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“Hospital Shields” and the Limits of International Law

Neve Gordon* and Nicola Perugini**

Abstract

Assaults on hospitals have become part of a widespread warfare strategy, propelling numerous actors to claim that belligerents are not being held accountable for attacking medical units. Acknowledging that IHL offers medical units protections, belligerents often claim that the hospitals were being used to shield military targets and therefore the bombing was legitimate. Tracing the history of hospital bombings alongside the development of legal articles dealing with the protection of medical units, we show how from the early twentieth century international law introduced a series of exceptions that legitimize attacks on hospitals that were framed as shields. Next, we demonstrate that the shielding argument justifies bombing hospitals because they have ostensibly assumed a threshold position in-between the two axiomatic poles informing the laws of war—combatants and civilians. We argue, however, that medical units tend to occupy a legal and spatial threshold during war and since IHL does not have the vocabulary to acknowledge the liminal nature of medical units and identifies between liminality and criminality, it introduces several exceptions that help belligerents legitimize their attacks. By way of conclusion, we maintain that the only way to address the deliberate and widespread destruction of medical units is by reforming the law through the introduction of an absolute ban.

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1 Introduction

From the war in Afghanistan through the US-backed Saudi intervention in Yemen to the Israeli occupation of Palestine, and the Syrian civil war, hospitals have constantly been bombed by military forces under the guise of “counter-terrorism.” In 2016 alone, attacks on health care facilities occurred in twenty-three countries across the globe.¹ In Syria, hospitals were attacked 108 times—an average of one every three and a half days. In Afghanistan the number of strikes targeting health facilities rose from sixty-three in 2015 to 119 in 2016, while in Yemen hospitals were attacked ninety-three times during a similar period. As the numbers clearly indicate, medical facilities have not only become a legitimate target but also part of a recurrent strategy of war aimed at systematically weakening the enemy.²

In 2016, Médecins Sans Frontières (MSF), one of the organizations whose medical facilities and staff have been targeted in different conflict zones, launched the international campaign “Not a Target.” MSF denounced the lack of “serious or impartial investigations” following attacks on medical units, exposing a “vacuum in the international humanitarian system and in the political system.”³ The same year, scores of humanitarian and human rights organizations launched another international advocacy initiative in an effort to curb the proliferation of attacks on medical facilities, this time calling upon the United Nations Security Council to intervene. The culmination of these campaigns resulted in the unanimous adoption of UN Security Council resolution 2286 (2016), which strongly condemned “acts of violence, attacks and threats against the wounded and sick, medical personnel and humanitarian personnel exclusively engaged in medical duties....”⁴ The Security Council also demanded that “all parties to armed conflict fully comply with their obligations under international law, including

¹ Safeguarding Health in Conflict, *Impunity Must End: Attacks on Health in 23 Countries in Conflict in 2016* (2017), available at <https://www.safeguardinghealth.org/sites/shcc/files/SHCC2017final.pdf> (last visited 11 January 2019).

² O. Dewachi, *Ungovernable Life: Mandatory Medicine and Statecraft in Iraq* (2017).

³ MSF, *Not A Target*, at <http://notatarget.msf.org> (last visited 11 January 2019).

⁴ SC Res. 2286, 3 May 2016.

international human rights law, as applicable, and international humanitarian law, in particular their obligations under the Geneva Conventions of 1949 and the obligations applicable to them under the Additional Protocols thereto of 1977 and 2005, to ensure the respect and protection of all medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities.”⁵

This brief account underscores the extreme gravity and global extent of attacks against medical units. Death is knocking on hospital doors, but this death is not the one embodied in the sick and wounded who are carried into the wards on stretchers. Rather it is death from the air, from missiles and mortar bombs targeting medical units whose primary objective is to sustain and prolong life. This account also suggests that, according to humanitarian and human rights organizations as well as the UN Security Council, one of the primary problems facing medical facilities and staff in conflict zones is that the warring parties are not being held accountable for attacking hospitals. Accordingly, in the numerous reports, recommendations and resolutions disseminated by these actors the underlying assumptions are that international humanitarian law (IHL) provides the necessary protections to medical units and that the ongoing and systematic targeting of hospitals is due to belligerents’ disregard of the law.⁶

Yet, belligerents charged with bombing medical units often disagree with these accusations. To be sure, in some cases the attacker provides no explanation, denies attribution, or maintains that the strike on the medical unit was not intended. Yet, increasingly, belligerents are blaming their enemies for violating international law, claiming that the bombed hospital was used as a shield. Their argument, in a nutshell, is that the hospital was shielding combatants or harboring weapons and therefore bombing it does not constitute a violation of IHL. Indeed, they are increasingly justifying attacks on medical facilities by claiming that the enemy has blurred the distinction between military targets and civilian structures through the use of hospitals as shields—hiding military activities behind them or placing their medical units close to military targets to

⁵ SC Res., *supra* note 4.

⁶ Human Rights Watch, *Hospitals, Health Workers Under Attack* (2015), available at <https://www.hrw.org/news/2017/05/24/hospitals-health-workers-under-attack> (last visited 11 January 2019); Human Rights Watch, *Yemen: Coalition Airstrikes Hit Hospital* (2015), available at <https://www.hrw.org/news/2015/10/27/yemen-coalition-airstrikes-hit-hospital> (last visited 11 January 2019); Safeguarding Health in Conflict, *supra* note 1.

protect them—which then legally allows them to bomb the hospital, provided they give adequate warning and do not breach the principles of proportionality and military necessity.

During the 2014 Gaza war, for example, Israeli strikes destroyed or damaged seventeen hospitals, fifty-six primary healthcare facilities, and forty-five ambulances.⁷ In an attempt to defend these attacks, Israel accused the Palestinian Islamist movement Hamas of using hospitals to store weapons and hide armed militants.⁸ In a similar vein, after the bombardment of an underground medical facility in a rebel controlled area, a Syrian regime official declared that militants would be targeted wherever they were found, “on the ground and underground,” while his Russian patron explained that rebels were using “so-called hospitals as human shields.”⁹ Saudi officials attempting to justify the high number of air strikes targeting medical facilities in Yemen have also adopted the same catchphrases. They, too, have accused their adversaries, the Houthi militias, of using hospitals to hide their military forces.¹⁰

Reacting to the increasing attacks on medical facilities, an editorial published by *The Lancet* ponders whether “the humanitarian principles as they are defined today still relevant for this changing warfare?”¹¹ This question begins to broach “the elephant in the room,” namely IHL’s capability to provide the legal toolkit needed to protect medical units within contemporary conflict zones. On the one hand, the question calls upon us to examine the tools IHL provides to protect hospitals and to interrogate whether the inability to defend them is indeed due to the changing modes of warfare (as *The Lancet* assumes) or, alternatively, to investigate whether the problem is

⁷ H. Kennedy, *The 2014 conflict left Gaza’s healthcare shattered. When will justice be done?* (2015), available at <https://www.theguardian.com/commentisfree/2015/jun/29/2014-conflict-gaza-healthcare-hospitals-war-crime-israel-hamas> (last visited 11 January 2019).

⁸ IDF Blog, *Hamas Terrorists Confess to Using Human Shields* (2014), available at <https://www.idf.il/en/minisites/hamas/hamas-terrorists-confess-to-using-human-shields> (last visited 11 January 2019).

⁹ E. Francis, *Even in a bunker under a mountain, Syrian hospital knocked out by strikes* (2016), available at <https://www.reuters.com/article/us-mideast-crisis-syria-hospital/even-in-a-bunker-under-a-mountain-syrian-hospital-knocked-out-by-strikes-idUSKCN1231RQ> (last visited 11 January 2019).

¹⁰ Al Jazeera English, *Jiat disputes claims against Arab coalition in Yemen* (2016), available at <https://www.aljazeera.com/news/2016/08/jiat-disputes-claims-arab-coalition-yemen-160806105813872.html> (last visited 11 January 2019).

¹¹ Editorial ‘Examining Humanitarian Principles in Changing Warfare’ 391(10121) *The Lancet* (2018), at 631.

actually rooted in the law itself and the way the protections were formulated in the different international conventions, from the 1864 Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field until the 1977 Additional Protocols to the Four Geneva Conventions. Surprisingly, aside from the commentary provided by the International Committee of the Red Cross (ICRC), there is hardly any scholarly literature on the protections IHL confers on medical units.

