

Medical immunity, international law and just war theory

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Received 16 July 2018

Revised 25 July 2018

Accepted 26 July 2018

Published Online First

16 October 2018

ABSTRACT

Under customary international law, the First Geneva Convention and Additional Protocol I, medical personnel are protected against intentional attack. In § 1 of this paper, we survey these legal norms and situate them within the broader international humanitarian law framework. In § 2, we explore the historical and philosophical basis of medical immunity, both of which have been underexplored in the academic literature. In § 3, we analyse these norms as applied to an attack in Afghanistan (2015) by the United States; the United States was attempting to target a Taliban command-and-control centre but inadvertently destroyed a Médecins Sans Frontières hospital instead, killing 42 people. In § 4, we consider forfeiture of medical immunity and, more sceptically, whether supreme emergency could justify infringement of non-forfeited protected status.

1. PROTECTED PEOPLE AND PLACES

In part, international humanitarian law aims to delimit legitimate military targets, as well as the ways in which those targets can be engaged.^{1–5} The International Committee of the Red Cross (ICRC) has promulgated a comprehensive set of customary norms in this regard, which we survey in this opening section. We also pay particular attention to the ways in which those norms intersect with the First Geneva Convention and Additional Protocol I.ⁱⁱ The customary law, though, warrants extended

ⁱ See ICRC.¹ We will reference the online version, which is also available in print. See Henckaerts and Doswald-Beck.² For philosophical discussion, see Frowe,³ especially chapters 6–8. See also Gross,⁴ especially chapters 3–4. See also Allhoff.⁵

ⁱⁱ The Geneva Conventions, comprising four treaties, were ratified in 1949 by 196 states. The First Geneva Convention, the third iteration of the 1864 original, deals with the armed forces' wounded and sick. The Second Geneva Convention replaced the Hague Convention X (1907) and extends the First Geneva Convention's discussions to maritime warfare. The Third Geneva Convention replaced a 1929 convention and addresses prisoners of war. The Fourth Geneva Convention protects civilians during war. Protocols I and II (1977) describe the protections due victims of international and non-international armed conflicts, respectively. Protocol III (2005) discusses the adoption of additional distinctive emblems. Additional Protocols I and II have been widely ratified; Additional Protocol III has been ratified less widely, in part due to its recency. For current ratification statuses of these, see <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/vwTreaties1949.xsp>. For the purposes of this paper, we will either reference a specific document or else refer to the 'Geneva Conventions' in general, by

Key messages

- ▶ Under customary international law, the First Geneva Convention, and Additional Protocol I, medical personnel are protected against intentional attack.
- ▶ This paper surveys these legal norms and situate them within the broader international humanitarian law framework.
- ▶ The historical and philosophical basis of medical immunity are developed, both of which have been underexplored in the academic literature.
- ▶ These norms are explored as applied to a United States attack in Afghanistan. The forfeiture of medical immunity is considered and whether supreme emergency could justify infringement of non-forfeited protected status.

discussion because of its historical significance and the foundations it ultimately laid for treaty law—we return to this discussion in § 2.

The ICRC's customary norms are broadly organised into six sections: the principle of distinction (part I); specifically protected persons and objects (part II); specific methods of warfare (part III); weapons (part IV); treatment of civilians and persons hors de combat (part V) and implementation (part VI). Each part subdivides into a series of rules, comprising 161 in total¹; furthermore, many of these customary norms have been codified by the Geneva Conventions and the Additional Protocols.¹ ⁱⁱⁱ For our purposes, we will focus on medical

which we mean the collection of four treaties ratified in 1949.

ⁱⁱⁱ For the sake of comprehensiveness, these include the ICRC rules ('Rule') and articles from both the First Geneva Convention of 1949 ('Article') and Additional Protocol I ('API Article'): medical personnel (Rule 25, Articles 24–25), medical activities (Rule 26), religious personnel (Rule 27, Article 24), medical units (Rule 28, Article 19), medical transports (Rule 29, Article 35), persons and objects displaying the distinctive emblem (Rule 30, Articles 38–44), humanitarian relief personnel (Rule 31, Article 26), humanitarian relief objects (Rule 32, Article 34), personnel and objects involved in a peacekeeping mission (Rule 33), journalists (Rule 34, API Article 79), hospital and safety zones and neutralised zones (Rule 35), demilitarised zones (Rule 36, API Article 60), open towns and non-defended localities (Rule 37, API Article 59), attacks against cultural property (Rule 38), use of cultural property for military purposes (Rule 39), respect for cultural property (Rule 40, API Article 53),



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To cite: Allhoff F, Potts K. *J R Army Med Corps* 2019;**165**:256–265.



immunity, which is most clearly articulated by Rule 25. This falls in part II and states that '[m]edical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. They lose their protection if they commit, outside their humanitarian function, acts harmful to the enemy'.^{1 6 iv v}

Before looking at Rule 25 in particular, it will be useful to situate it among the other norms protecting people and places. The various persons and objects covered by ICRC rules—some of which we specifically discuss below—are afforded four levels of protection. In order of increasing levels, these rules encompass people or objects that: (1) must be afforded special care or consideration, but can be directly attacked when militarily necessary; (2) cannot be intentionally attacked but can be exposed to expected harm; (3) cannot be exposed to intentional or expected harm; (4) are immune to intentional harm and must be assisted by combatants when possible.

Cultural property—including buildings dedicated to religion, art, science, education, historical monuments and property essential to cultural heritage—warrants special consideration, but can be intentionally attacked when militarily necessary.^{7 vi} Rule 38 protects cultural properties from being targeted unless they are military objectives or attacking them is 'imperatively required by military necessity'.^{1 vii} Additionally, Rule 39 prohibits people from using cultural property in a way that exposes it to this kind of harm or destruction.^{1 viii} Although these norms were omitted from the Geneva Conventions, many were eventually codified under Additional Protocol I, which builds on earlier efforts by the Hague Convention to protect cultural objects and places of worship.^{ix} The special considerations afforded to cultural property enforce minimal obligations on combatants, proscribing the pillaging, misappropriation or vandalism of cultural property solely to prevent their actions from hampering the peace-making process.^{1 x}

export and return of cultural property in occupied territory (Rule 41), works and installations containing dangerous forces (Rule 42, API Article 56), application of general principles on the conduct of hostilities to the natural environment (Rule 43), due regard for the natural environment in military operations (Rule 44) and causing serious damage to the natural environment (Rule 45, API Article 55).

^{iv} Rule 25. This protection is also incorporated in the First Geneva Convention, Article 24: '[m]edical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, staff exclusively engaged in the administration of medical units and establishments, as well as chaplains attached to the armed forces, shall be respected and protected in all circumstances'.

