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# Save the Injured – Don’t Kill IHL: Rejecting Absolute Immunity for ‘Shielding Hospitals’

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## Abstract

*This article is a response to Neve Gordon and Nicola Perugini’s thought-provoking article, “Hospital Shields” and the Limits of International Law’, published in this issue. The authors advocate reforming the law to allow hospitals absolute protection, even in cases where they are also used by combatants for military purposes that are harmful to their adversary (‘shielding hospitals’). Defining the contour of the desired protection for hospitals should start with both the institutional and personal attributes justifying their special protection as well as with the empirical data relating to the prevalence of attacks on hospitals – who and what triggers them. Against this background, this reply presents the prevailing law that grants strong protection to hospitals, albeit a contingent one that may be removed in exceptional cases of their abuse. It advocates retaining the contingent protection, though with some adjustments, and argues that the suggested absolute protection – in fact, immunity – for shielding hospitals is neither feasible nor normatively desirable. It would damage the current balance and rationale of the entire body of international humanitarian law in general and have a counter-effect upon the treatment of the sick and wounded in particular. Contrary to its apparent humanitarian rationale, absolute immunity for shielding hospitals would damage their ability to function as medical institutions and allow an adversary who controls a hospital full discretion in selecting its priorities regarding the use of its space and resources and might turn the sick and wounded into a means of warfare.*

## 1 Introduction

An essential mission of the law of armed conflict is to humanize war’s environment for combatants and non-combatants alike.<sup>1</sup> Its core interest is to spare the lives and

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<sup>1</sup> See generally G. Best, *Humanity in Warfare: The Modern History of the International Law of Armed Conflict* (1983).

property of non-combatants and to reduce the suffering of combatants. In reality, however, the law often is not applied properly, either in whole or in part, and fails in the fulfilment of this mission.<sup>2</sup> The failure to secure the actual protection of hospitals – especially in the prevailing asymmetric conflicts taking place, to a large extent, in densely populated urban areas<sup>3</sup> – is an integral part of the problematic performance of the law and the unacceptable gap between its rules and belligerents' actual practice.<sup>4</sup> Any reform suggested in this law should be normatively desired – taking into consideration its macro- and micro-effects – and practically feasible. Unfortunately, Neve Gordon and Nicola Perugini's thought-provoking and stimulating article “Hospital Shields” and the Limits of International Law’ does not provide a solution that appears to be capable of surmounting this challenge.<sup>5</sup>

Their article advocates for reforming the law by allowing hospitals absolute protection, even in cases where they are also used by combatants for military purposes that are harmful to their adversary (‘shielding hospitals’). It claims that the current contingent protection granted by international humanitarian law (IHL) legitimizes attacks on hospitals that are framed as shields. The disregard of ‘the legal and spatial threshold position occupied by medical units in the battlefield has allowed warring parties to legally defend their attacks’.<sup>6</sup> The article further argues 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 torture, can provide medical facilities with the legal protection that they actually need. The law, in other words, needs to be radically reformed’.<sup>7</sup>

While the article presents a serious problem, and its authors deserve praise for casting light on it, I would argue that the suggested absolute protection – in fact, immunity – of shielding hospitals is neither feasible nor desired. It damages the current balance and rationale of the entire body of IHL. If accepted, it would have a counter-effect upon the law in general and on the treatment of the sick and wounded in particular. Rather, the tools for increasing the protection of hospitals are to be found within the contours of the prevailing law. Indeed, the norm is, and should be, to afford protection to hospitals, but, in exceptional cases of their abuse, this special protection should be removed. The position of the International Committee of the Red Cross (ICRC) – that ‘[a]ttacks on a military target near a health-care facility or on a

<sup>2</sup> See, e.g., Morrow, ‘When Do States Follow the Laws of War?’, 101 *American Political Science Review* (2007) 559, at 567. In this empirical study, which examines states’ compliance with eight segments of the law of armed conflict through the 20th century, Morrow shows that the ‘treatment of civilians has the worst record’ of compliance in the entire law of armed conflict.

<sup>3</sup> For the general challenges to supplying medical care in the currently common form of urban belligerency, see Watkin, ‘Medical Care in Urban Conflict’, 95 *International Law Studies* (2019) 49.

<sup>4</sup> For a call to leverage military professionalism to reduce this gap and the human suffering caused by this reality, see Y. Beer, *Military Professionalism and Humanitarian Law: The Struggle to Reduce the Hazards of War* (2018).

<sup>5</sup> Gordon and Perugini, “Hospital Shields” and the Limits of International Law’, in this issue, 439.

<sup>6</sup> *Ibid.*, at 443.

<sup>7</sup> *Ibid.*

facility that has lost its protection must be exceptional and a last resort<sup>8</sup> – should be endorsed, not the article's suggested immunity. Indeed, influential non-governmental organizations (NGOs) and the United Nations (UN) have weighed in on this problem, all offering to preserve the contingent protection while strengthening countries' abidance of it through applicative recommendations.<sup>9</sup>

This reply starts by presenting the special case of hospitals and why the law has to grant them extra protection. Focusing on both the institutional and personal attributes justifying the special protection as well as the empirical data relating to the prevalence of attacks on hospitals and what triggers them, it lays the groundwork for the discussion regarding the effective alternatives for improving their protection. The presentation of empirical data reveals that harm to health care in belligerencies is attributable to all of the adversaries, not mainly the attackers, as Gordon and Perugini presume. Against this background, it presents the prevailing law that grants, contrary to the article's argument, strong protection to hospitals, albeit a contingent one that may be removed in exceptional cases. This reply advocates for retaining the contingent protection, though with some adjustments, while rejecting the absolute immunity suggested by the article as neither feasible nor normatively desired.