On the other hand, the editorial raises a more conceptual question about IHL's ability to grapple with what we call, following Victor Turner, *threshold* figures and institutions.¹² Medical staff and facilities operating in the midst of war, as we show below, can quite easily be accused of shielding precisely because they are frequently located in-between the two axiomatic poles informing the laws of war—combatants and civilians—and often spatially and conceptually between the warring parties.¹³ Our claim is that unlike other figures and institutions that may assume a threshold position during different periods in war, medical staff and facilities often occupy a legal borderline due to the kind of work they are charged with doing.

An analysis of the history of hospital bombings and the development of IHL reveals not only that international law does not adequately address the liminal position of medical units, but that it does not have the vocabulary to grasp it. In order to adequately confront the pervasive destruction of health facilities and to outline a solution to the problem, this shortcoming needs to be urgently addressed.

In what follows, then, we provide a concise history of hospital bombings alongside a thumbnail sketch of the development of the relevant articles in IHL dealing with the protection of medical units. We show how from the early twentieth century bombed hospitals were being framed as shields, while the legal and spatial threshold position occupied by medical units in the battlefield allowed warring parties to legally defend their attacks. Next, we show that, according to IHL, when hospitals are used as shields the principle of proportionality can be relaxed. Their liminality paves the way for constructing them as facilities that can be attacked. We accordingly argue that due to the incapacity of IHL to protect hospitals—the fact that it does not even have a lexicon to deal with liminal figures and institutions—only an absolute prohibition, similar to the ban against

¹² V. Turner, *The ritual process: Structure and anti-structure* (1969).

¹³ About the distinction between the two axiomatic figures see H. Kinsella, *The image before the weapon: A critical history of the distinction between combatant and civilian* (2011).

torture, can provide medical facilities the legal protection that they actually need. The law, in other words, needs to be radically reformed.

2 Hospital Bombing and International Law

The current attacks on hospitals as well as their justifications are part of the history of modern warfare and the emergence of international laws aimed at protecting medical units. Ever since 1911, when the Italians first introduced aerial bombings into armed conflict, medical units have been targeted from the air.¹⁴ Right after Louis Blériot flew across the English Channel, the Italian military rushed to acquire a squadron of Caproni planes and soon thereafter used them to quell a popular revolt in Libya, their north African colony. The pilots, who flew not much faster than 100 kilometers an hour, opened their cockpits and threw five-kilogram bombs at demonstrators.¹⁵ In response, the Ottoman Red Crescent sent a cable to the Geneva based ICRC, asking it to “Protest indignantly against bombing by Italian airplanes of hospitals marked with Red Crescent flag in Tripolitania.” Whilst the newly established air force continued bombing medical facilities in the colony, Geneva relayed the complaint to the Italian government, asking for a response.¹⁶

By the time the Italians introduced aerial bombings, the Geneva based humanitarian organization had been in existence almost half a century, having been established by Henry Dunant after he had witnessed the horrors of war at Solferino.¹⁷ The lack of medical resources to care for the wounded who were left lying in the battlefield motivated Dunant to create a voluntary organization of professionals who would provide medical assistance in the field. The International Committee for Relief to the Wounded, which would later become the International Committee of the Red Cross, assumed two central roles. It began recruiting and sending volunteer medical staff who were not beholden to any army or nation and therefore considered to be neutral and impartial to the field, and it became one of the key mobilizers for drafting humanitarian laws that

¹⁴ S. Lindqvist, *A history of bombing* (2001).

¹⁵ A. Durand and P. Boissier, *From Sarajevo to Hiroshima: History of the International Committee of the Red Cross* (1984).

¹⁶ Durand and Boissier, *supra* note 15, at 17.

¹⁷ H. Dunant, *A Memory of Solferino* (2013).

emphasized the protection of the victims of war, the sick, the wounded, prisoners, and civilians.¹⁸ Both of these roles aimed to expand a politics of life, which is inscribed in medicine, and to counter the politics of death propelled by war.

It was precisely the accentuation of medical neutrality during the 1863 Geneva Conference that enabled Dunant to convince the powerful countries of his time to sign the First Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field the following year.¹⁹ The recruitment of volunteer medical staff who are not parties to the conflict helped inaugurate the idea that medicine was somehow neutral, impartial and even external to the war effort, which, in turn, served to justify the protections provided in the 1864 Geneva Convention to medical units during war.²⁰ Yet, already in Article 1 of the First Geneva Convention the relationship between medicine as a biopolitical field aimed at prolonging life and war as necropolitical field is dealt with in a confounding way.²¹ The Convention highlights the protections offered to medical units, but immediately qualifies them by declaring that ambulances and military hospitals should be protected only as long as they remain neutral. Indeed, the word neutral appears in five out of the ten articles comprising the 1864 Convention. The protections, in other words, cease if medical units and staff are considered partial or become part of the war effort.²²

¹⁸ See T. Meron, 'The humanization of humanitarian law', 94(2) *American Journal of International Law* (2000) 239; M. Gross, *Bioethics and armed conflict: moral dilemmas of medicine and war* (2006).

¹⁹ First Geneva Convention, *Convention for the Amelioration of the Condition of the Wounded in Armies in the Field* (1864), available at <https://ihl-databases.icrc.org/ihl/INTRO/120?OpenDocument> (last visited 11 January 2019).

²⁰ Medical neutrality is grounded also in the right of wounded and sick soldiers and civilians to receive medical treatment. Accordingly, the protections offered to medical staff and facilities are, as Gross points out, a derivative right. Finally, medical personnel and facilities warrant protection because the ultimate purpose of the profession is to secure life while its ethical code calls on all health-care staff not to do harm. See Gross, *supra* note 18, at 194.

²¹ For the notion of biopolitical see M. Foucault, M. Senellart, G. Burchell, *Security, Territory, Population: Lectures at the Collège de France 1977-1978* (2007). For the notion of necropolitics see A. Mbembe, 'Necropolitics', 15 *Public culture* (2003) 11, at 11.

²² See ICRC, *Convention for the Amelioration of the Condition of the Wounded in Armies in the Field* (1864), available at <https://ihl-databases.icrc.org/ihl/INTRO/120?OpenDocument> (last visited 26 April 2018); ICRC, *Commentary on the First Geneva Convention* (2016).

In a similar vein, the 1906 Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field states that the protections offered to medical units cease “if they are used to commit acts injurious to the enemy.”²³ The protection of the medical field are thus predicated on a conception of neutrality, which, in effect, means a separation from the war effort; when medical units exceed their humanitarian duties the protections bestowed on them can be legally rescinded.

The Italian government was familiar with both Conventions. In its reply to ICRC, it did not claim that medical units had been used in an illegal manner in Libya, but rather contested the charges and requested that protective markings “should be clearly visible on tents, detachments, convoys, etc., so as to make them recognizable even from afar and from the air.”²⁴ The Italians thus suggested that the Libyans had not created an adequate separation between the medical units and protestors and therefore Italy could not be held responsible for damaging the hospitals. It consequently declared that during the fighting it expected medical personnel to keep a fair distance away from the forces engaged in combat and that separate and clearly visible areas should be allotted to hospitals and medical staff. Proximity to a military target, the Italians intimated, rendered hospitals susceptible to attack because fighters could use the medical units to hide. In conclusion, the Italian government asserted that it would refuse to assume any responsibility for harm caused by their attacks if such precautions were not observed at all times, for “it could not give up its capability of using all methods of attack authorized by international law, any more than the presence of *[medical] units could be allowed to serve as a safeguard for the enemy against its action.*”²⁵ Thus, from the very first instances in which medical units were bombed from the air, the charge of shielding enemy combatants – of undermining the separation between civilians and combatants and between the fields of life and death – was introduced as justification for the attacks.

These requests did not seem excessive to ICRC, revealing, as it were, how military and humanitarian professionals often share the same conceptual framework and speak the same legal

²³ ICRC, *Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field* (1906), available at <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Treaty.xsp?action=openDocument&documentId=C64C3E521F5CC28FC12563CD002D6737> (last visited 11 January 2019).

²⁴ Durand and Boissier, *supra* note 15, at 16.

²⁵ *Ibid.*, *supra* note 15, at 16. (Italics added).

vocabulary.²⁶ The ICRC consequently sent out directives on how to adapt markings so that medical facilities and ambulances could be seen from the air and recommended parking ambulances at some distance from barracks.²⁷ Notwithstanding the congenial exchange between ICRC and the Italian government, the systematic bombing of Red Cross units was to continue in different theatres of violence.