^v Protections afforded to religious personnel are phrased the same way, merely replacing each use of 'medical' with 'religious'. It is also prosecuted with the same Article 8, § 2.b.xxiv of the Rome Statute. Religious personnel may even be equipped with light armament for self-defence. See ICRC,¹ Rule 27. See also ICRC⁶ (The second volume of this work collects implementations or interpretations, 'Practice', corresponding to the first volume, 'Rules'. Unless otherwise indicated, references are to the first volume.)

^{vi} The issues pertaining to cultural artefacts can intersect with those pertaining to medical personnel. See Allhoff.⁷

^{vii} ICRC,¹ Rule 38.

^{viii} ICRC,¹ Rule 39.

^{ix} Additional Protocol I, Article 53.

^x ICRC,¹ Rules 40–41. This low level of special protection facilitates the peace process without imposing positive obligations on combatants.

The second class comprises humanitarian relief workers,^{1 xi} journalists^{1 xii} and protected zones.^{1 xiii} The customary practice of protecting these people and places was similarly omitted by the Geneva Conventions. However, Additional Protocol I remedies this omission, as well. Specifically, it protects: "journalists engaged in dangerous professional missions in areas of armed conflict", by requiring that they be treated as civilians, and allows them to carry identification that "attest[s] to (their) status as a journalist".^{xiv} Importantly, these identification cards offer little protection in comparison to the distinctive emblems worn by medical personnel.^{xv}

Due to their civilian status, members of this group are protected against direct attacks, although they can still be subject to collateral harm. Rule 1 provides that '[t]he parties to the conflict must at all times distinguish between civilians and combatants. Attacks must only be *directed* against combatants. Attacks must not be *directed* against civilians'.^{1 xvi} By focusing on *intentional* attacks, this permits combatants to claim their actions were not violations of Rule 1 if the harm cause to civilians was unintended. The same notion of protection applies to zones and objects belonging to this second class.^{1 xvii} In most cases, this level of protection is a corollary to the right against starvation and injured peoples' right to care. Parties to a conflict who harm members of this protected group often defend their actions by arguing that their intentional strike on a legitimate target unintentionally caused the collateral damage incurred by the victims.

Protections to the third class are substantial, and cover the natural environment and installations containing dangerous forces.^{1 xviii} For the most part, the protected status of people and places in this third class has been included in Additional Protocol I, which includes 'dams, dykes and nuclear electrical generating stations' within the class of installations protected by Article 56 due to the potential long-term effects of their destruction. Any attacks must be planned and carried out to avoid 'widespread, long-term and severe damage'.^{1 xix} In both customary and treaty law, this language also covers attacks that are expected to cause unintentional harm to the environment. For example, Rule 45 states that: "[t]he use of methods or means of warfare that are intended, or may be expected, to cause widespread, long-term and severe damage to the natural environment is prohibited".^{1 xx} Additional Protocol I goes so far as to prohibit attacks on legitimate military targets in the vicinity of these installations

^{xi} ICRC,¹ Rule 31.

^{xii} ICRC,¹ Rule 34.

^{xiii} ICRC,¹ Rules 35–37. A quick note on Rules 35 and 28: Rule 35 assigns protection to hospitals as civilian zones, which only implies a negative duty against attack. This is a weaker level of protection than the positive duty in Rule 28, which adds the responsibility to respect and protect '[m]edical units exclusively assigned to medical purposes'.

^{xiv} Additional Protocol I, Article 79.

^{xv} We discuss these in more detail in § 2.

^{xvi} See Additional Protocol I, Article 48 and ICRC,¹ Rule 1. See also ICRC,¹ Rule 7, which replaces 'civilian' (Rule 1) with 'civilian objects'.

^{xvii} ICRC,¹ Rules 35–37. Protected zones include areas established to shelter the wounded, sick or civilians, as well as demilitarised zones and non-defended localities.

^{xviii} ICRC,¹ Rules 42–45. See also Additional Protocol I, Articles 55–56.

^{xix} ICRC,¹ Rule 45. See also Rules 42–44.

^{xx} ICRC,¹ Rule 45.

and forbids reprisals that target the natural environment; even if this norm has been violated by opposing forces, a country must refrain from causing widespread environmental harm.^{xxi} The obligation to avoid attacks that may be expected to harm a protected group is rare and likely arises from the difficulty in restoring the natural environment or epistemic problems associated with calculating the long-term harms caused by attacks that can be expected to damage the environment.^{xxii} It is improbable that such attacks could ever be proportional—or, perhaps, militarily necessary—so international law prohibits them full stop.

Medical personnel, units and transports are given the most substantial protection of all.^{xxiii} These people and places have long been protected within customary international law; as a result, norms establishing medical immunity were codified into the 1864 Geneva Convention.^{xxiv} This fact attests to the fundamental role they play in limiting unnecessary harm.^{xxv} International law shelters medics and medical facilities from intentional attacks, and requires combatants to assist them in their humanitarian duties when possible. Although medical immunity is conditioned on the person's being *exclusively* assigned to medical operations, it is a substantial protection in that in that those who qualify for this level of immunity are protected from intended and unintended but foreseen harm.

Legal norms protecting medical immunity were some of the first tools that countries could employ to hold one another accountable for causing unnecessary harm. The principle of necessity has long been the primary means of making war more humane, so medical immunity deserves close attention. In the next section, we describe how medical units came to occupy this privileged status and the reasons international law grants them such extensive protections.

2. MEDICAL IMMUNITY IN HISTORICAL AND PHILOSOPHICAL CONTEXT

Before turning to medical immunity in particular, it will be useful to situate it within a the broader just war theory context—in other words, to pivot from the legal context to the philosophical. The advent of just war thinking is commonly attributed to Thomas Aquinas⁸. Although Aquinas is justifiably influential, the historical record is far less monolithic;^{9,xxvi} regardless, the contemporary discussion largely emanates from Michael Walzer's *Just and Unjust Wars*.¹⁰ Walzer proposes that we follow the Medieval distinction between *jus ad bellum* and *jus in bello*: the former gives us conditions for resorting to war at all, whereas the latter gives us conditions for how to conduct

ourselves during hostilities.^{1 xx xxvii} While much of the contemporary literature challenges the distinction independent of *jus ad bellum* and *jus in bello*—and adds a third doctrine, *jus post bello*^{11 12 xxviii}—the *in bello* principles themselves have largely held up in the intervening decades.^{3 13 14 xxix}

A hallmark *in bello* principle is that of distinction, which bars belligerents from intentionally targeting non-combatants.^{xxx} The incidental killing of non-combatants, however, may be justified. But such justification is subject to further *in bello* restrictions on proportionality and military necessity; or, more generally, the doctrine of double effect.^{15–19 xxxi} Norms pertaining to medical immunity were incorporated into international law comparatively recently,^{xxxii} and draw inspiration from the so-called Lieber Code.