## 2 The Special Case of Hospitals: Why Extra Protection Is Required

The protection granted to hospitals has both institutionally inherent and personal justifications. The first derives from their humanitarian mission and is contingent upon their actual use in light of this purpose.<sup>10</sup> The second justification – the vulnerability of their patients – is always present. The wounded and the sick are defenceless. In many cases, they are bedridden, and the lives of some of them are dependent upon the medical equipment and capabilities that are available only in hospitals. The medical staff in hospitals are bound to their patients. The ability of these two groups to respond actively to the hazards of war is very limited. To a large extent, they are weaker than 'regular civilians' who may be able to react to a forthcoming danger – for example, escaping from an urban battlefield or taking shelter. Furthermore, due to the inherent vulnerability of the wounded and the sick, any damage caused to a hospital may have a substantial impact on them, which is potentially much greater than it would be on healthy civilians. For example, limited damage to the electricity supply may cause an inconvenience to civilians. However, for patients whose lives are completely dependent upon electrical equipment, it can be deadly.

<sup>8</sup> International Committee for the Red Cross (ICRC), *Protecting Health Care: Key Recommendations* (2016), at 31, available at [www.icrc.org/en/publication/4266-protecting-health-care-key-recommendations](http://www.icrc.org/en/publication/4266-protecting-health-care-key-recommendations) (emphasis omitted).

<sup>9</sup> See text accompanying notes 68–73 below.

<sup>10</sup> As for the legal presumption of the 'civilian' classification of institutions 'normally dedicated to civilian purposes', such as schools or places of worship, see Additional Protocol I to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Additional Protocol I) 1977, 1125 UNTS 3, Art. 52(3).

These weaknesses require special scrutiny and legal adjustments, and the damage multiplier of the wounded and the sick should be brought into consideration when assessing the collateral damage that might be caused to them. Before examining the extent to which the prevailing law responds to these unique vulnerabilities, and to what extent a legal reform is required, the next discussion reflects on the scope of the vulnerabilities of health care in war zones as well as their attributes and causes.

### 3 The Current Scope of the Problem, Its Attributes and Its Causes

The ICRC's Health Care in Danger Project has collected comprehensive data regarding violent incidents against health care in situations of armed conflict and other emergencies. Its 2015 report, covering January 2012 to December 2014, analysed 2,398 incidents of violence against health care, which occurred in 11 different countries.<sup>11</sup> The comprehensive analysis was part of a global initiative to improve the protection granted to health care.<sup>12</sup> Though not scientifically proven due to sample bias,<sup>13</sup> the report allows us to view the phenomenon in a wider perspective, not just through the narrow prism of some serious incidents referred to in Gordon and Perugini's article.<sup>14</sup>

The report demonstrates that attacks on health care facilities in the armed conflicts that were analysed tend to fall into four main categories. The first category is the targeting/bombing of medical units, either intentionally or unintentionally. The second category is the misuse of services, which includes the takeover of hospitals, the storage of weapons in hospitals, the launching of an attack from a hospital and additional use for purposes other than medical ones. The third category is armed entry resulting in a disruption of the facility's functioning and its ability to deliver health care. The fourth category includes the looting of drugs and medical equipment from medical facilities.<sup>15</sup>

The numerical breakdown reveals that attacking states are not the only major perpetrators of violence against health care facilities; out of 2,398 incidents analysed in the report, about 33 per cent were committed by state armed forces, 30 per cent by non-state actors and the rest were perpetrated by individuals and/or unknown actors. Furthermore, out of all of the incidents, only 17 per cent (403) related to direct attacks against health care facilities.<sup>16</sup>

<sup>11</sup> ICRC, *Healthcare in Danger* (2015), at 5, available at [www.icrc.org/en/doc/assets/files/publications/icrc-002-4237.pdf](http://www.icrc.org/en/doc/assets/files/publications/icrc-002-4237.pdf). The list of countries where the information was collected is confidential, and there is no specification whether the armed conflicts analysed were international or non-international.

<sup>12</sup> *Ibid.*, at 1.

<sup>13</sup> Though the sample is impressive, 'bias in the collection of information and in the amount of information received by context does not allow general conclusions to be drawn'. *Ibid.*, at 6.

<sup>14</sup> For example, the interview conducted with Médecins Sans Frontières's (MSF) director of the analysis department. Gordon and Perugini, *supra* note 5, at 455.

<sup>15</sup> ICRC, *supra* note 11, at 7–14.

<sup>16</sup> *Ibid.*, at 7–8, 11.

In addition to this report, the ICRC commissioned three in-depth field studies to explore the issue in Afghanistan (2010), Somalia (2012) and the Democratic Republic of the Congo (2013). Fiona Terry found in her analysis of these reports that the main dangers to health care in these theatres are not the strategic use of violence against it.<sup>17</sup> Though such violence exists, 'the most common forms of violence encountered ... stem more from a lack of respect for the protected status of health care rather than an overt desire to misuse it or attack it'.<sup>18</sup> This non-respect is reflected by impediments to patients reaching health care due to active fighting in the streets, roadblocks and the prevention of access to hospitals, the looting of medical supplies, the extraction of *hors de combat*, violence against health care personnel and the presence of armed or uniformed men inside medical facilities.<sup>19</sup>

The Safeguarding Health in Conflict report on 23 different countries also reflects similar patterns of attacks on health care.<sup>20</sup> In 2016, armed takeovers and the occupation of health facilities were documented in seven countries.<sup>21</sup> For example, in Iraq, forces of the Islamic State of Iraq and Syria (ISIS) took over multiple health facilities<sup>22</sup> and also misused ambulances for military purposes, including the transport of explosives and use in suicide attacks.<sup>23</sup> In Yemen, anti-Houthi fighters set up tanks around the perimeter of a hospital.<sup>24</sup> In Afghanistan, the occupation of health care facilities by combatants on both sides resulted in the injuring and killing of staff, severe damage to the facilities and patients being deterred from visiting to receive medical care.<sup>25</sup>