During World War I, the ICRC received eighty complaints relating to the bombardment of medical units by artillery or aircraft.²⁸ One case that attracted considerable media attention involved the German bombing of several hospital wards in Étaples on the southern coast of France in May 1918. The medical wards were hit repeatedly, killing and injuring hundreds of patients and nurses. In one of the raids, a German pilot was shot down, and while he was being cared for in the damaged hospital he had bombed, the pilot was interrogated about the attack. “He tried at first to excuse himself by saying that he saw no Red Cross,” one newspaper reported, but “When challenged with the fact that he knew that he was attacking hospitals he endeavored to plead that hospitals should not be placed near railways, or if they are, they must take the consequences.”²⁹ The pilot’s claim was straightforward: during war those who help sustain enemy life cannot expect to be protected if they are located in proximity to legitimate targets.

In May 1939, while preparing for another world war, the attack on medical facilities at Étaples was raised in the House of Lords in London, and the German pilot’s point of view was reaffirmed by a much more prominent soldier. Hugh Trenchard, who had headed the Royal Air Force from 1918 until 1930 and had since become a member in the House of Lords, told his fellow parliamentarians that he was aware of the “popular idea” that “every hospital flying the Red Cross is purposely bombed.” “One heard very much the same about the bombing of the hospitals and camps at Étaples during the War,” he continued, “and it apparently did not occur to anybody that the real objectives there were the railway and the dumps.” Trenchard then went on to refer his

²⁶ N. Perugini and N. Gordon, *The Human Right to Dominate* (2015).

²⁷ Durand and Boissier, *supra* note 15, at 52.

²⁸ *Ibid.*, *supra* note 15, at 52.

²⁹ Cited in Derek Gregory, *Geographical Imaginations, The Hospital Raids* (2016), available at <https://geographicalimagination.com/2016/09/25/the-hospital-raids> (last visited 11 January 2019).

colleagues to Volume Six of the Official History, where the Director of Military Operations at the War Office said that “We have no right to have hospitals mixed up with reinforcement camps, and close to main railways and important bombing objectives, and until we remove the hospitals from the vicinity of these objectives, and place them in a region where there are no important objectives, I do not think we can reasonably accuse the Germans.”³⁰ In other words, the British War Office agreed with the Italian government that a hospital’s proximity to a military target makes it liable, because in their eyes it is being used to hide or shield the legitimate target. Consequently, culpability lies with those who place the hospital in such a location and not with those who bomb it. The blame rests with those who cannot sustain the distinction between life-enabling institutions and war-making infrastructures.

Between the two world wars assaults on medical units persisted in several theatres of violence, including the Italo-Ethiopian War, the Spanish Civil War and the Second Sino-Japanese war. While shielding accusations played a prominent role in the heated debate about the bombing of medical units in Ethiopia, the Red Cross issued complaints to the warring parties involved in the latter two conflicts, but these countries did not bother to explain or defend the bombings.³¹ Nonetheless, the protection of hospitals was on the mind of numerous people at the time, and, in 1929, General Georges Saint-Paul of the French Army Medical Corps published a plan to establish hospital zones far from large towns, where the wounded as well as “mothers and young children, expectant mothers, the aged, sick and crippled” could be protected during war.³² His idea of creating a clear separation between civilian infrastructures and military targets began circulating, and five years later, a commission of medical practitioners and legal experts met in Monaco to draw up a first Draft Convention, which included provisions concerning the creation of “hospital towns” for wounded and sick combatants as well as “cities of refuge” “for certain classes of the

³⁰ Lords Sitting of Wednesday, 15th March, 1939. Parliament:1938-39, Collection: 20th Century House of Lords Hansard Sessional Papers, Fifth Series, Volume 112:214-288, at 239.

³¹ For an analysis of attacks on medical facilities during the Italo-Ethiopian War, see N. Perugini and N. Gordon, ‘Between Sovereignty and Race: The Bombardment of Hospitals in the Italo-Ethiopian War and the Colonial Imprint of International Law’, *State Crime*, forthcoming Spring 2019. In August 1937, the Chinese blamed the Japanese for bombing a Red Cross hospital at Chen-Yu and several field ambulances, while in September the Japanese accused the Chinese for shelling two Japanese hospital ships, see Durand and Boissier, *supra* note 15, at 383.

³² ICRC, *Report Concerning Hospital and Safety Localities and Zones* (1946), at 1.

civilian population.”³³ In 1938, ICRC convened a conference aimed at proposing a “Convention for the establishment of Hospital Towns and Areas,” and while the meeting was extolled as a success, war broke out a year later and the proposal was shelved.³⁴ What is noteworthy, however, is the persistent attempt to create a bifurcation between zones of life and zones of death in times of war and to provide a series of protections to the zones of life. In other words, *the idea was to organize space according to the law, rather than rewrite the law according to what actually transpires in space in the midst of armed conflict.*

During World War II, when whole cities were bombed, and some completely flattened, there was no real effort to justify attacks on hospitals. Indeed, a mere thirty-four years after the first handheld explosives were thrown from a cockpit at Libyan protestors, the United States dropped atomic bombs on Hiroshima and Nagasaki, making it futile to separate civilian life from the effects of war, and, needless to say, to single out the destruction of hospitals as shocking. In what some have called “total war,” civilian life becomes expendable, and consequently bombing medical units was conceived to be par for the course.³⁵

Only in the aftermath of World War II did the protection of medical units re-emerge as a priority, when ICRC tried to develop new legal clauses aimed at protecting hospitals. These efforts resulted in the adoption of several provisions obliging warring parties to refrain from attacking medical facilities that display the red cross emblem—while also making clear that the protection conferred on these facilities could be forfeited in exceptional circumstances.³⁶ Civilian hospitals “may in no circumstances be the object of attack, but shall at all times be respected and protected by the Parties to the conflict,” reads Article 18 of the Fourth Geneva Convention. The Convention also establishes that “in view of the dangers to which hospitals may be exposed by being close to military objectives, it is recommended that such hospitals be situated as far as possible from such

³³ Ibid.

³⁴ Ibid.

³⁵ R. Aron, *The Century of Total War* (1965).

³⁶ M. W. Lewis, ‘The Law of Aerial Bombardment in the 1991 Gulf War’, 97(3) *American Journal of International Law* (2003) 481, at 481.

objectives.”³⁷ Finally, it notes that the “protection to which civilian hospitals are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy.”³⁸ This clause intimates, among other things, that medical units must be allowed to care for wounded combatants and do not lose the protections bestowed upon them by if they do. Nonetheless, Articles 18 and 19 of the Convention combine the protection of hospitals with the prohibition to shield military activities behind red cross emblems or to place medical facilities in proximity to military targets.

The fragility of these provisions became apparent during conflicts that took place in Southeast Asia right after World War II. In North Korea (1950-1953), American and United Nations forces destroyed several medical facilities, forcing the Koreans to move their hospitals underground.³⁹ In Vietnam, during the 1954 French defeat at Dien Bien Phu, the air force was accused of bombing medical units and evacuation convoys with napalm, to which the French government responded by accusing the Vietnamese resistance of violating the laws of war and “transporting munitions in medical aircraft marked with the red cross emblem.”⁴⁰ A decade and half later the Americans were charged with deliberately bombing Vietnamese hospitals marked with the red cross emblem, to which the military commanders responded by blaming the Vietcong of using the hospitals to shield attacking forces.⁴¹ After the infamous bombardment of the 940-bed Bach Mai Hospital, the United States military maintained that Vietnamese militants were using the red cross emblem as a shield, explaining that the hospital “frequently housed antiaircraft positions to defend the military complex,” while also adding that it was located less than 500

³⁷ Geneva Convention Relative to the Protection of Civilian Persons in Time of War, Aug. 12, 1949, 6 U.S.T. 3516, 75 U.N.T.S. 287 (Entered Into Force Oct. 21, 1950) [Hereinafter Fourth Geneva Convention]. Article 18.

³⁸ Fourth Geneva Convention, *supra* note 37, Article 19.

³⁹ C. K. Armstrong, ‘The Destruction and Reconstruction of North Korea, 1950–1960’, 7(0) *Asia-Pacific Journal* (2009) 1, at 2.

⁴⁰ F. Truninger and F. Bugnion, ‘The International Committee of the Red Cross and the Indochina War—From the Japanese defeat to the Geneva Agreements (1945–1954)’, 34(303) *International Review of the Red Cross Archive* (1994) 564, at 564.

⁴¹ See C. Rey-Schyr, *Histoire du Comité international de la Croix-Rouge, De Yalta à Dien Bien Phu 1945-1955*, (Vol. 3, 2007), at 395; F. Perret et F. Bugnion, *Histoire du Comité international de la Croix-Rouge, De Budapest à Saigon 1956-1965*, (Vol. 4, 2009), at 392.

meters from the Bach Mai airfield and military storage facility.⁴² The deployment of hospitals to conceal legitimate military targets and their proximity to such targets were thus invoked as justifications for the attack.

