretion to make such a permanent reassignment of personnel. It is more likely that such personnel could only be assigned permanently to combat duties after additional training and appropriate formalities required under domestic regulations and policies.
130. Additional Protocol I, above n 2, art 8.
131. Geneva Convention I, above n 1, art 22(2).
132. Ibid.

treatment of the sick and wounded.[133] Accordingly, such combatants are protected from attack because of their legitimate presence with a medical unit. Importantly, their combatant role is limited during the time that they are protecting or escorting a medical unit. They can only act in a 'purely defensive manner and may not oppose the occupation or control of the unit by the enemy';[134] that is, they can only protect the medical unit and the sick and wounded from unlawful attacks. They cannot oppose the lawful capture of the medical unit. Such combatants are not temporary medical personnel because they are not engaged in medical duties and they have no right to wear the protective emblem. They are engaged in the lawful protection of medical units and medical personnel but they are not themselves medical personnel. They benefit from protection from attack not because they are temporary medical personnel but because they are there to protect the wounded and sick.[135] This has been described as a form of 'practical immunity'.[136]

The status of combatants will be different when they engage in medical duties. For example, combatants may be sent out to the 'front line' to collect the wounded. Such combatants are only entitled to wear an internationally recognised protective emblem such as the red-cross brassard where they are entitled to protection under international humanitarian law. Ordinarily, these combatants could be lawfully targeted by the adversary. However, if a commander was satisfied that his or her combatants could be re-categorised as temporary medical personnel during the activity, he or she could lawfully order them to wear red-cross brassards and they would be entitled to the protection afforded to medical personnel, provided that they strictly comply with the requirements of temporary medical personnel as outlined in Geneva Convention I and Additional Protocol I.

While collecting the wounded, they will be devoted to medical purposes but it is likely that this will not be for an extended period of time. Whilst there is no fixed time limit, the ICRC commentary on Additional Protocol I suggests that common sense dictates that, to the greatest possible extent, there should be little or no change in the assignment of personnel between medical and non-medical duties during an operation.[137] If the medical assignment of a combatant is too short and changes too often, this will only 'serve to introduce a generally harmful mistrust regarding the protection of medical personnel and medical objects.'[138] It could even amount to perfidy. In addition, a combatant trained in targeting the enemy would need to ignore that training and restrain from engaging with the enemy whilst engaged in medical purposes except for the use of force in self-defence.

133. Geneva Convention I, above n 1, art 25; Additional Protocol I, above n 2, art 8.
134. Pictet, above n 79, 204.
135. Ibid.
136. Ibid.
137. Sandoz, Swinarski & Zimmermann, above n 33, [395].
138. Ibid.

If the reassignment is simply too short for the combatants to have been exclusively assigned to the collecting of and caring for the sick and wounded, then the combatants should not be categorised as temporary medical personnel capable of protection or eligible to wear the red-cross brassards. It is important to adopt a conservative approach to ensure that the system of protection is not abused.

If temporary military medical personnel are to be assigned to medical duties for a short period of time, it is a requirement that they carry identity documents specifying 'what special training they have received, the temporary character of the duties they are engaged upon and their authority for wearing the armlet'.[139] This is a critical requirement. If a combatant wearing a distinctive protective armlet or brassard does so without the appropriate documentation, they could be liable for misuse of the protective emblem.[140]

Another consequence of using temporary medical personnel in such a manner is that it is likely to instil a harmful mistrust of the system of protection. For example, if an adversary were to observe personnel wearing red-cross brassards by day and removing the brassards by night it would be reasonable for the adversary to assume that the system of protection was being abused. The more that temporary medical personnel are switched from their medical roles to their non-medical roles, the greater the risk to the overall system of protection.

One solution to this problem would be for military commanders to prohibit temporary medical personnel from wearing their red-cross brassards per se. The advantage of this is that commanders would not run the risk of eroding the system of protection caused by constant re-assignments. The obvious disadvantage would be that such personnel would not be easily distinguished from combatants when carrying out medical duties and this could result in them being the object of an attack.

Notwithstanding, it would appear that the requirements of article 8(k) of Additional Protocol I were designed to avoid the 'revolving door' issues of regularly revolving personnel between protected and non-protected status. Under article 8(k), temporary medical personnel must be 'devoted exclusively' to medical purposes for limited periods during the whole of such periods. Specific time limits are not set, presumably so that the rules can be applied with due regard to the circumstances of each case. However, temporal limitations are of significant importance.

139. Geneva Convention I, above n 1, art 41. The right of permanent medical personnel not to be deprived of their insignia or identity card outlined in art 40 does not apply to temporary medical personnel.

140. Geneva Convention I, ibid, arts 53 & 54.

CONCLUSION

The use of permanent military medical personnel for non-medical tasks in armed conflicts can have significant legal consequences. The same applies to the use of combatants for medical tasks if those combatants propose to claim protection available to temporary medical personnel.

Where permanent military medical personnel engage in non-medical tasks that can be characterised as acts harmful to the enemy and inconsistent with their humanitarian functions, those personnel will not be entitled to protection while completing those tasks unless they are permanently reassigned to combatant roles. But to be permanently reassigned, commanders would need to ensure that red-cross brassards and special identity cards are removed from medical personnel prior to them undertaking such tasks so that perfidy is not committed. Formal reassignment from the medical category to a non-medical category would also be required. If these conditions are not strictly complied with, any permanent military medical member of the armed forces will be taking a direct part in hostilities without combatant immunity. The consequences are such that persons can be prosecuted for acts that they commit, including murder.

In relation to combatants performing medical duties on a temporary basis, it is important to appreciate that simply performing those duties exclusively for a short period of time is not sufficient to claim protection from attack. To claim protection, it is a requirement that such combatants have some training for those medical tasks and that they possess documentation confirming that training and the authority for wearing the protective brassard. If combatants do not meet these conditions, they cannot lawfully wear a protective brassard. They can, of course, perform medical duties and assist their permanent medical colleagues but they would be doing so as combatants and without specific protection from attack. This poses its own problem in that such combatants may lawfully be attacked while assisting the sick and wounded, provided the principle of proportionality is complied with. Therefore, there is a danger in having combatants assist with medical duties on a temporary basis without protection from attack, because permanent medical personnel and the sick and wounded may be injured during any attack on the combatants. It is therefore preferable to identify combatants who can be trained to meet the requirements of temporary medical personnel under Geneva Convention I ahead of time. In this way they can assist a medical unit as temporary medical personnel, rather than as combatants, and their protected status will enhance the protection of the unit.

Universal recognition of the protection regime for medical personnel is critical. The regime needs to be strictly complied with so that medical personnel are protected and the sick and wounded receive necessary care. As the ICRC noted in its commentary on Additional Protocol I, it is essential in practice to find a balance between 'the flexibility necessary to ensure the greatest possible aid

for the wounded, and strict rules regarding the exclusive character of medical assignment which is indispensable to the survival of this system of protection, based as it is, on trust'.[141] The balance is set out in conventional and customary international humanitarian law and the consequence of non-compliance can both erode the system of protection and have severe legal consequences for the individuals concerned.

141. Sandoz, Swinarski & Zimmermann, above n 33, [396].