

# GENEVA CONVENTION I: WOUNDED AND SICK IN THE FIELD

## I. OBJECTIVES

- A. Understand the importance of GC I's protections for the wounded and sick in the field.
- B. Recognize the beneficiaries of GC I's protections.
- C. Understand the obligations GC I imposes on the belligerents.
- D. Recognize the different status given to medical personnel and chaplains, and the implications of such status, including the protections they are afforded, and the difference between being a retained person vice being a prisoner of war.
- E. Understand the protections afforded to medical facilities/units/transport/aircraft.
- F. Recognize the distinctive emblems which enjoy the Convention's protections, as well as the additional distinctive emblem introduced by AP III.
- G. Be aware of GC II, which protects the wounded, sick, and shipwrecked members of the armed forces at sea.
- H. Be aware of the legal developments that AP I and AP II introduced for the wounded, sick, and shipwrecked.

## II. INTRODUCTION

- A. Background.
  - 1. Henry Dunant's book "*A Memory of Solferino*," published in 1862, served as a catalyst in Europe to discuss the treatment of wounded and sick on the battlefield.
    - a. Led to 1863 Conference in Geneva.
    - b. The Conference resulted in the 1864 Geneva Convention, which the U.S. ratified in 1882. Key provisions include:
      - i. Military ambulances and hospitals are neutral.

- ii. Medical personnel and Chaplains are neutral. Repatriation is the rule.
  - iii. Must care for the wounded. Repatriation if incapable of further service and agree not to take up arms again.
- 2. Updated in 1906 (followed shortly by the Hague Convention (X) of October 18, 1907, for the adaption to Maritime Warfare of the principles of the Geneva Convention (of 1906)). Note that the 1907 Hague Convention contained fourteen parts, of which the Convention on Maritime Warfare was Part X. The Xth (Tenth) Hague convention was replaced in 1949 by a new Geneva Convention related to the shipwrecked (GC II). (*See* GC II, art. 58)
- 3. Updated again in 1929, adding a new Geneva Convention related to POWs.
- 4. Updated again in 1949, adding yet another Convention related to civilians (GC IV).
- 5. Most recently updated in 1977 by AP I for *international* armed conflicts, and by AP II for *non-international* armed conflicts.
  - a. The U.S. signed both AP I and AP II, but there is no indication that the U.S. will ratify them any time soon, especially since the U.S. has expressed its opposition to certain provisions.
  - b. Despite the fact that the U.S. has not ratified these treaties, understanding AP I and AP II is important for at least two reasons: (1) Certain provisions of AP I and AP II are considered customary international law, and therefore binding on the U.S.; and (2) many U.S. coalition partners have ratified AP I and AP II and, therefore, may have different legal obligations than the U.S. during a combined operation.
  - c. AP I, Part II, concerns “Wounded, sick and shipwrecked” in *international* armed conflict. It further developed the protections and obligations contained within GC I and II in a number of ways, including:
    - i. Defined the terms, which was not done in GC I and GC II;
    - ii. Recognized that civilian medical personnel and units shall receive the same protection as that formerly reserved for military medical personnel and units;

- iii. Confirmed and extended the humanitarian role of the civilian population and of relief societies;
  - iv. Extended the scope of the protection for medical transportation by air by developing the procedures required to invoke this right;
  - v. Introduced the right of families to be informed of the fate of their relatives and developed the provisions concerning missing persons and the remains of the deceased.
- d. AP II, Part III, concerns “Wounded, sick and shipwrecked” in *non-international* armed conflict and supplements AP I, Part II (Humane Treatment). This Part reiterates the essential substance of AP I, Part II, but taking into account the particular context of *non-international* armed conflict. It develops the protections and obligations contained within Common Article 3, attempting to make explicit what were implicit in that article’s very simple statements.

B. Geneva Conventions – Scope of Application. The purpose of this section is to provide a brief review of the applicability of the Geneva Conventions. Students should consult the chapter on the Framework of the Law of Armed Conflict in this deskbook for a more in-depth discussion. When conducting a legal analysis applying the Geneva Conventions, a recommended starting point is to answer the following two questions: (1) In what type of conflict are the parties engaged?; and (2) What type of person is the subject of the analysis?