Due to these and other attacks on hospitals, medical units received significant attention in the Diplomatic Conference on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts (1974-1977), which led to the formulation of the 1977 Additional Protocols to the Geneva Conventions. During the Conference, the British delegation secured the introduction of an amendment emphasizing the illegality of using medical facilities to protect military activities, while suggesting that Additional Protocol I include the following clause: “The Parties to the conflict shall ensure that medical units are situated as far as possible so that attacks against military objectives cannot imperil their safety. Under no circumstances shall they be used in an attempt to protect military objectives from attack.”⁴³ The British delegate thus underscored the two situations whereby the protections offered to hospitals can be forfeited, the first involving their proximity to legitimate military targets and the second relating to hiding combatants or arms. Ultimately, both situations were formulated as a form of shielding and incorporated in Article 12 of Additional Protocol I, which states that “under no circumstances shall medical units be used in an attempt to *shield* military objectives from attack. Whenever possible, the Parties to the conflict shall ensure that medical units are so sited that attacks against military objectives do not imperil their safety”⁴⁴ ICRC adds in its commentary that the “deliberate siting of a medical unit in a position where it would impede an enemy attack” is sufficient for it to lose protection, knowing full well that “deliberate” is often in the eyes of the beholder.⁴⁵

Article 12 thus draws a direct link between shielding and proximity, categorically forbidding the use of hospitals as shields, while urging parties to distance medical units from

⁴² W. H. Parks, ‘Linebacker and the Law of War’, 34(2) *Air University Review* (1983) 2, at 12.

⁴³ Diplomatic Conference on the Reaffirmation and Development of International Humanitarian Law Applicable in Armed Conflicts (1974-1977), CDDH/II/22, 11 March 1974, United Northern Kingdom of Great Ireland Britain.

⁴⁴ Geneva Protocol I Additional to The Geneva Conventions Of 12 August 1949, Relating To The Protection Of Victims Of International Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 3 (here thereafter Additional Protocol I).

⁴⁵ J. Pictet *et al.*, *Commentary on the Additional Protocols: of 8 June 1977 to the Geneva Conventions of 12 August 1949* (1987), at 175.

combat zones whenever possible. This is not coincidental. Indeed, the two concepts actually have parallel trajectories in IHL since the charge that a medical unit is located in proximity to a military target suggests that it can be used to shield the target.

Examining current discussions about human shields helps clarify the relation between shielding and proximity. For instance, in the days leading up to the Iraqi military campaign aimed at recapturing Mosul from ISIS militants, the United Nations disseminated a press release, warning that ISIS was using “tens of thousands” of Mosul residents as human shields. Surely thousands of Iraqi civilians did not volunteer to become shields, and, most likely, the vast majority of them were not coerced into becoming involuntary shields.⁴⁶ The *proximity* to the fighting of tens of thousands of civilians who were trapped in Mosul was enough to categorize them as human shields, thereby stripping them of some of the protections IHL bestows on civilians.⁴⁷ In a similar vein, the proximity of a hospital to a military target is sufficient to render it a shield. Accordingly, the decision to inscribe “hospital shields” in Article 12 paves the way for the hospital shield charge, protecting, as it were, those who bomb hospitals rather than the doctors, nurses and patients who use them.⁴⁸

3 Hospital Shields

When accusing enemies of hospital shielding, belligerents are not disputing the claim that the facility is being used for medical purposes, but they maintain that their enemy is also using it to enhance hostilities by harboring or hiding a legitimate target. The claim that a hospital did not maintain the separation between life-enabling and death-making functions serves as a robust

⁴⁶ CBSNEWS, *U.N.: ISIS using “tens of thousands” as human shields in Mosul* (2016), available at <https://www.cbsnews.com/news/united-nations-says-isis-using-tens-of-thousands-as-human-shields-in-mosul-iraq/> (last visited 11 January 2018). For a discussion of voluntary, involuntary and proximate shields see M. W. Ezzo & A. N. Guiora, *A Critical Decision Point on the Battlefield – Friend, Foe or Innocent Bystander*, in C. M. Bailliet (eds), *Security: A Multidisciplinary Normative Approach* (2009).

⁴⁷ N. Gordon and N. Perugini, ‘Human Shields, Sovereign Power, and the Evisceration of the Civilian’, 110 *American Journal of International Law* (2016), 329.

⁴⁸ ICRC’s official commentary offers a lengthy explanation of Article 12 paragraph 4. See Pictet *et al.*, *supra* note 45, at 165-172.

defense because medical personnel actually lose the protections IHL allocates to them if they “commit, outside their humanitarian function, acts harmful to the enemy.”⁴⁹ According to ICRC, “Such harmful acts would, for example, include 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; another instance would be the deliberate siting of a medical unit in a position where it would impede an enemy attack.”⁵⁰ It is consequently sufficient to claim that a hospital was used to shield military activities—either by concealing a military target or by being too close to a target—after bombing the hospital, provided the principles of proportionality and military necessity were followed.

Israel, for example, invoked both kinds of exceptions following the 2014 war on Gaza. It published a legal report accusing “ Hamas and other terrorist organizations” of exploiting “hospitals and ambulances to conduct military operations, despite the special protection afforded these units and transports under customary international law.” It claimed that hospitals were used both as “command and control centers, gunfire and missile launching sites, and covers for combat tunnels,” and as proximate shields for Hamas militants who fired “multiple rockets and mortars within 25 meters of hospitals and health clinics.”⁵¹ Often Israel even called hospitals in advance of an attack, warning the staff that it was about to bomb their facility.⁵² This allowed the Israeli government to claim that it was providing medical units due warning and reasonable time to

⁴⁹ The quote refers to Article 13 of Additional Protocol I, *supra* note 44. Article 19 Fourth Geneva Convention, *supra* note 37 adds that “[t]he fact that sick or wounded members of the armed forces are nursed in these hospitals, or the presence of small arms and ammunition taken from such combatants and not yet been handed to the proper service, shall not be considered to be acts harmful to the enemy.”

⁵⁰ See Pictet *et al.*, *supra* note 45, at 175.

⁵¹ The State of Israel, *The 2014 Gaza Conflict: Factual and Legal Aspects* (2015).

⁵² C. Alfred, *Hospitals Are Supposed To Be For Healing. In Gaza, They're Part Of The War Zone* (2014), available at https://www.huffingtonpost.co.uk/entry/hospitals-bombed-gaza_n_5630606 accessed October 18 (last visited 11 January 2019).; N. Barrows-Friedman, *Israel used fabricated images to justify bombing al-Wafa hospital* (2014), available at <https://electronicintifada.net/blogs/nora-barrows-friedman/israel-used-fabricated-images-justify-bombing-al-wafa-hospital> accessed October 18 (last visited 11 January 2019).

evacuate the buildings before launching a strike, and therefore had not violated IHL articles requiring belligerents to warn medical units before bombing them.⁵³

A year later, the Joint Incidents Assessment Team of Saudi Arabia's military coalition in Yemen released a similar response following MSF protests against the bombardment of one of its medical units: "The [Assessment Team] found that the targeting was based on solid intelligence information... After verification, it became clear that the building was a medical facility used by Houthi armed militia as a military shelter in violation of the rules of international humanitarian law." According to the report, one of the medical facilities targeted by the coalition "was not directly bombed but was accidentally affected by the bombing due to its close location to the grouping which was targeted without causing any human damage. It is necessary to keep the mobile clinic away from military targets so as not to be subjected to any incidental effects."⁵⁴ Even though hospitals had been bombed, the Assessment Team concluded that coalition forces had not violated the law.

In these and numerous other cases we see how different actors with different political agendas have been classifying hospitals as shields, and, as such, not immune from attacks. What connects these responses is not merely the use of similar rhetoric or the accusation that a clear separation between life-enabling and war-making activities was not sustained, but also—and more importantly—the same underlying assumption: when health care facilities become "hospital shields" they are liable to lose the protected status IHL bestows upon them. Moreover, in the event that hospital shields are bombed, the party held responsible for the attack is often not necessarily the perpetrator but rather the one who has ostensibly used the medical unit to conceal a legitimate military target.

Our point is that the peculiar and often disturbing way that clauses pertaining to medical units are currently operationalized by an array of warring parties is intricately tied to the fact that these units occupy a threshold position and do not sit well with IHL's dichotomous categorization

⁵³ Article 21 Convention I, Article 19 Convention IV, Article 13 Protocol I, and Article 11 Protocol II.