Indeed, these reports are subject to the challenges of obtaining accurate data from myriad actors operating in war zones, especially in undeveloped countries;<sup>26</sup> yet they make clear that the misuse of hospitals by belligerents is a real and major risk.<sup>27</sup> The lesson to be drawn from the empirical data, reflecting the scope of the problem and its attributes, is that improving the protection of health care requires consideration of all aspects of the problem in their wider context, including the fact that hospitals are used by belligerents and taken over, disrupting the availability of health care to those who

<sup>17</sup> Terry, 'Violence against Health Care: Insights from Afghanistan, Somalia, and the Democratic Republic of the Congo', 95 *International Review of the Red Cross (IRRC)* (2013) 23. But see the unempirically-based conclusion of Gordon and Perugini: '[I]t is safe to infer that the shielding claim is being used not only to legitimize specific assaults but also to justify wholesale strategic bombings aimed at destroying the distribution of health care in a given region or country.' Gordon and Perugini, *supra* note 5, at 459.

<sup>18</sup> Terry, *supra* note 17, at 28.

<sup>19</sup> *Ibid.*, at 31–34.

<sup>20</sup> Safeguarding Health in Conflict, *Impunity Must End: Attacks on Health in 23 Countries in Conflict in 2016* (2016), available at [www.safeguardinghealth.org/sites/shcc/files/SHCC2017final.pdf](http://www.safeguardinghealth.org/sites/shcc/files/SHCC2017final.pdf).

<sup>21</sup> Afghanistan, Iraq, Somalia, South Sudan, Turkey, Ukraine and Yemen. *Ibid.*, at 12.

<sup>22</sup> *Ibid.*, at 12. The same trend was documented in 2017. See Safeguarding Health in Conflict, *Violence on the Front Line: Attacks on Health Care in 2017* (2017), available at <https://reliefweb.int/sites/reliefweb.int/files/resources/SHCC2018final.pdf>.

<sup>23</sup> Safeguarding Health in Conflict, *supra* note 20, at 12.

<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*

<sup>26</sup> Terry, *supra* note 17, at 26–28.

<sup>27</sup> Safeguarding Health in Conflict, *supra* note 20, at 12.

need it. This is not a hypothetical situation, as suggested by Gordon and Perugini; it is already a well-documented occurrence.<sup>28</sup>

## 4 The Relative, but Strong, Protection Granted to Hospitals by the Law

The prevailing protection granted to hospitals by IHL reflects the current equilibrium between humanity and necessity principles. Each rule of the law has a built-in balancing mechanism intended to strike a compromise between humanitarian concerns and military necessity.<sup>29</sup> In this context, the law grants strong protection, albeit a contingent one that may be removed in exceptional cases of their abuse, in light of the circumstances prevailing at the belligerency arena. The rules of targeting – regulating who, what, when and how militaries may attack – are part of this legal regime that attempts to protect humanitarian concerns amidst the hazards of war, to the extent possible given the military interests of the parties to the conflict. This balancing is reflected in the guiding principles of targeting in IHL – distinction, proportionality and precautions – which dictate the legality of targeting a potential object of attack. These rules are customary<sup>30</sup> and relevant in both international and non-international armed conflicts.<sup>31</sup>

The distinction between those who may be attacked lawfully and those who are protected is enshrined in Article 48 of Additional Protocol I as a basic rule.<sup>32</sup> It has two aspects – one relating to individuals, found in Article 51(2), and one relating to objects, found in Article 52. Both individuals and objects are either civilian and, therefore, protected or military and, therefore, not protected. Civilians are not part of the ‘war game’. By contrast, all ‘members of the armed forces of a Party to a conflict’ (except medical personnel and chaplains), as a collective, are combatants<sup>33</sup> and considered to be lawful targets, unless they are *hors de combat* (‘outside the combat’, in French).<sup>34</sup> The underlying rationale behind this classification is the notion that combatants, as a class, threaten their opponent’s army, either actually or potentially, because they

<sup>28</sup> See note 86 below. Without any empirical proof of the frequency of the relative incidents, Gordon and Perugini state: ‘Even though we are aware that armed groups have, on 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.’ Gordon and Perugini, *supra* note 5, at 458.

<sup>29</sup> See, e.g., Schmitt, ‘Military Necessity and Humanity in International Humanitarian Law: Preserving the Delicate Balance’, 50 *Virginia Journal of International Law* (2010) 795, at 798.

<sup>30</sup> J.M. Henckaerts and L. Doswald-Beck, *Customary International Humanitarian Law* (2005), at 25–36, Rules 7–10 (distinction between civilian objects and military objectives); at 46–50, Rule 14 (proportionality in attack); and at 51–67, Rules 15–21 (precautions in attack).

<sup>31</sup> For the rules protecting medical units, see ICRC, *Customary IHL*, Rule 28, available at [https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1\\_rul\\_rule28](https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule28).

<sup>32</sup> Additional Protocol I, *supra* note 10, Art. 48.

<sup>33</sup> *Ibid.*, Art. 43(2).