In 1863, Francis Lieber synthesised a range of customs guiding conduct in war, creating the first formal treatise in this regard²⁰; prior to its publication, war was largely carried out according to ad hoc agreements between warring parties and ill-defined customary practices.²¹ Lieber's work established the customary international law basis on which the Geneva Conventions were ultimately built.²¹ Before the American Civil War (1860–1865), Lieber served as a professor of history at Columbia University where his lectures on the laws of war caught the attention of Union General Henry Halleck.^{xxxiii} After providing Halleck copies of his lectures and following ensuing correspondence, Lieber formally drafted the Code, which comprised 157 rules grouped into 10 separate categories.^{20 21 xxxiv}

^{xxvii} As Walzer famous writes: '[t]he moral reality of war is divided into two parts. War is always judged twice, first with reference to the reasons states have for fighting, second with reference to the means they adopt. The first kind of judgement is adjectival in character: we say that a war is just or unjust. The second is adverbial: we say that the war is being fought justly or unjustly'. See ICRC,¹ Rule 25.

^{xxviii} See, for example, Orend.¹¹ See also Orend,¹² especially chapters 6–7.

^{xxix} For the contemporary state of play, Frowe³ and Lazar.¹³ Much of the current trajectory has been shaped by the work of Jeff McMahan, which is usefully summarised in the aforementioned treatments by Frowe and Lazar. See also McMahan.¹⁴

^{xxx} More colloquially, the distinction is often drawn between civilians and the military. But, as we shall see, there are overwhelming theoretical reasons to resist this approach. Specifically, some civilians are combatants (eg, private military contractors), whereas some with functional roles in the military (eg, medical personnel and clergy) are non-combatants.

^{xxxii} For an introduction to the doctrine of double effect, see Frowe³ (p. 21). For its historical roots, see Aquinas.¹⁵ The contemporary literature is quite substantial but see, for example, Foot¹⁶; see also Quinn¹⁷; see also Kagan¹⁸; see also Thomson⁴⁹ (1991), p. 293. For direct application to just war theory, see Walzer¹⁰ (pp. 151 – 159). For an extended critique—especially as pertains to just war theory—see Kamm.¹⁹

^{xxxiii} The 1864 Geneva Convention was the first attempt to generate a formal document capable of binding states' behaviours in international armed conflicts; it was more readily enforceable than a loose collection of customary practices.

^{xxxiiii} See Solis²¹ (p. 45).

^{xxxv} See Solis.²¹ The structure of the code is a bit unwieldy, but comprises 157 rules, grouped into 10 categories: (1) 'martial law, military jurisdiction, military necessity and retaliation'; (2) 'public and private property of the enemy, protection of persons and especially of women, of religion, the arts and sciences and punishment of crimes against the inhabitants of hostile

^{xxi} Additional Protocol I, Article 56.

^{xxiii} Although Rule 45 explicitly prohibits foreseeable or expected long-term harm, Rule 43 complicates this protection by permitting the destruction of natural environment when required by 'imperative military necessity'. We return to this issue in § 4.

^{xxiii} ICRC,¹ Rules 25–30. Many of these protections also extend to religious personnel in war zones. See also the First Geneva Convention, Articles 19–25.

^{xxiv} The 1864 Geneva Convention evolved into the First Geneva Convention (1949), after substantive revisions in 1906 and 1929. The original text is available at <https://www.icrc.org/eng/resources/documents/treaty/geneva-convention-1864.htm>.

^{xxv} In fact, of the 10 total articles in the 1864 Geneva Convention, 7 pertain to medical immunity and the remaining 3 describe the means of enforcement.

^{xxvi} See Reichberg *et al.*⁹ Various thinkers predate Aquinas, including Thucydides, Plato, Aristotle, Cicero, St. Augustine and others.

At first glance, the role the Lieber Code played in shaping international law may seem surprising. When first published, it had little influence: because it contains orders given by President Lincoln, it bound only Union soldiers. Furthermore, the content of the Code was not particularly novel; it merely compiled customs that countries around the world had recognised for years²¹ (p. 45). The Code's key contribution was its synthesis, which facilitated the international effort to create widely accepted laws of armed conflict. Aspects of the Code would be incorporated in the 1864 Geneva Convention and were later incorporated into the Geneva Conventions and Additional Protocols I and II.^{20 xxxv}

Lieber's work expanded the concept of military necessity as a principled means of limiting permissible conduct in war.^{20 xxxvi} Consider, for example, the rights of the wounded: '[e]very captured wounded enemy shall be medically treated, according to the ability of medical staff'.^{20 xxxvii} Soldiers must abstain from causing suffering beyond what is necessary to remove an enemy from the field. Since captured enemies are already *hors de combat*, any further harm would be unnecessary.^{1 xxxviii}

Lieber only grants the right of medical care to captured wounded enemy soldiers.^{20 xxxix} Since this duty could be fulfilled off the battlefield, the obligation placed on medical personnel is more limited than that assigned by Rule 25 or Article 24 of the First Geneva Convention.^{20 xl} The Lieber Code's formulation of the soldiers' negative duty to respect medical immunity mirrors this limitation insofar as it only extends protection to hospitals, not to the medical staff themselves. This is because it was uncommon for medical personnel to care for the wounded on in the field. The only affordance the Code provides to medical staff exempts them from prisoner of war status, which allows them to go free unless they choose to remain with their comrades.^{20 xli} So, although they had privileged status once they

countries'; (3) 'deserters, prisoners of war, hostages, and booty on the battlefield'; (4) partisans, armed enemies not belonging to the hostile army, scouts, armed prowlers, war rebels'; (5) 'safe conduct, spies, war traitors, captured messengers, abuse of the flag of truce'; (6) 'exchange of prisoners, flags of truce, flags of protection'; (7) 'parole'; (8) 'armistice, capitulation'; (9) 'assassination' and (10) 'insurrection, civil war, rebellion'. See also Lieber.²⁰

^{xxxv} See Solis.²¹ In addition to providing the basis for the Geneva Convention, the Lieber Code 'provide[d] the basis of similar codes issued by Great Britain, France, Prussia, Spain, Russia, Serbia, Argentina and the Netherlands'. See also Lieber.²⁰

^{xxxvi} In addition to necessity, proportionality also constrains soldiers' conduct, as seen in Article 70: '[w]hoever intentionally inflicts additional wounds on an enemy already wholly disabled, or kills such an enemy, or who orders or encourages soldiers to do so, shall suffer death'. See also Lieber.²⁰

^{xxxvii} See Lieber,²⁰ Article 79.

^{xxxviii} Cf., Rule 70: '[t]he use of means and methods of warfare which are of a nature to cause superfluous injury or unnecessary suffering is prohibited'. ICRC.¹

^{xxxix} Lieber,²⁰ Article 53.