1. Geneva Trigger: What Type of Conflict? All four Geneva Conventions of 1949 have “common articles,” which are verbatim in each. Common Article 2 sets up all four Conventions with an “either/or” condition/trigger:
  - a. Either it is an *international* armed conflict (IAC), in which case Common Article 2 states that the Geneva Conventions apply in their entirety.
  - b. Or it is a *non-international* conflict (NIAC), in which case Common Article 3 states that, although the Geneva Conventions do not apply, there are still certain minimum protections (discussed *infra*) which do apply.
  - c. However, it is also possible to have a hybrid situation, with both an IAC and a NIAC occurring simultaneously. For example, during the most recent conflict in Libya, there was an IAC between NATO and Libya (Gaddafi), as well as a NIAC between Libya (Gaddafi) and armed Libyan insurgents/rebels.

- d. Note 1: Both IAC and NIAC—as suggested by their terms—depend upon a state of armed conflict being attained. If there is no armed conflict, then no part of the Geneva Conventions applies as a matter of law. However, the U.S. may still apply the Geneva Conventions by policy, as discussed below.
  - e. Note 2: For States party to AP I, article 1(4) expands the scope of IAC to “include armed conflicts which peoples are fighting against colonial domination and alien occupation and against racist regimes in the exercise of their right of self-determination.” This expansion is one of the reasons the U.S. has not ratified AP I.
  - f. Note 3: For States party to AP II, article 1 expands legal protections beyond Common Article 3 when a NIAC reaches a certain level, to include control of territory by a non-state group.<sup>1</sup> The U.S. opposed AP II on the grounds that its additional protections only applied to certain NIACs, and thus created a “bifurcated system” of legal protections in these conflicts.
2. Geneva Trigger: What Type of Person? A legal analysis involving the Geneva Conventions must not only inquire into the nature of the conflict (as discussed above), but must also ask what is the type of person that is the subject of the analysis? Since each Convention, and parts of those Conventions, protects different types of persons, one must understand the person’s identity and role in the armed conflict to determine that person’s associated legal protections.
- a. For instance, civilians are primarily protected by GC IV, while the protections governing a shipwrecked sailor would generally be found in GC II.
  - b. The types of persons protected by GC I is discussed below. However, the point made here is that persons who do **not** fit into a GC I category are not legally protected by that particular Convention, but might be protected by another. For example, a shipwrecked sailor, initially protected by GC II, who is sick or wounded, is protected by GC I once put ashore; if captured as he recovers, he is protected as a POW by GC III.
3. Even if a State is not legally required to apply the protections of the Geneva Conventions based on the “Type of Conflict/Type of Person” analysis, the State

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<sup>1</sup> See COMMENTARY ON THE ADDITIONAL PROTOCOLS OF JUNE 1977 TO THE GENEVA CONVENTIONS OF 12 AUGUST 1949 1348 (Yves Sandoz et al. eds., 1987). Also see MESSAGE FROM THE PRESIDENT OF THE UNITED STATES TRANSMITTING THE PROTOCOL II ADDITIONAL TO THE GENEVA CONVENTIONS OF AUGUST 12, 1949, AND RELATING TO THE PROTECTION OF VICTIMS OF NONINTERNATIONAL ARMED CONFLICTS, CONCLUDED AT GENEVA ON JUNE 10, 1977 (Jan. 29, 1987).

may choose by means of a policy decision to provide that protections/treatment anyway. For instance, DoD Directive 2311.01E, the DoD Law of War Program (change 1 of November 15, 2010), states that U.S. Forces will “comply with the law of war during all armed conflicts, however such conflicts are characterized, and in all other military operations.”

### C. Definitions.

1. The term “**wounded and sick**” is not defined in GC I or GC II. Concerned that any definition would be misinterpreted, the drafters decided that the meaning of the words was a matter of “common sense and good faith.”<sup>2</sup> However, AP I, art. 8(1), contains the following definition of “wounded” and “sick”: “Persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility.”
2. “**Shipwrecked**” is also not defined in GC II, though it includes shipwrecks “from any cause and includes forced landings at sea by or from aircraft.” (GC II, art. 12). AP I, art. 8(2) provides a more detailed definition of “shipwrecked” to mean “persons, whether military or civilian, who are in peril at sea or in other waters as a result of misfortune affecting them or the vessel or aircraft carrying them.”