<sup>34</sup> *Ibid.*, Art. 41(1) forbids attacking *hors de combat*, defined under Art. 41(2) as prisoners of war, surrendering combatants or the wounded and sick incapable of defending themselves.

have the right to fight,<sup>35</sup> and soldiers can protect themselves against an adversary's personnel or objects that threaten their lives.<sup>36</sup> The targeting rules are based on the threatening class. Their contour is determined by the notion of threat, and the actual or potential harm is inherent to the distinction rule. Indeed, as Michael Walzer observes, with reference to the historical development of the distinction rule between individuals, 'protection has been offered only to those people who are not trained and prepared for war, who do not fight or cannot ... What all these groups have in common is that they are not currently engaged in the business of war'.<sup>37</sup> Accordingly, civilian objects and individuals may nonetheless lose their protected status when they take an active belligerent role or are used in such activities, turning them into legitimate objects of attack. This happens, for example, when civilians take 'a direct part in hostilities'.<sup>38</sup>

Applying the distinction rule to a shielding hospital – for example, a hospital being used to shield enemy forces – requires the attacker to do its utmost to distinguish between its military use and its vulnerable occupants and medical staff. Even in the exceptional cases in which the special institutional protection might be legally removed from a shielding hospital,<sup>39</sup> the personal vulnerability of the sick and wounded and medical staff always remains and requires special scrutiny, especially while weighing the collateral damage that might be unintentionally caused to them, pursuant to the constraints of proportionality in IHL.<sup>40</sup> Due to the damage multiplier of the sick and wounded, only in a very limited number of cases would the potential collateral damage to both persons and infrastructure from targeting hospitals – which, by definition, would be very substantial – not be considered 'excessive' *vis-à-vis* the 'concrete and direct military advantage anticipated'.<sup>41</sup>

Furthermore, only in relatively few instances might the institutional protection be removed from shielding hospitals due to the high threshold required for them to

<sup>35</sup> For criticism of the unjust killing, due to the classification of all soldiers as a collective lawful target, see Beer, *supra* note 4, at 45–52 (suggesting the introduction of a targeting-constraining test, based upon the effective operational contribution of military units to the *in bello* necessity); see also Blum, 'The Dispensable Lives of Soldiers', 2 *Journal of Legal Analysis* (2010) 69 (suggesting that the status-based classification be complemented by a test of threat).

<sup>36</sup> Blum observes: 'The rules about *hors de combat* all share one underlying principle: Once soldiers are incapacitated – through surrender, capture, or injury – they no longer pose a threat.' *Ibid.*, at 80.

<sup>37</sup> M. Walzer, *Just and Unjust Wars: A Moral Argument with Historical Illustrations* (5th edn, 2015), at 43.

<sup>38</sup> Additional Protocol I, *supra* note 10, Art. 51(3).

<sup>39</sup> Examples of acts that would lead a hospital to forfeit its special protections – while the regular protections afforded to civilian objects and individuals stay in place – might include 'firing at the enemy for reasons other than individual self-defence, installing a firing position in a medical post, the use of a hospital as a shelter for able-bodied combatants, as an arms or ammunition dump, or as a military observation post, or the placing of a medical unit in proximity to a military objective with the intention of shielding it from the enemy's military operations'. ICRC, *Commentary on Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field* (2016), at 1842, 1855.

<sup>40</sup> Additional Protocol I considers as indiscriminate, and therefore prohibited, 'an attack which may be expected to cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated'. Additional Protocol I, *supra* note 10, Art. 51(5)(b).

<sup>41</sup> *Ibid.*

be considered lawful targets. The cumulative requirements for deeming an object a legitimate military target ('military objective') are (i) that its 'nature, location, purpose or use' makes an 'effective contribution to military action' (of the adversary) and (ii) that its total or partial destruction or neutralization must offer a 'definite military advantage' in 'the circumstances ruling at the time'.<sup>42</sup> The following discussion will demonstrate that, for a hospital to become a military object, the two requirements create a wide legal rubicon that is very difficult to cross. Legally, the general rule is that hospitals, even shielding ones, are civilian objects. The shielding *per se* does not justify targeting a hospital. It might only remove the special protection, which is only one of its protective layers. However, the mistaken starting point in Gordon and Perugini's article is that a shielding hospital might be targeted: '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.'<sup>43</sup>

Under the first requirement, hospitals can only become military targets through their actual 'use' by combatants (and not by their 'nature, location or purpose')<sup>44</sup> and only for the duration of their usage.<sup>45</sup> For a hospital to become a military object, the required use is set at a higher threshold due to its special protection. This special protection of hospitals 'shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy'.<sup>46</sup> Geneva Conventions I and IV, as well as the Additional Protocol I, list acts that do not deprive hospitals of the special protection granted to them – that is, acts that shall not be considered 'acts harmful to the enemy' – and Additional Protocol I extends the protections to civilian medical units.<sup>47</sup> For example, even if there are 'small arms and ammunition' inside a hospital – a 'use'

<sup>42</sup> *Ibid.*, Art. 52(2).

<sup>43</sup> Gordon and Perugini, *supra* note 5, at 450. The mistaken confusion between losing one protective layer, the special protection and the legality of a hospital's targeting (losing all layers) is reflected in the following statement: 'Nonetheless, the shielding argument can serve as a robust defence because Article 21 of the 1864 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"' (at 455). A similar legal mistake relates to the perfidy argument: 'Hence, belligerents are permitted to bomb hospitals that are framed as shields so as to prevent their perfidious use in the future' (at 454).

<sup>44</sup> W.H. Boothby, *The Law of Targeting* (2012), at 233 (arguing that 'there are, indeed, special characteristics to the protection accorded to civilian medical units. They do not lose their protection if they become military objectives by location nor by purpose').

<sup>45</sup> This is true of all military objectives. Additional Protocol I, *supra* note 10, Art. 52(2), states that an assessment whether an object is a military objective will be based on 'the circumstances ruling at the time'.

<sup>46</sup> Geneva Convention I for the Amelioration of the Condition of Wounded and Sick in Armed Forces in the Field (Geneva Convention I) 1949, 75 UNTS 31, Art. 21; see also Geneva Convention IV Relative to the Protection of Civilian Persons in Time of War (Geneva Convention IV) 1949, 75 UNTS 287, Art. 19; Additional Protocol I, *supra* note 10, Art. 13; Additional Protocol II to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Additional Protocol II) 1977, 1125 UNTS 609, Art. 11(2). While all treaties kept the phrase 'harmful' acts, Additional Protocol II replaces it with 'hostile' acts.