^{xl} Lieber,²⁰ Article 35. Whereas Rule 25 and Article 24 of the First Geneva Convention enforce the responsibility to protect medical personnel, Article 35 of the Lieber Code requires that only the hospitals themselves 'must be secured against all avoidable injury'. So, if personnel were outside a hospital—which would be rare in 1864—they would not have any protections beyond those enjoyed by civilians.

^{xli} Article 53 provides that '[t]he enemy's chaplains, officers of the medical staff, apothecaries, hospital nurses and servants, if

were captured, medical personnel did not enjoy the immunity that they have today. As medical staff began to appear on the battlefield towards the end of the 19th century, the drafters of the 1864 Geneva Convention saw the need to extend the right to medical care to all wounded soldiers, not just those who had been captured.^{20 xlii} Subsequently, the negative duty to respect medical immunity grew beyond hospitals to encompass medical personnel as well. This development shows that protections afforded to the wounded are positively correlated with medical personnel's obligations and immunity.

In 1864, Henry Jean Dunant continued Lieber's work, forming the ICRC and assembling the drafters of the 1864 Geneva Convention²¹ (p. 50). Dunant witnessed the horrific fate of wounded soldiers at the Battle of Solferino, which he recorded and published in *A Memory of Solferino*²¹ (p. 52). Dunant's depiction of the suffering of those *hors de combat* inspired people across western Europe to redress the situation (pp. 52–53).²¹ The nature of warfare constantly changed as rapid development of military technology towards the end of the 1800s was matched by the cultivation of new medical technologies that allowed medics to appear on the battlefield in greater numbers than ever before.^{22 xliii}

The First Geneva Convention justifies considerable protections for medical personnel because they are key agents in the effort to minimise suffering in war.^{xliv} Furthermore, the right of combatants to medical care^{xlv} necessitates the protection of medical personnel, such that care can be provided²² (p. 177).^{xlvi} Medical immunity therefore seeks to ameliorate the burden resulting from the obligation to provide medical care to the wounded.²³^{xlvii} Before evaluating legal norms protecting medical personnel, we must understand three things about its extent: (1) the positive and negative duty medical immunity imposes on soldiers charged to respect it; (2) who is entitled to immunity and (3) how this protection can be lost.

they fall into the hands of the American Army are not prisoners of war, unless the commander has reasons to retain them. In this latter case, or if, at their own request, they are allowed to remain with their captured companions, they are treated as prisoners of war'. See also Lieber.²⁰

^{xliii} In modern customary international law protections granted to religious personnel and medical personnel are nearly identical. The Lieber Code, however, requires that soldiers 'acknowledge and protect, in hostile countries occupied by them, religion and morality' without placing a parallel obligation on service members when it comes to medical staff. Lieber,²⁰ Article 37.

^{xliii} The St. Petersburg agreement is an early member of a long series of agreements that ban or limit the use of particular weapons because their use causes unnecessary suffering.

^{xliv} First Geneva Convention, Article 24.

^{xlv} The First Geneva Convention, Article 12 requires medical care for soldiers fighting on land. The Second Geneva Convention, Article 12 does the same for soldiers at sea.

^{xlvi} Gross²² (p. 177). For this reason, Gross considers medical personnel's right to immunity a derivative right.

^{xlvii} See also Spain's Law of Armed Conflict Manual which says that the 'protection of medical personnel is not a personal privilege but rather a corollary of the respect and protection due to the wounded and sick'. ICRC.¹ Rule 110 provides some evidence⁴⁹ suggesting that this burden is substantial insofar as it guarantees a soldier's right to receive medical care 'to the fullest extent practicable and with the least possible delay' allowing for distinctions only on the basis of medical grounds.

The customary practices of various states display a range of interpretations of the obligations encompassed by the requirement to respect and protect medical personnel. The UK *Military Manual* and US *Field Manual* focus primarily on negative duties, stipulating that medical personnel 'must not knowingly be attacked, fired on or unnecessarily prevented from discharging their proper functions'.²⁴ ^{xlviii} Spain goes on to add a positive duty to 'defend, assist and support medical personnel when needed'.²⁴ Despite the range of state practices regulating the obligation of combatants to assist medical personnel, Additional Protocols I and II are clear on the matter: medical personnel must be granted all available assistance in fulfilling their humanitarian functions.^{xlix}

'Medical personnel' are defined as those personnel exclusively assigned, temporarily or permanently, to the commission of medical duties. This includes, but is not limited to searching for, collecting, treating and transporting wounded soldiers or civilians.²⁴ ^{li} This extends protection to those who are associated with a party in the conflict, members of a voluntary aid society—like the ICRC—and staff made available by a neutral state or an impartial humanitarian organisation. Humanitarian workers and civilian medical personnel not authorised by a party to the conflict or international authority to provide medical relief are also protected as medical personnel.^{li} However, only authorised medical personnel may display distinctive emblems of the Red Cross, Red Crescent or Red Crystal established by the First Geneva Convention and Additional Protocol III.

Rules 28 and 29 extend these protections to hospitals and medical transports, respectively.^{liii} The interpretation set forth in the customary international humanitarian laws of what respecting and protecting medical units amounts to mirrors that of the obligation imposed by immunity for medical personnel. State practice varies in much the same way that it does regarding the duties combatants have to medical personnel. Some states

require their armed forces to ensure the unhampered functioning of medical units,²⁴ ^{liii} while the US *Air Force Commander's Handbook* implicitly allows forces to prevent medical units from properly functioning if it is deemed necessary.^{liv}

Finally, medical personnel, units and transports can forfeit their protected status when they commit acts harmful to the enemy outside their humanitarian function. ICRC Rules 25–30 and the First Geneva Convention only extend immunity to those who are *exclusively* assigned to humanitarian functions.^{lv} So, even medical personnel carrying out hybrid missions, with one medical and one military objective, forfeit their immunity. Consider, for example, an ambulance transporting a patient. If this ambulance also actively collects intelligence regarding enemy location and armament, it forfeits its immunity.^{lvi} While Additional Protocols I and II merely strip medical personnel of their immunity once they participate in a hostile act, some national codes provide that partaking in a hostile act may constitute perfidy if personnel intentionally abuse their protected status or fail to remove their distinctive emblems.^{lvii}

Medical immunity and battlefield neutrality evolved together; medics began appearing on the battlefield just before the 1864 Geneva Convention established their protected status. Prior to 1864, medical immunity was limited to hospitals, but as medical technology enabled physicians to effectively treat wounded soldiers on active battlefields, their duties to wounded soldiers became more substantial. The increased risk associated with this new obligation necessitated stronger protections. So, the concepts of neutrality and immunity have become deeply intertwined. Because medical immunity developed during the end of the 19th and throughout the 20th century, a time when wars typically took place between one or more states, it has been heavily influenced by the particularities of interstate conflict.^{lviii} ²⁶ ²⁷ Under this regime, norms establishing immunity for medical personnel are widely recognised.^{lix} Despite

^{xlviii} It is also worth noting that these codes permit military necessity to justify infringing on medical immunity, while Article 24 of the First Geneva Convention and Article 36 of the Second Geneva Convention do not include a similar provision.