⁵⁴ JIAT, *Joint Incidents Assessment Team (JIAT) on Yemen Responds to Claims on Coalition Forces' Violations in Decisive Storm Operations* (2016), available at <http://www.spa.gov.sa/viewstory.php?lang=en&newsid=1524799> (last visited 11 January 2019).

of actors within the battlespace.⁵⁵ Put differently, the in-betweenness of hospitals both exposes and produces a series of loopholes within IHL that can be exploited by those who attack protected people and sites.

4 Medicine as Threshold

A central part of IHL's inability to offer the necessary protections to medical units is rooted in the law's incapacity to account for the threshold position they occupy. ICRC's president between the two World Wars, Max Huber, alluded to the liminal position of medicine during war when he claimed that the humanitarian organization's "task [is] to form a third front above and cutting across the two belligerent fronts, a third front which is directed against neither of them, but which works for the benefit of both."⁵⁶ Following Huber, our claim is that their position as a legal, conceptual and spatial threshold opens the door for the "hospital shield" argument since one of the problems informing IHL articles dealing specifically with medical units is the underlying assumption that these units somehow belong to the civilian side of the combatant/noncombatant divide. Efforts to situate medical staff alongside IHL's civilian figure ignore the type of work doctors, nurses and medics carry out and the situations they inevitably encounter during war.

As mentioned in the introduction, by threshold position we mean that medical staff and facilities are located *in-between* the two axiomatic figures informing the laws of war—combatants and civilians—and often spatially and conceptually between the warring parties. Indeed, medical units do not sit well within the dichotomous framework that underpins IHL. This framework, as Hellen Kinsella reminds us, is based on the distinction between combatant and civilian, whereby the former is portrayed as an active agent and a participant in hostilities, while the latter is described as a passive subject, one who is defined by and through non-participation in hostilities.⁵⁷

⁵⁵ N. Gordon and N. Perugini, 'Human Shields, Sovereign Power, and the Evisceration of the Civilian', 110 *American Journal of International Law* (2016), 329; V. Nesiah, 'Human Shields/Human Crosshairs: Colonial Legacies and Contemporary Wars', 110 *AJIL Unbound*, (2016), 323.

⁵⁶ Cited in M. Junod, *Warrior Without Weapons* (1951), at 9-10.

⁵⁷ See H. Kinsella, *The Image Before the Weapon: A Critical History of the Distinction between Combatant and Civilian* (2011); C. Garraway, 'Changing Character of the Participants in War: Civilianization of Warfighting and the Concept of Direct Participation in Hostilities', 87

The death-maker is conceptualized as an active agent, while the doctor and nurse who are responsible for sustaining and prolonging life—and are clearly active agents as well—are identified with the passive side of the divide. International law bestows on each legal figure obligations and protections, which are informed by the way the figure is imagined and the role attributed to it within the legal framework.⁵⁸ The civilian or doctor, for example, is allotted a series of protections precisely because—and only as long as—he or she does not participate in hostilities and is passive in the legal sense.⁵⁹ The problem, of course, is that medical staff and the facilities they occupy do not really fit these binary poles (frequently civilians do not either, an issue we do not deal with here), since they clearly are—and are expected to be—active actors and part of the war effort.

But what exactly do we mean when we say that medical staff participate in the war effort? IHL draws a distinction between direct participation in hostilities and participation in the war effort.⁶⁰ In essence, taking an active part in hostilities implies participation in military operations, which then negates one's civilian status and protections. By contrast, a civilian working in a munitions factory is aiding the war effort but does not cease to be a civilian or lose his or her general mantle of protection, although he or she is running a risk of being legitimately killed while working in a space that constitutes a legitimate military objective.⁶¹ Two points about this scenario help clarify our argument about hospitals. First, civilians participate in the war effort when they *assume* a threshold position; namely, when the protected civilian enters the space of a legitimate target—the munitions factory. Second, participation in the war effort by occupying a threshold position increases a protected person's probability of being *legitimately* killed.

International Law Studies (2011) 177, at 177; C. Wilke, *Civilians, Combatants, and Histories of International Law* (2014), available at <http://criticallegalthinking.com/2014/07/28/civilians-combatants-histories-international-law> (last visited 11 January 2019).

⁵⁸ M. Sassòli, A. A. Bouvier and A. Quintin, *How Does Law Protect in War?* (2011).

⁵⁹ H. Kinsella, 'Gender and Human Shielding', 110 *American Journal of International Law* (2016) 305, at 305. See also N. Perugini and N. Gordon, 'Distinction and the Ethics of Violence: On the Legal Construction of Liminal Subjects and Spaces', 49(5) *Antipode* (2017) 1385, at 1385.

⁶⁰ See Pictet *et al.*, *supra* note 45, at J. Pictet *et al.*, at 613-628.

⁶¹ Y. Dinstein, *The conduct of hostilities under the law of international armed conflict* (2004), at 152.

The crux of the matter is that a hospital is very different from a civilian in a munition factory in which the spatial overlapping between a protected person and a legitimate target produces a legal threshold that endangers the life of the civilian. So long as they are kept separate—i.e., the civilian does not enter the munition factory—the civilian preserves all the protections allocated to him or her by the law. In the case of medical units, by contrast, the threshold is always potentially there, since it is embodied in the functionality of health-care as a field that is a constitutive part of war. The medical unit's proximity to the fray and the fact that combatants often frequent it even if only to visit their wounded friends cannot be dissociated from the kind of work medical staff do. And because medical units occupy a threshold position, belligerents are inclined to bomb them and can more readily accuse them of abetting their enemy's war effort while classifying them as shields. The history of hospital bombings elucidates this point.

Moreover, one can accept, in principle, the distinction between medicine as a biopolitical field dedicated to prolonging life versus war as a necropolitical field that provides the legitimate framework for ending life, and still appreciate that medicine can save and prolong the life of those who return to the battlefield and are reintegrated into the war machine. In this sense, the medical field is crucial for the war effort rather than a field that is either completely external or even antithetical to it. It has become a necessary component of modern militaries, not only because it provides care for wounded combatants who may later return to take part in the fray, but because the knowledge that medical facilities and staff are available is vital for sustaining military (and civilian) morale during periods of armed conflict. Simply put, soldiers want to know that if they are wounded they will receive medical attention and will not be left in the field to die. These are the reasons why IHL permits medical units to provide care to wounded combatants.

But it is precisely medicine's mandate to save lives as well as its structural position as an always potential legal threshold that sets it apart from other protected persons and sites, such as religious personnel and cultural objects and places of worship. Closely examining the relevant clauses in IHL in light of the history of hospital bombings and this threshold condition underscores that belligerents who attack medical units do not need to perform legal acrobatics to show that the bombing was carried out in accordance with the law. Indeed, the fact that hospitals are often located in war zones, that belligerents frequently enter and exit them, even if only to evacuate their wounded, and that the medical staff assist the war effort by carrying out their work helps to justify this claim.

5 The Legal Arguments

Two main legal arguments inform the invocation of “hospital shields” by warring parties that have attacked medical sites: perfidy and dual use. Interestingly, both are threshold situations, thus indicating that international law not only creates an identification between the threshold and legitimate military targets, but also draws a connection between the threshold and breaching the law.

Additional Protocol I defines perfidy as “Acts inviting the confidence of an adversary to lead him to believe that he is entitled to, or is obliged to accord, protection under the rules of international law applicable in armed conflict, with intent to betray that confidence, shall constitute perfidy.”⁶² ICRC explains that when militants in civilian garb “capture, injure, or kill an adversary and in doing so they fail to distinguish themselves from the civilian population in order to lead the adversary to believe that they are entitled to civilian protection against direct attack, this may amount to perfidy in violation of customary and treaty IHL.”⁶³ As we have seen from the examples above, warring parties that attack hospitals at times accuse their enemies of having deceitfully used the medical unit to shield combatants or weapons, knowing that in cases of perfidy medical facilities lose some of their protections.⁶⁴ Hence, belligerents are permitted to bomb hospitals that are framed as shields so as to prevent their perfidious use in the future. The idea, of course, is based on deterrence, on discouraging the shielding practice in the present in order to prevent its proliferation in the future, a topic we return to in the concluding section. Here we want to emphasize that according to the rationale of those who support targeting “hospital shields,” the protections to which medical units are entitled and the lives of those occupying them now can be sacrificed to secure the lives of those who will be in the hospital in the future. Bombing hospitals can thus be framed as a life generating activity.

⁶² For additional examples of perfidy see Article 37 of Additional Protocol I *supra* note 44.

⁶³ N. Melzer, *Direct Participation in Hostilities Under International Humanitarian Law* (2009), at 85.