<sup>47</sup> Geneva Convention I, *supra* note 46, Art. 22; Geneva Convention IV, *supra* note 46, Art. 19; Additional Protocol I, *supra* note 10, Art. 13(2).



that may render other civilian objects military targets – this would not discontinue the protections granted to hospitals.<sup>48</sup>

The second requirement for a hospital to become a military object seems to be even more difficult for an attacker to meet. Even if a hospital was 'used' for 'harmful' acts, the attacker must prove that attacking it makes an 'effective contribution to military action' and that its 'total or partial destruction, capture or neutralization, in the circumstances ruling at the time, offers a definite military advantage'.<sup>49</sup> Due to the special attributes of hospitals, such a threshold can only be crossed in a limited number of cases, and since 'civilian objects' are defined negatively as 'all objects which are not military objectives',<sup>50</sup> the general rule is that hospitals are civilian objects.<sup>51</sup> Furthermore, in case of doubt, as with all civilian objects, there should be a presumption of civilian status.<sup>52</sup>

The extra protection granted to hospitals and the responsibility to insulate hospitals from the hazards of war, to the extent possible, is not limited to the attacker. The belligerent who controls the hospital's territory is required by law to take two concrete measures aimed at achieving this goal: first, to determine the location of medical establishments and units 'as far as possible ... that attacks against military objectives cannot imperil their safety'.<sup>53</sup> This requirement is coherent with the general precaution, applicable to all civilian objects, requiring adversaries 'to the maximum extent feasible: (a) ... [to] endeavour to remove the civilian population, individual civilians and civilian objects under their control from the vicinity of military objectives; (b) avoid locating military objectives within or near densely populated areas'.<sup>54</sup> The second measure is a mandatory rule: 'Under no circumstances shall medical units be used in an attempt to shield military objectives from attack.'<sup>55</sup> The prohibition on shielding hospitals is consistent with the general rule prohibiting the use of civilians 'to shield military objectives from attacks or to shield, favour or impede military operations'.<sup>56</sup> Indeed, the coherency of these hospital-related rules with the entire regime protecting civilians gainsays their functioning as a specific faulty legal scheme providing an easy pretext for attacking transgressors, as Gordon and Perugini's article claims.<sup>57</sup>

<sup>48</sup> Additional Protocol I, *supra* note 10, Art. 13(2): 'The following shall not be considered as acts harmful to the enemy: (a) that the personnel of the unit are equipped with light individual weapons: ... (c) that small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service, are found in the units.'

<sup>49</sup> *Ibid.*, Art. 52(2).

<sup>50</sup> *Ibid.*, Art. 52(1).

<sup>51</sup> The ICRC's *Commentary* states that 'for the purpose of the law regulating the conduct of hostilities, military medical objects are civilian objects'. ICRC, *supra* note 39, at 1794.

<sup>52</sup> Additional Protocol I, *supra* note 10, Art. 52(3).

<sup>53</sup> Geneva Convention I, *supra* note 46, Art. 19. In Geneva Convention IV, *supra* note 46, Art. 18, situating hospitals 'as far as possible' from military objectives is framed as a recommendation, and in Additional Protocol I, *supra* note 10, Art. 12(4), as an obligation 'whenever possible'.

<sup>54</sup> Additional Protocol I, *supra* note 10, Art. 58.

<sup>55</sup> *Ibid.*, Art. 12(4).

<sup>56</sup> *Ibid.*, Art. 51(7).

<sup>57</sup> For example, 'from the early twentieth century, international law has introduced a series of exceptions that legitimize attacks on hospitals that were framed as shields'. Gordon and Perugini, *supra* note 5, abstract.

On top of these already extensive safeguards, additional ones are provided under the precaution requirements in IHL. Some derive from the general protection that relates to all civilians, and one is especially afforded only to medical units. Generally, an attacker is required to ‘do everything feasible to verify that the objectives to be attacked are ... military objectives’,<sup>58</sup> and it has to select the means and methods of attack that avoid or minimize incidental damage.<sup>59</sup> The special precaution relating only to medical units is found in the Geneva Conventions<sup>60</sup> and in both Additional Protocols I and II: (i) due warning must be given; (ii) a reasonable time limit must be granted when appropriate; and (iii) these warnings need to have remained unheeded before an attack is allowed.<sup>61</sup>

Indeed, the shielding argument – especially an overblown one that might turn a hospital into a lawful target – might be a pretext for transgression. But any *in bello* or *ad bellum* rule may be manipulated too, especially in the absence of an effective international law enforcement and judicial mechanism. Even self-defence, *per se*, can be abused and manipulated by an aggressor pretending to be an ostensible defendant and used as a pretext for the illegal use of force. However, that does not mean that the right of self-defence should be abolished. From this perspective, Gordon and Perugini’s argument regarding the threshold position of medical units – namely, ‘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’<sup>62</sup> – is a factual issue that, though susceptible to manipulation by transgressors, should not change the substantive law. The same holds true for their argument that ‘[t]he 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’.<sup>63</sup> The proximity to the battle factors into the risk of an unintended mistake, and the *bona fide* visit of combatants *per se* would not turn a hospital into a military objective, as discussed above, although these facts can indeed be manipulated by transgressors. However, the answers to these challenges do not lie in changing the rule, if normatively desired, but, rather, in improving law enforcement and compliance – for example, by widening transparency and accountability.<sup>64</sup>

<sup>58</sup> Additional Protocol I, *supra* note 10, Art. 57(2)(a)(i).

<sup>59</sup> *Ibid.*, Art. 57(2)(a)(ii).

<sup>60</sup> Geneva Convention I, *supra* note 46, Art. 21; Geneva Convention IV, *supra* note 46, Art. 19.

<sup>61</sup> Additional Protocol I, *supra* note 10, Art. 13(1); Additional Protocol II, *supra* note 46, Art. 11(2). This warning – which favours protecting medical units over protecting one’s own forces and obliges an attacker to take the risk of future encounters with the fleeing combatants – challenges, from a different perspective, Gordon and Perugini’s statement that ‘IHL privileges those who attack over those who shield’. Gordon and Perugini, *supra* note 5, at 457.