^{xlix} See Additional Protocol I, Article 15(2): 'if needed, all available help shall be afforded to civilian medical personnel in an area where civilian medical services are disrupted by reason of combat activity'. See also Additional Protocol II, Article 9 (1): '[m]edical and religious personnel...shall be granted all available help for the performance of their duties'. The ICRC recognises the following established functions: 'the search for, collection, transportation, diagnosis or treatment, including first-aid treatment, of the wounded, sick and shipwrecked, and the prevention of disease, to the administration of medical units or to the operation or administration of medical transports'. Similar language appears in Canada's *Law of Armed Conflict Manual*, Ireland's *Basic Law of Armed Conflict Guide*, Madagascar's *Military Manual*, Ukraine's *International Humanitarian Law Manual*. It was also in Article 11(f) of a draft of Additional Protocol II, but omitted for the final version.

^l ICRC,¹ Rules 1–24, 31. See also Article 26 of the First Geneva Convention and Articles 23–24 of the Second Geneva Convention.

^{li} First Geneva Convention, Article 53. Article 2 of Additional Protocol III adds the Red Crystal in the shape of a square on its edge to the class of distinctive emblems. Civilian medical personnel may wear other emblems to convey their status as humanitarian workers, but these do not carry the same weight as the Red Cross, Red Crescent or Red Crystal.

^{liii} Attacks on medical units are proscribed by ICC Article 8 (2) (b)(ix).

^{liii} Germany and Switzerland are two examples.

^{liv} Medical units 'should not be deliberately attacked, fired on, or *unnecessarily* prevented from performing their medical duties' (emphasis added). See also Lazar,¹³ for more general discussion of attendant issues in necessity and proportionality.

^{lv} First Geneva Convention, Articles 19–24.

^{lvi} If the ambulance passively collects the information then it is still entitled to immunity. For example, an ambulance driving from A to B, not trying to collect intelligence, that notices something and ultimately reports back would retain its immunity. Even if an adversary realises that the ambulance probably saw something it was not supposed to see, the transport will remain protected so long as it does not go out of its way to collect the information.

^{lvii} See, for example, Additional Protocol I, Article 15; Additional Protocol II, Article 9; and Spain *Law of Armed Conflict Manual*.²⁴

^{lviii} See Benton and Atshan (p. 154).²⁶ See also Allhoff.²⁷

^{lix} See the military manuals of Burkina Faso (§ 27), Canada (§ 31), Colombia (§§ 32–33), Congo (§ 34), Croatia (§ 36), Dominican Republic (§ 37), Ecuador (§ 38), El Salvador (§ 39), France, (§ 40), Hungary (§ 44), Lebanon (§ 51), Mali (§ 53), Morocco (§ 54), the Netherlands (§ 56), Nicaragua (§ 58), Nigeria (§§ 59 and 61–62), Romania (§ 63), Russian Federation (§ 64), Senegal (§ 65), Switzerland (§ 69), the UK (§ 72) and the United States (§ 76); the legislation of Bosnia and Herzegovina (§ 81), Colombia (§§ 82–83), Croatia (§ 84), El Salvador (§ 85), Estonia (§ 87), Ethiopia (§ 88), Georgia (§ 89), Nicaragua (§ 93), Poland (§ 96), Slovenia (§ 98), Spain (§§ 99–100), Tajikistan (§ 101), Ukraine (§ 102), Bolivarian Republic of Venezuela (§§ 103–104) and

widespread endorsement of medical neutrality—under which medical care should be provided based on medical need, not national allegiance—medical practitioners frequently become entangled in partisan conflicts.^{26 28 29} Parties to a conflict sometimes use medical facilities strategically, gaining cover for their military operations by leveraging medical immunity (eg, putting command and control centres in hospital basements),³⁰ or even illicitly debilitating their adversaries' medical infrastructure in order to hamper morale.³¹ We return to these issues in § 4.

Impartiality became the defining feature because warring nations recognised the benefit of agreeing that each side would treat the other's wounded soldiers if needed²⁶ (p. 154).^{lx} As mentioned earlier, Rule 25 applies to non-international conflicts as well. However, this extension glosses over morally relevant differences between paradigmatic international wars and the non-traditional conflicts prevalent today. Increasingly, asymmetrical conflict occurs between state and substate actors, who differ in military capacity, adherence to international humanitarian law—including identifying themselves as combatants and honouring the principle of discrimination—and so on²² (p. 182). The contract on which Rule 25 is predicated breaks down when one side routinely abuses medical immunity, or when a state is engaged with a non-state actor that does not recognise traditional laws of war.

Even in interstate armed conflicts, making impartiality a prerequisite for immunity imposes a significant burden on medical personnel. Remaining impartial in the face of tremendous suffering may ask too much of physicians, particularly if one state is clearly unjust. For example, some physicians running field hospitals during the 2011 protests in Tahrir Square in Cairo who “insisted that they were ‘apolitical’ before the uprisings, noted that their intimate encounters with state violence against unarmed protesters had motivated them to condemn the government’s reaction to the protests”²⁶ (p. 154). This puts pressure on the link between impartiality and immunity.

To illustrate how significant this pressure can become, imagine the following scenario: a medic for country A provides medical care to a wounded soldier from enemy country B. During the course of treating the enemy soldier's wounds, a friendly soldier from country A notices the medic is treating an enemy soldier and rushes headlong to kill the enemy soldier before they can be stabilised. Impartiality imposes a positive obligation on the medic to kill their friendly soldier to defend their patient.²⁵ ^{lxii}

Medical impartiality and medical immunity are more fragile than they appear at first glance. For example, medical immunity is forfeited when insurgents use medical facilities or emblems to carry out military objectives, regardless of whether the staff are complicit or actively assist them. Such actions erode the

status of these symbols. Additionally, countries can distribute medical services politically, thereby jeopardising the safety of the medical staff providing service. For instance, the United States engineered a medical stabilising operation to eliminate support for the insurgency in Vietnam by inhibiting guerrilla recruitment efforts and undercutting their popular support²² (pp. 187–208).

Neutrality is itself a political stance and adopting it often exposes medical personnel to violence. By maintaining impartiality during war, the healthcare worker's ‘claim to an international norm...may be understood as a direct challenge to the state's claim to sovereignty’²⁶ (p. 156), particularly in the case of humanitarian intervention where treating the wounded underlines the state's failures. Recent conflicts have eroded the immunity of medical personnel and demonstrated how readily healthcare providers become military targets, justly or unjustly.