⁶⁴ M. Schmitt, ‘Precision Attack and International Humanitarian Law’, 87(859) *International Review of the Red Cross* (2005) 445, at 445.

Dual use denotes the simultaneous use of the same structure for two different purposes—civilian and military. While the concept is not explicitly part of IHL, certain interpretations of Article 52 of Additional Protocol I suggest that the article refers to threshold cases of concomitant civilian-military use, allowing belligerents to target dual-use objects if this results in a “definite military advantage.”⁶⁵ Marco Sassoli stresses that “under the wording of Additional Protocol I, an attack on a dual-use object is in any event unlawful if the effect on the civilian aspect is intended.” Nevertheless, Sassoli admits that “the respect of that particular rule is impossible to assess in the heat of the battle.”⁶⁶ Henry Shue and David Wippman take this line of thinking one step further, arguing that the concept of dual-use ultimately enables “extraordinarily permissive” use of lethal force.⁶⁷ Notwithstanding the differences among these legal experts, they tend to agree that objects with a civilian function can concomitantly acquire a military one and when they do they become legitimate targets according to IHL.

Even the UN Security Council’s condemnation of the bombing of hospitals limits the resolution to instances that do not include dual use, where personnel are “*exclusively* engaged in medical duties.”⁶⁸ When describing a “hospital shield” as having served dual use, belligerents are not disputing the claim that the facility was used for medical purposes, but they maintain that their enemy simultaneously used it to enhance hostilities by harboring a legitimate target. The shielding argument aspires to explain, for example, why in 2016 and 2017, on average more than one medical unit operated by MSF staff was attacked each week. According to an interview conducted with MSF’s director of analysis department, to the best of his knowledge none of the medical units in question were shielding combatants or weapons. He does note, however, that for some belligerents a wounded combatant using his cell phone to make a call from a hospital bed could

⁶⁵ H. Shue and D. Wippman, ‘Limiting attacks on dual-use facilities performing indispensable civilian functions’, 35(3) *Cornell International Law Journal* (2001) 559, at 561. On targeting and dual-use see J. Dill, *Legitimate Targets?: Social Construction, International Law and US Bombing* (2014).

⁶⁶ M. Sassòli, ‘Legitimate targets of attacks under international humanitarian law’, *HPCR Policy Brief* (2003) 1, at 7.

⁶⁷ Shue and Wippman *supra* note 65.

⁶⁸ United Nations Res. 2286, *supra* note 4, (*Italics added*).

signify that the hospital was shielding. Shielding, he says, is a very slippery concept.⁶⁹ Nonetheless, the shielding argument can serve as a robust defense because Article 21 of the First Geneva Convention and Article 13 of Additional Protocol I state that medical units lose the protections allocated to them if they exceed the act of their mission or are in some way complicit in carrying out “acts harmful to the enemy”⁷⁰

The fact that medical units are located both legally and spatially in a threshold position that can be readily marshalled by the attacking party is the crucial factor opening the doors to accusations of perfidy and dual use. ICRC’s commentary explains that belligerents must take all “precautionary measures” laid out in the Protocol I’s Article 57 before attacking medical units.⁷¹ However, as Théo Boutruche notes, precautionary obligations under IHL are crafted in relative terms.⁷² The relevant clauses in Article 57 require the fighting parties to weigh the anticipated military advantages against the damage caused to protected people and sites and to take the necessary precautions.⁷³

Adil Ahmad Haque explains that “while precautions regulate *how* to carry out an attack, proportionality regulates *whether* to carry out an attack at all.”⁷⁴ Haque goes on to give an example, using the following scenario: “A fleeing combatant takes refuge in a hospital. The most discriminate weapons and tactics available to attackers will destroy half of the hospital, killing half of the patients.” Under the principle of proportionality, Haque explains, belligerents are prohibited

⁶⁹ Email interview with Jonathan Whittall, March 26, 2018.

⁷⁰ Fourth Geneva Convention, *supra* note 37.

⁷¹ Pictet *et al.*, *supra* note 45.

⁷² T. Boutruche, *Expert Opinion on the Meaning and Scope of Feasible Precautions under International Humanitarian Law and Related Assessment of the Conduct of the Parties to the Gaza Conflict in the Context of the Operation ‘Protective Edge* (2015), available at <https://www.diakonia.se/globalassets/blocks-ihl-site/ihl-file-list/ihl--expert-opinions/precautions-under-international-humanitarian-law-of-the-operation-protective-edge.pdf> (last visited 11 January 2019).

⁷³ Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 1125 UNTS 609, (entered into force Dec. 7, 1978).

⁷⁴ A. A. Haque, *The Defense Department’s Indefensible Position on Killing Human Shields* (2015), available at <https://www.justsecurity.org/24077/human-shields-law-war-manual> (last visited 11 January 2019).

from attacking the hospital if the expected harm to civilians outweighs the military advantage that they seek; therefore, instead of inflicting disproportionate harm on civilians, the attacking forces must find another way to win. By contrast, precautions are considerations that are taken in the midst of fighting and need to be carried out in a “feasible” or “reasonable” manner. Precaution is accordingly “conceived as a more demanding constraint than just doing what is merely possible,” but it ultimately only requires “those precautions that are practically possible given the circumstances ruling at the time.”⁷⁵ Precaution, moreover, works simultaneously in two directions: taking necessary precautions not to harm protected people located near the target, and taking precaution not to increase operational risks that might lead to injury of one’s own forces or the risk of failing to accomplish the mission. All of which leads Haque to conclude that “under international law, such an attack on the hospital would satisfy the precautions rule but violate the proportionality rule.”⁷⁶

But does the principle of proportionality actually protect medical units accused of shielding from being bombed? First, as Yoram Dinstein points out, “it must be appreciated that a military objective does not cease being a military objective on account of the disproportionate collateral civilian casualties. The principle of proportionality provides a further restriction by disallowing attacks against impeccable military objectives owing to anticipated disproportionate injury and damage to civilians or civilian objects.”⁷⁷ Actually, Additional Protocol I uses the term “excessive” instead of “disproportionate,” and as Dinstein stresses “what ultimately counts, in appraising whether an attack which engenders incidental loss of civilian life or damage to civilian objects is ‘excessive,’ is not the actual outcome of the attack but the initial expectation and anticipation.”⁷⁸

Taking this into account, let’s examine a similar scenario to the one provided by Haque, only this time a warring party has intel that a group of “high asset” targets have entered a hospital. It is unclear where the combatants are located in the hospital, and since the pursuers do not want them to flee they give the medical staff only a ten-minute warning before bombing the facility. They anticipate that in the attack parts of the medical unit will be destroyed and twenty patients

⁷⁵ Boutruche, *supra* note 72.

⁷⁶ Haque, *supra* note 74.

⁷⁷ Meron, *supra* note 18.

⁷⁸ Dinstein, *supra* note 61, at 122.

and health staff will be killed. Would such an expectation be excessive or proportionate? One way to justify such an attack is by inflating the weight of the expected military advantage. “The more the military task can be presented as crucial, the more civilian casualties the principle is willing to tolerate.”⁷⁹ Another way of sanctioning the expected deaths to patients and medical staff is by diminishing the anticipated weight of the harm they will be subjected to in order to render the military attack more acceptable. The issue is that key concepts such as “excessive” and “disproportionate” are left undefined in IHL, making it difficult to determine how exactly to apply the abstract principle of proportionality to and in the real world.⁸⁰

In its official commentary, ICRC does address a situation of hospital shielding, noting that the wounded and sick as well as the medical units caring for them “should not have to pay for trickery for which they are not responsible.... However, it is clear that if one of the Parties to the conflict is unmistakably continuing to use this unlawful method for endeavoring to shield military objectives from attack, the delicate balance established in the Conventions and the Protocols between military necessity and humanitarian needs would be in great danger of being jeopardized and consequently so would the protection of the units concerned.”⁸¹ Ultimately, then, what such an examination of shielding reveals is that IHL privileges those who attack over those who shield.

While the condemnation against those who use hospitals as shields is unconditional and their act is framed as a war crime, the protection offered to hospitals targeted by the attacking party is only ever conditional and the attackers can quite easily justify their acts using IHL. All a warring party has to do is to provide a feasible argument that a medical unit was being used to shield a target, claim that before it bombed the unit it warned the medical personnel, that it anticipated the attack would be proportional, and, finally, that during the assault it took all the necessary precautions. And, indeed, Article 13 of Additional Protocol I underscores in its first clause that “The protection to which civilian medical units are entitled shall not cease *unless* they are used to commit, outside their humanitarian function, acts harmful to the enemy...”⁸² While we have already mentioned the wide scope of the phrase “harmful to the enemy,” here it is important to

⁷⁹ E. Weizman, *Forensic Architecture: Violence at the Threshold of Detectability* (2017), at 178.