<sup>62</sup> *Ibid.*, at 451.

<sup>63</sup> *Ibid.*, at 453.

<sup>64</sup> See, e.g., Watkin, *supra* note 3, at 87–88.

Another mistaken legal assumption by Gordon and Perugini relates to the burden of proof. The law is not satisfied merely with attackers' arguments in regard to shielding hospitals; a heavy burden lies on their shoulders to prove all of the facts justifying their attacks.<sup>65</sup> Yet the article assumes that the burden lies on the attacked: 'Indeed, trying to prove that a given hospital was not used as a shield is virtually impossible.'<sup>66</sup> It asserts that '[a]ll 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, claim that it anticipated the attack would be proportional and, finally, assert that during the assault it took all of the necessary precautions'.<sup>67</sup> Legally, however, an attacker is required to prove its arguments and not just claim them.<sup>68</sup>

In sum, the prevailing law, contrary to Gordon and Perugini's perception of it, grants strong protection to hospitals. Non-abidance by the law, whenever it takes place, suggests that the remedy lies in compliance and enforcement rather than in reform of the law. Indeed, influential international bodies and NGOs that have dealt with health care protection have all offered to preserve the contingent immunity while strengthening abidance by the law through applicative recommendations. Thus, the ICRC has proposed developing domestic legislation, engaging armed groups and promoting military practices that make delivering and accessing health care safer.<sup>69</sup> The Safeguarding Health in Conflict coalition, a group of international NGOs, has recommended condemning attacks, promoting adherence to IHL, collecting data and seeking accountability.<sup>70</sup> Human Rights Watch has called on the UN to 'collect information on all health facility attacks, press governments to fully investigate them, and recommend avenues for accountability'.<sup>71</sup> In May 2016, the UN Security Council adopted Resolution 2286, which condemns attacks on health care, demands compliance with IHL and asks the UN secretary-general to recommend steps aimed at enhancing health care protection.<sup>72</sup> The secretary-general's recommendations were also applicative in nature, similar to those suggested by the NGOs.<sup>73</sup>

<sup>65</sup> On a belligerent lies both the *ad bellum* and *in bello* burdens. First, a self-defendant has the burden of establishing in a definite manner that an armed attack was launched against it by a specific attacker and that its response was necessitated as a matter of last resort. Second, it must establish that its targets are lawful. See, e.g., *Oil Platforms (Islamic Republic of Iran v. United States of America)*, Judgment, 6 November 2003, ICJ Reports 90, para. 51.

<sup>66</sup> Gordon and Perugini, *supra* note 5, at 459.

<sup>67</sup> *Ibid.*, at 457.

<sup>68</sup> Indeed, the 'claim sufficiency' wrongly leads the authors to conclude that the problem is not necessarily one of compliance: '[A]s 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.' Gordon and Perugini, *supra* note 5, at 458.

<sup>69</sup> ICRC, *supra* note 8, at 31–32.

<sup>70</sup> Safeguarding Health in Conflict, *supra* note 20, at 15–16.

<sup>71</sup> Human Rights Watch, *Hospitals, Health Workers under Attack*, 24 May 2017, available at [www.hrw.org/news/2017/05/24/hospitals-health-workers-under-attack](http://www.hrw.org/news/2017/05/24/hospitals-health-workers-under-attack).

<sup>72</sup> SC Res. 2286 (2016).

<sup>73</sup> United Nations Security Council, *Letter dated 18 August 2016 from the Secretary-General Addressed to the President of the Security Council* (2016), available at <https://reliefweb.int/sites/reliefweb.int/files/resources/N1626255.pdf>.

## 5 Absolute Immunity for Harmful Hospitals: Neither Practical nor Desirable

The contingent immunity currently granted to hospitals is consistent with the contour of IHL in general and with the distinction rule in particular. However, the suggested absolute immunity would undermine them. The current equilibrium between humanity and necessity principles is reflected in the distinction rule outlawing the intended targeting of civilians (including their objects) and minimizes the collateral damage that can lawfully occur to them, while allowing the targeting of combatants as a collective class, unless they are *hors de combat*.<sup>74</sup> As explained earlier, the targeting rules are based on the threatening class, and the existence of actual or potential harm is inherent to the distinction rule and crucial to its being respected.<sup>75</sup> Indeed, the rule requires that all parties to a conflict distinguish between civilians – both population and objects – and combatants ‘[i]n order to ensure respect for and protection of the civilian population and civilian objects’.<sup>76</sup> Similarly, the Geneva Conventions and their Additional Protocols require that hospitals ‘shall at all times be respected and protected by the Parties to the conflict’.<sup>77</sup> There will be no ‘respect’ for the rule when a military objective, which threatens soldiers’ lives, is absolutely immune from targeting. Indeed, as our earlier discussion demonstrated, even when the ‘use’ of hospitals is ‘harmful’, their lawful targeting is currently very restricted.<sup>78</sup> However, granting absolute protection to a shielding hospital, whatever its harm may be, seems to undermine the distinction rule and its threat-based rationale.

The suggested immunity is not practical. IHL is founded on either consent or states’ practice, supported by *opinio juris*.<sup>79</sup> States will never accept a rule that requires their combatants to accept all of the risks posed by ‘harmful’ hospitals and remain passive in the face of a threat, regardless of how dire it is. Morally and practically, states have to protect their soldiers; they will not be willing to pay a premium on soldiers’ lives for an intended and substantial abuse of the law by the shielding party, nor will they accept a rule that encourages their adversary to exploit hospitals for military ends.<sup>80</sup> The threat-based rationale of targeting is fundamental in the current delicate balance

<sup>74</sup> Additional Protocol I, *supra* note 10, Art. 41. By definition, medical personnel and chaplains are not ‘combatants’ (Art. 43(2)).