Medical personnel enjoy greater immunity than other non-combatants for two reasons: because they shoulder the absolute humanitarian obligation to care for the wounded and because each side of a conflict benefits from strict adherence to medical neutrality²² (pp. 176). The development of weapons technologies and military strategy drove the international community to enshrine international laws of armed conflict. We must not forget that these laws were drafted in response to particular kinds of armed conflict, namely, symmetrical conflicts between two sovereign states. Modern asymmetrical conflicts with non-state actors have given way to rampant violations of medical immunity by both parties. As these foundations of medical immunity are increasingly undermined, it is worth considering whether the harms resulting from the failure of the international legal system should be explained by the inability to enforce the norms, or by norms' content.

3. MEDICAL IMMUNITY IN PRACTICE

To properly function as a norm, medical immunity must assign duties to medical personnel and combatants without overburdening either party. In determining whether the current norms ought to be revised, we recognise that asking those engaged in humanitarian relief during armed conflicts to remain impartial imposes a substantial burden. Additionally, asking soldiers to incur greater risk of harm to themselves—or others they have a duty to protect—as they determine whether a medical unit is being used for hostile purposes requires substantial justification.^{lxiii} ³² The bombing of an Afghan hospital by the United States and the Taliban's use of an ambulance car bomb to terrorise the people of Kabul raise the question of whether these norms serve their proper function, both as guides for how combatants should act and as metrics for determining whether actions were permissible.

On 3 October 2015, an AC-130 manned by US airmen circled above Kunduz, Afghanistan struggling to find their target after missile fire forced them off course. They were searching for a cluster of buildings comprising the Taliban compound they had been sent to destroy.³³ After spotting people walking between buildings that matched the description of the compound, the plane's navigator radioed for confirmation and was given the green light to fire on the position. Tragically, the Taliban command centre was 1450 feet to the northeast. The crew had just bombed a hospital operated by Médecins Sans Frontières (MSF),^{lxiv} killing 42 people and destroying the facility.

Yugoslavia (§ 105); see also the draft legislation of Argentina (§ 79), El Salvador (§ 86), Nicaragua (§ 94) and the statements of China (§ 109), Iraq (§ 116), Kuwait (§§ 118–119), the UK (§ 126), the United States (§ 131) and Bolivarian Republic of Venezuela (§ 135). Cited in ICRC.²⁴

^{lx} Benton and Atshan²⁶ demonstrate the importance of making sure the norms are sensitive to the burdens they impose on those whom they govern. See also Adams.²⁸ See also List.²⁹

^{lxii} See also Allhoff²⁷ for representative papers.

^{lxiii} See ICRC.¹ Furthermore, Rule 111 imposes a positive obligation on medical personnel to protect the sick and wounded. Because of this obligation, and because of the need to effectively defend themselves, medical personnel are allowed to carry small weapons without forfeiting immunity.

^{lxiii} See, for example, Lazar.¹³ See also Allhoff.³²

^{lxiv} Headquartered in Geneva, Switzerland, the French represents this historical origins; Doctors without Borders is the more

The international response was swift and unforgiving. MSF General Director Christopher Stokes accused the USA of defaulting on its obligation to respect and protect medical personnel and facilities: '[w]ith one hand States sign a resolution to protect health facilities, while with the other they continue to be directly involved or complicit in the ongoing onslaught against health workers and patients in conflict zones'.³⁴ The USA launched an internal military investigation revealed that the soldiers had deemed the whole city of Kunduz hostile, assuming that all those who had not fled were active Taliban.³⁵ The gravity of this failure is compounded by the extent of the negligence of the United States: the MSF had diligently reminded American forces of the exact location of the hospital, the most recent reminder taking place less than a week before the attack.

The USA leaned heavily on the doctrine of double effect in their report explaining the errors that led up to this tragedy.^{lxv} The language explaining why none of the soldiers was prosecuted for war crimes makes this evident: 'war criminal' is 'a label typically reserved for intentional acts—*intentionally* targeting civilians or *intentionally* targeting protected objects'.³⁶ The US officials attributed the mistake to the 'fog of war' characterised by 'fatigue and high operational tempo', which was further exacerbated by 'process and equipment errors'.³⁶ So, although the 16 service members accountable for these mistakes were disciplined, none was found guilty of war crimes.^{36 lxxvi}

MSF officials expected no less from an internal investigation, which is why they had called for the assembly of an international humanitarian fact-finding commission to review the attack.³⁷ The Additional Protocols and the Geneva Conventions provide a mechanism for forming such a commission that was used for the first time at the end of 2016.^{37 lxxvii} This case gives rise to the question of whether the service members of the United States fulfilled their obligation to respect and protect medical personnel operating in the theatre of armed conflict. A warning issued by General Director Stokes makes it painfully clear why it is imperative to prosecute those responsible for such war crimes: '[a] war without limits leads to a battlefield without doctors'.³⁵

Despite disagreement on the proper punishment for these American soldiers, all parties agree that they defaulted on their obligation to honour medical immunity. However, soldiers' obligation to respect medical personnel is often more complicated than this agreement leads us to believe. Recent asymmetrical wars have displayed the horrendous effectiveness insurgents achieve by manipulating medical immunity. The emergence of new military tactics and technology may reveal the limits of the international law's conception of medical immunity. Earlier this year,

familiar English translation.

^{lxv} The US Department of Defense posted a transcript of the 25 November 2015 hearing. Available at <https://www.defense.gov/News/Transcripts/Transcript-View/Article/631359/department-of-defense-press-briefing-by-general-campbell-via-teleconference-fro>.

^{lxvi} Punishments for these soldiers ranged from suspensions, to removal from command, to counselling, to extensive training. Only 5 of the 16 were removed from the theatre entirely.

^{lxvii} See also Article 52 of the First Geneva Convention, Article 53 of the Second Geneva Convention and Article 90 of Additional Protocol I. Whereas the Geneva Conventions specifically mention agreement by the parties concerned, Article 90 of Additional Protocol I envisions an commission 'consisting of 15 members of high moral standing and acknowledged impartiality'.

the Taliban used an ambulance as a car bomb to target one of the safest places in Kabul. The driver successfully passed through the first check point by claiming he was transporting a patient before he detonated the bomb at the second check point, killing over 100 people.³⁶ In light of the frequent abuse of the Red Cross and Red Crescent emblems to facilitate acts of terror, does affording them protected status still minimise harm in warfare?

Notably, the Taliban denounced ISIS's attack on a military hospital in 2017, leading some to suggest that their abuse of medical immunity marks a troubling change in tactics: '[i]t's possibly a sign the Taliban does not want to lose out to its younger, nastier competitor insurgency in the extremism stakes. A year ago, medical facilities were off-limits; now, an ambulance can be used as a bomb'.³⁶ The Taliban meant for the attack to send a message to President Trump in response to his decision to increase support to Afghan forces and send more troops to the country.