⁸⁰ T. M. Franck, ‘On Proportionality of Countermeasures in International Law’, 102(4) *American Journal of International Law* (2008) 715, at 715.

⁸¹ Pictet *et al.*, *supra* note 45, at 171.

⁸² Additional Protocol I, *supra* note 44.

emphasize how in situations of dual use, whereby a hospital treats patients and is simultaneously used as an arms depot or a militant hideout, the military function overrides the caring one, paving the way for belligerents to legitimately attack hospitals. Notwithstanding the fact that the medical unit did not constitute an immediate or direct threat, the belligerents can also introduce a robust legal argument by claiming that the medical unit was bombed as part of a self-defense strategy.

The threshold position thus opens the doors to accusations of perfidy and dual use, and they in turn legitimize the bombing of medical units. As mentioned earlier, the law simply does not have the vocabulary to capture the threshold. Instead of trying to develop such a vocabulary while attempting to address the complications that might arise, IHL ultimately renders those who occupy a liminal position as legitimate targets. Henry Dunant intuitively understood that the threshold would serve as a threat to governments and therefore he presented medical staff and facilities as both neutral and external to the war effort; what we could call the “fiction of neutrality” and “fiction of externality” were necessary in order to ensure governmental approval for the 1864 Geneva Convention.

By way of conclusion, we would like to suggest how international law might be reformed so that it can better protect medical units. In one of his essays, the criminologist Stanley Cohen invokes a Woody Allen joke about the Jewish woman complaining after having eaten at a restaurant: the food was lousy, she says, and then adds that the portions were too small. Cohen concludes that the law is all we have and despite its flaws, we want it to be implemented more rather than less seriously.⁸³ We believe that the problem is more complex, since as we have shown belligerents bombing hospitals can claim that the medical unit exceeded its humanitarian mission and therefore when they bombed it they did not violate the law. This suggests that the lack of implementation is not necessarily the problem. Adding a little flavor to the food might therefore be a better solution.

⁸³ S. Cohen, ‘Neither honesty nor hypocrisy: The legal reconstruction of torture’, in D. M. Downes, T. Newburn and P. E. Rock (eds), *The politics of crime control: essays in honour of David Downes* (2009) 297.

6 Reforming the Law

If international law is to provide medical units the protections they actually need, two intricately tied issues must be addressed: 1) the threshold position of medical units must be acknowledged and the conflation between liminality and criminality must be rejected; and 2) the wording of the law must be modified to insist that the prohibition of attacking medical units is established under customary international law (i.e., *jus cogens*) and that no derogation is permitted. Not unlike the protection against sexual attack and torture, medical immunity should be absolute.⁸⁴ In the remaining pages, we uncover the shortcomings of the argument posed by those who argue against introducing a legal reform of this kind.

Even though we are aware that armed groups have, in some occasions, used medical units as shields, much more frequent and alarming is the way different governments are increasingly invoking the “hospital shield” argument as justification for the deliberate and widespread attack on health care. As we pointed out in the introduction, since 2016 on average a hospital is bombed every single day. Yet, as we have shown, because medical units can readily be framed as a shield due to their threshold position, then like a human shield, they can be legally bombed so long as the attack is carried out in accordance with the principle of proportionality and that necessary precautions are taken.⁸⁵ Those who insist that it is sufficient to enforce the existing legal framework in order to prevent attacks on hospitals, deny the liminality of medical facilities and that the non-categorical immunity conferred on them is jeopardized relatively easily through the mobilization of IHL’s exceptional clauses.

As the official ICRC commentary underscores, the protection to which civilian medical units are entitled shall cease if they are used to commit, outside their humanitarian function, acts harmful to the enemy. “The definition of harmful,” ICRC goes on to explain, “is very broad. It refers not only to direct harm inflicted on the enemy, for example, by firing at him, but also to any

⁸⁴ T. Meron, *Human Rights and Humanitarian Norms as Customary Law* (1989).

⁸⁵ Even the 2002 Rome Statute, which defines intentional attacks against medical units as a war crime, adds the qualification that in order to be crimes the attacks must be carried out in violation of the law. Rome Statute of the International Criminal Court, Art. 8, July 17, 1998, U.N. Doc. 32/A/Conf. 183/9, 37 I.L.M. 999 (Entered Into Force July 1, 2002) [Hereinafter Rome Statute], see Art. 8.2, (b)(xxiii).

attempts at deliberately hindering his military operations in any way whatsoever.”⁸⁶ Providing cosmetic corrections to the existing legal norms and standards—such as prohibiting belligerents from bombing medical units in instances when hospitals are used “as an observation post,” while allowing them to bomb hospitals when they provide “shelter for able-bodied combatants or fugitives” will inevitably be inadequate.⁸⁷ Indeed, trying to prove that a given hospital was not used as a shield is virtually impossible. The only way then to make sure that medical units stop being fair game is by offering them absolute protection, again, not unlike the ban on torture.⁸⁸ This is particularly important if one seriously considers the true objective of the extensive attacks on medical units in recent years. For the most part, the people or objects that are ostensibly being shielded are not the real target, but rather the enemy’s infrastructure of existence. Destroying the hospital is often the goal.

Considering the widespread attacks on medical units, it is safe to infer that the shielding claim is being used not only to legitimize specific assaults, but to justify wholesale strategic bombings aimed at destroying the distribution of health-care in a given region or country. As recent research has shown, health destruction can be part of a strategy of: a) punishing a targeted population;⁸⁹ b) systematic weakening of a targeted population to induce either submission (e.g., when carried out by a state against its own population)⁹⁰ or resistance (e.g., when carried out by a

⁸⁶ See Pictet *et al.*, *supra* note 45, at 175.

⁸⁷ These are examples given in the commentary on Article 21 of the First Convention, see Pictet *et al.*, *supra* note 45, at 175.

⁸⁸ M. Nowak, E. McArthur and K. Buchinger, *The United Nations Convention Against Torture: A Commentary* (2008).

⁸⁹ J. Kennedy and D. Michailidou, ‘Civil war, contested sovereignty and the limits of global health partnerships: A case study of the Syrian polio outbreak in 2013’, 32(5) *Health policy and planning* (2017) 690.

⁹⁰ D. Feierstein, *Genocide as Social Practice: Reorganizing Society Under the Nazis and Argentina's Military Juntas* (2017).

state against a population of another state in the hope of spurring an uprising against the regime);⁹¹ c) facilitating forced mass eviction;⁹² and even d) enhancing genocide.⁹³

Several legal scholars have nonetheless voiced their opposition to the introduction of an absolute prohibition on bombing medical units.⁹⁴ They basically advance two arguments. One argument is that an absolute prohibition will produce an incentive for combatants to use hospitals as shields. Kevin Jon Heller formulates his objection in the following manner: “[S]uch a prohibition would ensure that combatants who don’t respect IHL will use hospitals as a shield as often as possible.... A categorical prohibition will not prevent IHL from being misused; it will simply ensure that IHL is ignored — resulting in far more ‘incidental’ deaths than under the current IHL rules.”⁹⁵ The existing formulation of IHL is, in Heller’s view, a lesser evil and even if it allows for the fabrication of shielding stories in order to legitimize bombing hospitals, changing it will produce a greater evil.⁹⁶

In a similar vein, Lieutenant Colonel Kurt Sanger, a judge advocate in the United States Marine Corps, argues that absolute prohibition “invites warfighters to use hospitals as base camps and fighting positions. Belligerent groups will force hospitals to host them. It is unlikely that effective healthcare will remain a priority, but it is certain that in many if not most cases a hospital’s occupiers of that character will be cruel to the innocents found there. Medical treatment will be subordinate to the belligerents’ needs, and countless doctors and patients, no matter how

⁹¹ O. Dewachi, *Ungovernable Life: Mandatory Medicine and Statecraft in Iraq* (2017).

⁹² OHCHR and UN Habitat, *Forced Evictions*, Fact Sheet 25/Rev. 1, 1-50.

⁹³ T. MacManus, P. Green and A. de la Cour Venning, *Countdown to annihilation: genocide in Myanmar* (2015).