<sup>75</sup> See text accompanying notes 34–38 above.

<sup>76</sup> Additional Protocol I, *supra* note 10, Art. 48.

<sup>77</sup> Geneva Convention I, *supra* note 46, Art. 19; Geneva Convention IV, *supra* note 46, Art. 18; see also Additional Protocol I, *supra* note 10, Art. 12; Additional Protocol II, *supra* note 46, Art. 11.

<sup>78</sup> See text accompanying notes 41–52 above.

<sup>79</sup> State practice is considered the objective element required to establish customary law; the subjective element is an *opinio juris* explicitly supporting this practice. See, e.g., Wood and Sender, ‘State Practice’, in *Max Planck Encyclopaedia of Public International Law* (2014), para. 2, available at <http://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e1107?rskey=8U0gao&result=1&pid=EPIL>.

<sup>80</sup> Furthermore, even if an absolute immunity were to be introduced to the law, it would not be abided by. See K. 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/> (arguing that ‘[a] categorical prohibition will not prevent IHL from being misused; it will simply ensure that IHL is ignored’).

between military necessity and humanitarian needs.<sup>81</sup> The suggested immunity undermines this delicate balance and the entire basis of IHL, as agreed upon by states.

The suggested immunity is not desirable either. It changes the balance between all adversaries regarding the actual obligations imposed upon them. The current *in bello* rules are not one-sided; they apply to all belligerents. And even though many of them apply mainly to the attacking party,<sup>82</sup> the law does not release the defending side from its obligations towards civilians and in matters that are under its control.<sup>83</sup> Although the suggested immunity would not formally release the shielding party from its obligation not to use hospitals for its military purposes, practically, to a large extent, it would. Under an absolute immunity rule, a defendant fighting a law-abiding state would probably leverage the immunity into an exemption from its obligation. If hospitals are immune and protected, whatever the scope of their shielding activities, the defendant has an inherent incentive to use them as a safe haven for its military purposes. The more law abiding the attacker is, the greater the defendant's temptation not to respect 'its' hospitals' neutrality. Instead of being deterred from shielding – due either to moral and legal considerations, relating to the protection of the wounded and the sick, or utilitarian ones – belligerents would be incentivized to do so. Thus, the suggested immunity encourages moral hazard. The shielding defendant would engage in shielding behaviour because it is insured against its own costly consequences. Under the suggested approach, only the law-abiding attacker would be required to pay the premium for this intended and substantial violation of the law by its adversary.

Indeed, the suggested approach would probably have counter-effects, contrary to its humanitarian rationale. The suggested immunity of shielding hospitals would damage their ability to function as medical institutions. The empirical data presented earlier demonstrate that a substantial part of the current threat to hospitals comes from belligerents who control a hospital's territory but who do not respect the neutrality of hospitals and subject them to their military priorities.<sup>84</sup> In such an environment, where the abuse, looting and exploitation of hospitals prevails, absolute immunity would only add fuel to the fire. It would, in fact, allow an adversary who controls a hospital full discretion in selecting its priorities regarding the use of the hospital's space and resources. The concern, in many cases, is that its military considerations will prevail over the humanitarian ones in the hospital's area. In some

<sup>81</sup> This delicacy in protecting the state's personnel – and not only its military forces – is reflected in the prohibition of targeting innocent civilians in belligerent reprisals, currently disputed by leading Western democracies, in case their enemy deliberately attacks their civilians. For conflicting views, see Beer, *supra* note 4, at 4–6.

<sup>82</sup> See, e.g., A. Sari, *Urban Warfare: The Obligations of Defenders* (2019), available at [www.lawfareblog.com/urban-warfare-obligations-defenders](http://www.lawfareblog.com/urban-warfare-obligations-defenders) (arguing that '[e]ven though the law of armed conflict does not systematically distinguish between defenders and attackers, it has always imposed differentiated rights and obligations in certain areas').

<sup>83</sup> See Additional Protocol I, *supra* note 10, Art. 58, requiring all parties to take certain precautions against the effects of attacks, to the maximum extent feasible. Sari, *supra* note 82, rightly observes: 'These precautionary duties bind all belligerents, but they are of particular relevance to defenders, due to the circumstances in which those duties arise.'

<sup>84</sup> See Part 3 of this article.

cases, the medical needs of the hospital's patients might be rendered residual.<sup>85</sup> In any case, any use of hospitals and their resources for military purposes would come at the expense of the wounded and sick. Relying on David Luban's argument against the ticking bomb challenge to the torture prohibition – which 'is purely hypothetical and has not been corroborated by any evidence' – Gordon and Perugini argue that the potential abuse argument is 'imaginary' and 'purely hypothetical'.<sup>86</sup> Our earlier discussion demonstrates that, even currently, under the rule of contingent protection, the abuse is already a factual reality; introducing the suggested safe haven for controlling combatants would only make it worse.

Furthermore, the use of the wounded and sick as a means by the defendant belligerent would probably not end in utilizing hospitals and their resources at their expense. Gordon and Perugini do not define what a 'hospital' that deserves their suggested absolute immunity is. The un-contingent protection creates an inherent incentive for a shielding defendant to disperse the wounded and sick among as many clinics as it can and wants (and, if necessary, establish new ones). Such manipulative scattering of dual-use shielding clinics – which is contrary to the sick and wounded's interest to enjoy the benefits of hospital facilities and their professional staff – would change the war arena dramatically. It would create many no-entry zones for the attacker and would allow the cynical defendant to channel the attacker, especially in urban combat, to the defendant's preferred sites of engagement. Thus, the traditional means for channelling an attacker – for example, trenches, obstacles and minefields – might be replaced, under the suggested approach, by the most vulnerable: the sick and wounded.<sup>87</sup> Though their use as a means in war zones is not a new phenomenon, as the empirical data show, the suggested approach, in a counter-effect to the humanitarian cause it seeks to advance, would only encourage it.