Again, the international community condemned the bombing as a crime against humanity. Both the USA and Afghanistan have accused Pakistan of either directly aiding the terrorists or defaulting on its obligation to stamp out terrorist groups within its borders.^{lxviii 37} The international community's denouncement of the bombing in Kunduz by the United States and the Taliban's ambulance bomb in Kabul indicates strong consensus regarding the importance of immunity for medical personnel. Rule 25 and Article 24 of the First Geneva Convention outline the protections afforded to medical personnel in armed conflict.

Our evaluation of the legal norms is motivated by the fact that their consistent violation may call for at least two distinct but non-exclusive remedies: first, the international community might accept existing norms, while lamenting failures of enforcement; or, second, we might read this track record of violation as an indication that the norms themselves should be circumscribed or revisited. In general, scholars have opted for the first path, pointing to the failures of the international court system.^{lxix 38–40} In the rest of this paper, we explore the second option, specifically as pertains to forfeiture or infringement.

4. FORFEITURE AND SUPREME EMERGENCY

The discussion so far has sketched the *positive* case for medical immunity, both under international law and just war theory. In this last section, we want to consider the limits of that argument. Specifically, we can postulate two. The first is well-grounded in international law and amounts to forfeiture of medical immunity when personnel or facilities are used for military purposes. In these instances, medical immunity is not outweighed by other considerations—the medical immunity quite literally ceases to exist. In this discussion, there will be broad agreement across commentators. The second will be far more controversial: the question there is whether, *despite* medical immunity, an

^{lxviii} The United States responded by cutting security aid to Pakistan, while Afghanistan's envoy to the UN, Mahmoud Saikal went so far as to accuse Pakistan of direct involvement: '[g]iven the degree of sophistication...can you expect an illiterate Taliban to come up with this kind of genius plot, using ambulances?'

^{lxix} For example, Carter³⁸ focuses on revising our understanding of complementarity to improve the International Criminal Court. By contrast, Luban³⁹ suggests that the solution is to create a statute for state criminality. Finally, Weiner⁴⁰ argues that the International Criminal Court should be politically prudent in deciding whether to intervene, even if this means disproportionately high involvement in smaller, less politically powerful countries than in the affairs of global superpowers.

aggressive force can nevertheless intentionally target personnel or facilities. International law will clearly take a dim view on this, but we want to at least sketch what the most promising philosophical reasons could be, while being clear that we do not see this as having broad—or necessarily any—application, for reasons we will discuss.

Regarding forfeiture, consider the sorts of cases in which enemy forces conduct hostilities from within a hospital, or any other facility that would otherwise be protected.^{lxx} The First Geneva Convention indicates that those facilities lose their protected status:

The protection to which fixed establishments and mobile medical units of the medical service are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy. Protection may, however, cease only after a due warning has been given, naming, in all appropriate cases, a reasonable time limit and after such warning has remained unheeded.^{lxxi}

Here, the medical immunity that would otherwise be enjoyed by that facility is lost. Parallel reasoning shows up in customary international law as well. Rule 28, for example, confers protection on medical units, saying that they must 'be respected and protected in all circumstances'.⁴¹ However, it continues that such units 'lose their protection if they are being used, outside their humanitarian function, to commit acts harmful to the enemy'.⁴¹

Various domestic military documents also codify this principle, including Australia's *Commander's Guide*, Australia's *Defense Force Manual*, Australia's *Law of Armed Conflict Manual*, Bosnia and Herzegovina's *Military Instructions*, Germany's *Military Manual*, Sierra Leone's *Instructor Manual* and the *US Air Force Commander's Handbook*. The principle has also been upheld in the International Criminal Tribunal for the former Yugoslavia in *Galic* (2006).⁴¹

Interestingly, though, some of these documents or decisions, while allowing for forfeiture, nevertheless circumscribe application. The most common is that warning must be provided before engagement.^{lxxii} As we saw above, the First Geneva Convention

makes this explicit: '[p]rotection may, however, cease only after a due warning has been given, naming, in all appropriate cases, a reasonable time limit and after such warning has remained unheeded'.^{lxxii} Rule 20 speaks to warning more generally (ie, not specifically with regard to medical immunity) and provides that: '[e]ach party to the conflict must give effective advance warning of attacks which may affect the civilian population, unless circumstances do not permit'.^{1 lxxiii} And so many domestic military manuals have directly synthesised that principle with their directives on loss of immunity.

All three of the aforementioned Australian documents, for example, identically say that '[b]efore the protection of medical personnel and facilities is lost, a warning will normally be provided and reasonable time allowed to permit cessation of improper activities. In extreme cases, overriding military necessity may preclude such a warning'.⁴¹ Bosnia and Herzegovina allows medical facilities and units to defend themselves against deliberate or direct attack.⁴¹ Germany's *Military Manual* also carves out self-defence and defence of wounded or sentries as not comprising hostile attacks and, therefore, not forfeiting immunity.⁴¹ Sierra Leone makes an exception for 'light individual weapons' possessed by medical personnel.⁴¹ The United States also makes explicit reference to warning:

For example, using a hospital as an observation post, or to store non-medical military supplies, or firing at the enemy from an ambulance, would deprive the hospital and the ambulance of protected status... Both the Geneva Conventions and the rules of engagement may impose additional restrictions on actually attacking medical activities that are improperly used. Thus, hospitals and mobile medical units may not be attacked *until after a warning has been given* setting, in proper cases, a reasonable time limit to correct past abuses.^{41 lxxiv}

But what constitutes appropriate warning? How must it be announced? And far in advance of engagement? This is left fairly open:

The period of respite is not specified. All that is said is that it must be reasonable. How is it to be determined? It will obviously vary according to the particular case. One thing is certain, however. It must be long enough either to allow the unlawful acts to be stopped or for the wounded and sick who are present with the unit to be removed to a place of safety. The respite will also give the unit an opportunity of replying to an unfounded accusation and clearing itself.^{lxxv}

Certainly, we can suppose that opposing parties would disagree with what counts as 'reasonable' warning, but we can just as easily suppose warnings that were patently unreasonable or ones that were patently reasonable. It would be implausible to ask the law to adjudicate every possible case in advance, and so a context-dependent reasonableness consideration is likely the best that it can do.

And so the upshot is that medical immunity is not absolute, but can be forfeited once hostile forces use medical units to commit hostile acts. But even that forfeiture is contingent on appropriate notice, and 'hostile acts' is not a trivial bar: should medical personnel use light arms in personal self-defence, that

^{lxx} See also Commentary of 1952 on Article 21: '[s]uch 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'. Available at <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=859FF3DB19BCAC7BC-12563CD00420FE1>. See also Commentary of 2016 on Article 21: "[a]ny use by a Party to the conflict of military medical establishments or units for military purposes may be considered an 'act harmful to the enemy.' Examples of such use 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" (internal citations omitted). Available at <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=A3FED10C8AF9145DC1257F7A0054BEA2>.