⁹⁴ See K. J. Heller, *Don’t Blame IHL for Attacks on “Hospital Shields”* (2016), available at <http://opiniojuris.org/2016/10/21/dont-blame-ihl-for-attacks-on-hospitals> (last visited 11 January 2019); Gabon Rona, *Bombing Hospitals: Why Bad Actors—Not the Laws of War—Are to Blame* (2016), available at <https://www.justsecurity.org/33742/bombing-hospitals-bad-actors-and-law-is-blame> (last visited 11 January 2019); K. Sanger, *The Best Way to Protect Hospitals in Wartime—Enforce Existing Law* (2016), available at <https://www.justsecurity.org/33805/letter-editor-protect-hospitals-wartime-enforce-existing-law> (last visited 11 January 2019).

⁹⁵ Heller *supra* note 94.

⁹⁶ E. Weizman, *The Least of All Possible Evils: Humanitarian Violence from Arendt to Gaza* (2012).

infirm, will be forced to accommodate or support their captors' cause."⁹⁷ The perverse incentive created by an absolute prohibition will, according to these legal scholars, have detrimental results that are far worse than the current situation.

Obviously, an absolute prohibition against torture is, in certain ways, different from the prohibition against attacking medical units. In the case of torture, a specific form of coercive violence, which is considered inhumane, is banned; with respect to hospitals the prohibition refers to specific sites that should be unconditionally protected. The first is a ban on certain repertoires of violence, while the second would be on bombing a site that is characterized by and through its medical functionality. But briefly examining the primary response posed by those who are against the non-derogable prohibition of torture can help uncover the shortcomings of Heller and Sanger's argument.

The torture prohibition constitutes a peremptory norm of customary international law, which binds all states even in the absence of treaty ratification.⁹⁸ Whether the conflict is international (between countries) or internal (within a single country) all parties have to refrain from subjecting anyone in their hands to torture and other ill-treatment, including combatants taking part in the fighting. An act of torture committed in the context of an armed conflict is a war crime.⁹⁹ The argument against the absolute prohibition of torture has been the ticking bomb scenario, whereby security services catch a terrorist who has planted a bomb or knows where a bomb has been planted and—as the argument goes—they need to use torture to swiftly obtain information about the bomb's location in order to save the lives of many potential victims.¹⁰⁰ While it would be very difficult to find a single “ticking bomb” case where torturing a suspect led to the revelation of a bomb, this scenario has been repeatedly invoked to justify the torture of thousands of detainees and innocent people.¹⁰¹

⁹⁷ Sanger *supra* note 94.

⁹⁸ Nowak, McArthur and Buchinger, *supra* note 88.

⁹⁹ Rome Statute *supra* note 85.

¹⁰⁰ A. Dershowitz, *Why Terrorism Works: Understanding the Threat, Responding to the Challenge* (2002).

¹⁰¹ See Human Rights Watch, *Torture Doesn't Work* (2006), available at <https://www.hrw.org/news/2006/04/26/torture-doesnt-work> (last visited 11 January 2019); Lisa Hajjar, *Torture and the Future* (2004).

Two assumptions inform the ticking-bomb scenario: 1) an absolute prohibition can limit the ability of security forces to defend the civilian population, and 2) terrorists can take advantage of this prohibition. These are the underlying reasons informing those who advocate the employment of torture in “ticking bomb situations.”¹⁰² Formally, Heller and Sanger’s claim is uncannily similar. They, too, think that an absolute prohibition will tie the hands of security forces and incentivize combatants to violate the law. Hence, the criticism posed by legal scholars such as Henry Shue and David Luban to the ticking bomb story can help reveal the shortcomings of the “incentive argument.”

Shue maintains that it is never wise to base general policy on exceptional cases since such cases make bad laws. He adds that it is misguided to base any institutional preparations on imaginary cases, since “artificial cases make bad ethics.” Heller and Sanger’s argument for maintaining exceptions to the prohibition of bombing medical units is based precisely on an imaginary case, while failing to address the systematic assaults on hospitals and the deliberate and pervasive strategy informing them. Moreover, it is unclear that an absolute prohibition will actually incentivize combatants to subordinate medical treatment to military needs. The assumption that today combatants do not use hospitals as shields or use them much less because they know that hospitals are protected is purely hypothetical and has not been corroborated by interviews with such combatants or by any other kind of empirical evidence.

David Luban highlights the numerous empirical problems informing the ticking-bomb story, claiming, *inter alia*, that it is purely hypothetical and has not been corroborated by any evidence. Just as significantly, on a formal level the ticking bomb story is built on a set of flawed assumptions. In Luban’s words, it amounts to “intellectual fraud” because it depicts the ticking bomb as an emergency exception, using the exceptional case to justify institutionalized practices and procedures of torture. In his view, the “ticking bomb begins by denying that torture belongs to liberal culture, and ends by constructing a torture culture.”¹⁰³ It begins by disavowing torture only to avow its legitimacy.

¹⁰² O. Gross, ‘Are Torture Warrants Warranted-Pragmatic Absolutism and Official Disobedience’ 88(6) *Minnesota Law Review* (2003) 1481, at 1481.

¹⁰³ D. Luban, ‘Liberalism, Torture, and the Ticking Bomb’, in P. Lee (eds), *Intervention, Terrorism, and Torture - Contemporary Challenges to Just War Theory* (2007) 249.

Along similar lines, Heller and Sanger begin their argument by advocating a prohibition of bombing medical units, since the bombing of hospitals is not part of liberal culture. Simultaneously, however, they advocate exceptions to this prohibition, which empirical evidence has shown helps construct a hospital bombing culture. There is, to be sure, an irony here, since Heller and Sanger's opposition to absolute prohibition is based on the assumption that the "incentivized belligerents" are illiberal people who do have an interest in the availability of efficient medical care and are unable to draw a distinction between protected and unprotected sites. "It is certain," Sanger writes, "that in many if not most cases a hospital's occupiers of that character will be cruel to the innocents found there." This assumption leads them to adopt a logic that facilitates attacks against medical units, privileging those who bomb hospitals over those who (ostensibly) use them as shields. The troubling rationale informing their argument is that the only way to prevent the war crime of militants using hospitals as shields is by allowing belligerents to commit the war crime of targeting hospitals.

The second argument suggests that a reform of international law is needed, but that it should not entail an absolute ban. Heller formulates this line of reasoning in the following manner: "it is possible to criticize this understanding of [Protocol I's Article 13's notion of] harmful acts [that provide exceptions allowing belligerent's to legally attack hospitals] as being overbroad and in need of revision. I, for one, have a problem with the idea that a hospital can be attacked simply because combatants are using it as 'an arms or ammunition dump.' Given the importance IHL puts on protecting medical units, that doesn't strike me as enough to justify a hospital forfeiting its protected status. I might even be convinced that the mere presence of unwounded combatants in a hospital shouldn't justify a deliberate attack...[but the hospital should not be] immune from attack *even when combatants are using it to attack the enemy.*"¹⁰⁴

All of the instances which Heller mentions are threshold cases, where military and non-military functions overlap, where the protected and non-protected occupy the same space. As we have shown, medical facilities can always be accused of occupying a threshold position during war, and the examples Heller provides simply reveal that this threshold can be stretched from participation in the war effort to different forms of direct participation in hostilities. Heller thinks

¹⁰⁴ Heller, *supra* note 94.

that some of these threshold situations do not warrant attack (when, for example, the hospital is used as an arms depot), while others do (when combatants shoot from a hospital window).

Presumably, cases that do not warrant an attack are those in which the balance between medicine and hostilities is, in Heller's view, in favor of the hospital's function of saving life. All of which brings us back to torture and the ticking bomb argument. Not unlike Heller, most ticking bomb proponents are against torture but claim that certain situations exist in which suspects should be tortured. This view has been largely rejected not because suspects are necessarily deemed innocent or that the threat they pose considered false, overblown or not imminent, but because torture is inhumane. Our claim is that targeting hospitals is also inhumane.

Reforming international law so as to include an absolute prohibition of bombing medical units and staff could help prevent the systemic and egregious violations we are currently witnessing and the disturbing logic informing them. It would necessitate a rethinking of the very peculiar notion of medical neutrality and would take into account the threshold position of medicine during war. With an absolute prohibition of bombing hospitals, medical staff would acquire an absolute protection that would allow them to continue carrying out their function of saving lives according to their ethical code and with less risk of being targeted.

All of which brings us back to our introductory remarks. Global health actors, human rights organizations and numerous other institutions are claiming that belligerents are not being held accountable for bombing hospitals. We have shown that due to the threshold position of medical units, IHL actually provides these belligerents a toolkit with which they can claim that the bombing was legitimate. We have therefore argued for an absolute ban. While we know that a ban has not stopped the use of torture, it has helped create a normative framework against torture, driving those who deploy it to "black holes" and other secret interrogation cells. It will, we maintain, be much more difficult to bomb hospitals in the dark.