The threshold position argument might have another counter-effect, which would be potentially damaging to civilians currently protected under the distinction rule. Gordon and Perugini argue: '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.'<sup>88</sup> Challenging the dichotomy between combatants and civilians, they further argue: 'The problem, of course, is that medical staff and the facilities they occupy do not really fit these binary poles ... since they clearly are – and are expected to be – active actors and part of the war effort.'<sup>89</sup> Such an argument may open a Pandora's box relating to civilians who are 'active actors and part of the war effort' yet not direct participants in the hostilities who are currently

<sup>85</sup> See also Heller, *supra* note 80; K. Sanger, *The Best Way to Protect Hospitals in Wartime: Enforce Existing Law* (2016), available at [www.justsecurity.org/33805/letter-editor-protect-hospitals-wartime-enforce-existing-law](http://www.justsecurity.org/33805/letter-editor-protect-hospitals-wartime-enforce-existing-law).

<sup>86</sup> Gordon and Perugini, *supra* note 5, at 461, referring to Luban, 'Liberalism, Torture, and the Ticking Bomb', in P. Lee (eds), *Intervention, Terrorism, and Torture: Contemporary Challenges to Just War Theory* (2007) 249.

<sup>87</sup> Such channelling of an attacker would also come at the expense of the civilians living in the manipulatively created war zones.

<sup>88</sup> Gordon and Perugini, *supra* note 5, at 451.

<sup>89</sup> *Ibid.*, at 452.

considered civilians.<sup>90</sup> The authors argue that medical units differ from 'active' civilians: '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.'<sup>91</sup> The article's attempt to fine-tune the classification of health care employees, if successful, might endanger all civilians whose mission 'is a constitutive part of war' but who are not health care employees. For example, civilians who work and live during the entire belligerency in a munitions factory on a military base are currently considered civilians.<sup>92</sup> Indeed, the munitions factory is a military objective and might be a lawful target, subject to the proportionality rule,<sup>93</sup> but the working civilians do not lose their classification as such in spite of their 'constitutive' role and their complete association with the war effort. Though unintended, the article's challenge to the distinction rule, aimed at saving medical facilities and personnel, might undermine the classification of civilians – who are 'active actors and part of the war effort' and are not 'separated' from it yet are also not direct participants in the hostilities – while not privileging them with absolute immunity.

## 6 Concluding Remarks

It is best to contemplate supplementary protections to hospitals within the prevailing legal contour of the contingent protection. These measures might include guidelines for implementing the unique precautions afforded to hospitals under the prevailing law: elevating the threshold for 'harmful acts'; leveraging modern technology, whenever possible, by requiring verification of the actual threat, and the potential collateral damage, before responding to 'harmful acts' emanating from hospitals; dictating the use of precise ammunition, whenever feasible, and minimizing the collateral damage within hospitals<sup>94</sup> and demanding increased transparency and accountability from attackers.

Rather than calling for evolution, Gordon and Perugini call for revolutionary reform. Their approach does not appear to be consistent with the empirical data, nor do they convincingly address the practical effect that absolute immunity might have on the functioning of hospitals and the safety of their patients and staff if they become safe havens for belligerents. By discounting the different layers of protection currently granted to hospitals, they disregard the inherent advantages of the contingent

<sup>90</sup> Additional Protocol I, *supra* note 10, Art. 51(3).

<sup>91</sup> Gordon and Perugini, *supra* note 5, at 452–453.

<sup>92</sup> See, e.g., Y. Dinstein, *The Conduct of Hostilities under the Law of International Armed Conflict* (2010), at 131, 136–137.

<sup>93</sup> Additional Protocol I, *supra* note 10, Art. 51(5)(b). Gordon and Perugini's article distinguishes the factory from hospitals: 'The crux of the matter is that medical units and staff are very different from civilians 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 civilians are kept separate – that is, the civilian does not enter the munition factory – they preserve all of the protections allocated to them by the law.' Gordon and Perugini, *supra* note 5, at 452. The above discussion demonstrates that active civilians, even if not 'separated', still remain civilians.

<sup>94</sup> See generally, Schmitt, 'Precision Attack and International Humanitarian Law', 87 *IRRC* (2005) 445.

protection, which, indeed, like any other IHL rule, requires compliance and enforcement. The authors rely on the pretext arguments of transgressors regarding shielding hospitals – without distinguishing between the *bona fide* mistakes of law-abiding militaries and intended targeting – in an attempt to convince the reader that the law is faulty and should be reformed. However, in order to counter manipulations and rhetoric by transgressors, it is necessary to establish the facts of each attack and then apply the law to each case. Indeed, it is difficult to accept the authors' broad conclusion that 'IHL ultimately renders those who occupy a liminal position as legitimate targets'.<sup>95</sup>

This reply, which is based upon the data relating to the scope of the health care problems in belligerency, argues that the absolute immunity suggested is neither feasible nor normatively desired. Not surprisingly, influential NGOs, including the ICRC, which is the custodian of IHL, have not suggested it nor has the UN.<sup>96</sup> The contingent protection granted to hospitals by IHL reflects the current equilibrium between humanity and necessity principles. Gordon and Perugini's article claims that just as 'torture is inhumane ... targeting hospitals is also inhumane'.<sup>97</sup> Indeed, war is an inhumane project by definition. But if just wars are to be fought, any reform aimed at reducing war's hazards, while allowing law-abiding states to fight morally and legally, should be endorsed. As this reply has argued, the suggested reform does not take into account justified military necessities and promises a humanitarian counter-effect that, although unintended, may increase war's hazards.

<sup>95</sup> Gordon and Perugini, *supra* note 5, at 457.

<sup>96</sup> See text accompanying notes 68–73 above.

<sup>97</sup> Gordon and Perugini, *supra* note 5, at 462.