^{lxxi} First Geneva Convention, Article 21.

^{lxxii} See First Geneva Convention, Article 21. See also Commentary of 1952 ('Discontinuance of Protection of Medical Establishment and Units'). Available at <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=859FF3DB19BCAC7BC12563CD00420FE1>.

^{lxxiii} See ICRC,¹ Rule 20.

^{lxxiv} See ICRC,⁴¹ (emphasis ours).

^{lxxv} Commentary of 1952 on Article 21 ('Discontinuance of Protection of Medical Establishment and Units'). Available at <https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=859FF3DB19BCAC7BC-12563CD00420FE1>.

hardly gives their adversaries license to destroy the entire facility. Or to put it in the language of just war theory as opposed to international law, medical immunity is only forfeited when the *in bello* requirements of military necessity and proportionality are established. Warning goes to necessity: it is generally not necessary to engage a medical unit *before* giving advance notice. If it were, in rare cases, then the ‘reasonableness’ prong of Article 21 might be satisfied regardless (ie, because it would not be reasonable to wait at all). But, generally, there will be the possibility of warning, which could go to any number of outcomes other than direct engagement, including surrender or evacuation. Second, proportionality still matters. Targeting a medical unit with hundreds of injured in order to secure a comparatively minor military advantage is ruled out by *in bello* considerations. And so, while the prospect of forfeiture undermines the absoluteness of medical immunity, it does not do so brazenly or uncritically.

Before concluding, though, let us at least gesture toward a more controversial issue, namely directly targeting a medical unit that has *not* forfeited immunity. As to what this could even possibly have going for it, suppose, for the sake of argument, that targeting a protected medical unit might break the aggressor’s will, say by crushing the morale of the civilian population.^{lxxvi} Michael Walzer, for example, thinks that some of the Allied bombings of German cities—which killed thousands of civilians—were justified given the ‘enormity of the Nazi threat and the reasonable fear of its imminent triumph’.⁴² John Rawls expressed a similar view while, at the same time, condemning the bombings of Hiroshima and Nagasaki, which killed over a 100,000 Japanese.⁴³ ^{lxxvii} World War II invites us to consider a terrible evil against which victory is absolutely necessary. By bombing German cities—so-called ‘terror bombing’—we had the opportunity to affect the morale of the population, perhaps undermining support for Hitler, making it harder for the German government to stay in the war as its own civilians were killed, and so on. There is no doubt that the killing of these civilians was a tragedy, but let us suppose that the tragedy is less than the one we would have otherwise been forced to face, whether through more war or a stronger and more dominant Nazi Germany.

Such scenarios give rise to what Walzer¹⁰ calls ‘supreme emergencies’, which he characterises in terms of their seriousness and imminence⁴⁴ (p. 252).^{lxxviii} If the threat is not sufficiently serious, then there is no point in countenancing the violation of non-combatant immunity; the moral harm of violating this principle could not be sufficiently countervailed by any other moral good. And if the threat is not imminent, then there is similarly no reason to jeopardise non-combatant immunity since some other solution might present itself before the threat is actualised.^{lxxix}

The first thing to note is that the details of the cases are, of course, going to make all the difference. For example, some have been sceptical about whether the imminence condition was actually satisfied in terror bombings of German cities undertaken from February of 1942, presumably including

the cases that Walzer wants to defend.^{lxxx} And whether it was necessary to bomb Nagasaki *after* bombing Hiroshima is also historically dubious. So the first line of defence against this potential relegation of medical immunity is just to seriously doubt whether the moral calculus would ever *actually* make sure a dire recommendation. People disagree, of course, about whether the *mere possibility* of such an outcome is enough to ridicule the framework on which that outcome would be suggested. Throughout the literature on torture, for example, even the spectre of ticking time-bomb cases causes opponents to level charges of ‘intellectual fraud’⁴⁵ (p. 1427).

Our point is not to rehash that debate here, particularly insofar as the coauthors would likely disagree.^{lxxxii} Rather, they would both emphasise that, *at most*, this is an empirical inquiry, and neither has found any historical precedent that would redeem it. Furthermore, they would both emphasise that there would be serious risks in attacking *protected* medical units, on any range of axes: policy, precedent, moral capital and so on. Finally, there is no necessity defence in international law in the same way there is, let us say, in various domestic laws. Article 25 of the Responsibility of States for Intentionally Wrongful Acts (2001) ostensibly provides for one, but three quick comments. First, necessity is always a high bar, sometimes nearly hopelessly so.⁴⁶ Second, it is far from obvious that this statement on necessity would apply to blatant violations of international humanitarian law.⁴⁷ Third, the commentary on Article 25 makes this scepticism quite explicit.⁴⁸ And so, while nominally on the table as a philosophical thought experiment, we can likely quarantine it.

5. CONCLUSION

In this paper, we surveyed the international legal framework grounding medical immunity. In this undertaking, customary international law figured prominently, particularly Rule 25. But we also considered ways in which the customary law intersected with treaty law, specifically the First Geneva Convention and Additional Protocol I. We then went on to explore the historical and philosophical foundations of these legal norms, making connections between just war theory and international law. We explored the 2015 bombing of an MSF hospital as a way to connect theory and practice; specifically, how the doctrine of double effect figured into the United States’ response to this tragedy. Finally, we considered limits on medical immunity. The first limit is through forfeiture, such as when hostile acts originate from a medical facility. But even forfeiture must be carefully circumscribed, particularly through the attackers’ duty to warn. Second, we considered whether, in the absence of forfeiture, protected status could nevertheless be justifiably infringed. We were sceptical here, particularly as would reasonably apply to any actual conflicts—the doctrines of proportionality and military necessity are likely substantial obstacles.

Acknowledgements The authors thank Michael Gross, Sarah Heathcote and Stephen Ratner for helpful discussions.

Funding Parts of this paper were written while Dr. Allhoff was a Fellow in the Center for Law and the Biosciences at Stanford University and as a Fulbright Specialist in the Faculty of Political Science at the University of Iceland; he thanks those institutions for their support. He also thanks the United States National Science Foundation, which has provided generous support under award #1317798.

Competing interests None declared.

^{lxxvi} See Allhoff.⁵ Parts of the ensuing discussion are adapted from § 2.2.

^{lxxvii} Referenced in Coady⁴² (p. 77).

^{lxxviii} See Statman, especially §1.⁴⁴

^{lxxix} In other words, military necessity and proportionality are still the operative principles, even if Walzer does not frame it in those exact words.

^{lxxx} See, for example, Coady.⁴²

^{lxxxii} For one’s view, see Allhoff.⁵

Patient consent Not required.

Provenance and peer review Commissioned; internally peer reviewed.

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