### D. General Substantive Protections.

1. NIAC and Common Article 3 Protections for the Wounded and Sick. Common Article 3, also known as the “Mini-Convention” because it alone provided protections in NIAC, does include some protections for the wounded and sick.
  - a. “Persons . . . placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.” (Common Article 3, para. (1))
  - b. “The wounded and sick shall be collected and cared for.” (Common Article 3, para. (2))
  - c. Recall that AP II also applies to NIAC. For those nations which are parties to AP II (the United States is not a party), the Protocol expands slightly the protection for the wounded and sick and those who aid them beyond that provided for in Common Article 3.

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<sup>2</sup> COMMENTARY: I GENEVA CONVENTION FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK IN ARMED FORCES IN THE FIELD 136 (Jean S. Pictet ed. 1952).

2. **IAC and Protections for the Wounded and Sick.** In a Common Article 2 conflict, the full GC I (and GC II for those at sea) are applicable. These protections are the focus of the remainder of this chapter. The protections consist of three main pillars:
  - a. Treatment of the wounded and sick;
  - b. Protections for personnel aiding the wounded and sick; and
  - c. Distinctive emblems/symbols to identify protected personnel, units, and establishments.

### III. CATEGORIES OF WOUNDED AND SICK

- A. Protected Persons. Note that the title of GC I—Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field—implies that its application is limited to Armed Forces. This is largely, though not entirely, true. Article 13 sets forth those persons protected by GC I. This article **is the same** as GC III, art. 4; therefore, the analysis to determine whether the person is protected by GC I is identical to the analysis of whether the person is entitled to POW status under GC III, art. 4. Students should refer to the deskbook chapter on Geneva Convention III – Prisoners of War, for a more detailed discussion of these categories.
- B. Other Persons. Wounded and sick persons who do not qualify under any of the categories in GC I, art. 13, will be covered as civilians by GC IV.
  1. GC IV, art. 16, provides: “The wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect.”
    - a. This coverage of civilians is qualified by the following language in GC IV, art. 16: “*As far as military considerations allow, each Party to the conflict shall facilitate the steps taken to search for the killed and wounded, to assist the shipwrecked and other persons exposed to grave danger, and to protect them against pillage and ill-treatment*” (emphasis added). This recognizes the fact that saving civilians is the responsibility of the civilian authorities rather than of the military. The military is not required to provide injured civilians with medical care in a combat zone. However, once the military starts to provide treatment, the provisions of GC I apply.<sup>3</sup>

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<sup>3</sup> Department of the Army, Tactics, Techniques, and Procedures 4-02, Army Health System, para. 4-12 (7 October 2011) (hereinafter ATTP 4-02).

- b. It is U.S. policy that “[c]ivilians who are injured, wounded, or become sick as a result of military operations *may* be collected and provided *initial* medical treatment in accordance with theater policies.”<sup>4</sup>
3. AP I, art. 8(a), however, expressly includes civilians within its definition of “wounded and sick.” Though the U.S. is not bound by AP I, practitioners should be wary of treating wounded and sick civilians in a manner different from wounded and sick combatants. Given the GC IV protections and the development of the law by AP I, as a practical matter, all wounded and sick, military and civilian, in the hands of the enemy must be respected and protected. (*See also* FM 27-10, para. 208)
4. The rules applicable to civilians connected with medical transports may vary depending on whether such persons accompany the armed forces (GC III, art. 4.A.(4)), are members of the staff of voluntary aid societies either of a belligerent State (GC I, art. 26) or of a neutral State (GC I, art. 27), or are civilians not otherwise protected by GC I or GC III (GC IV, art. 4).

#### IV. THE HANDLING OF THE WOUNDED AND SICK

##### A. Respect and Protect. (GC I, art. 12)

1. General: “Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be *respected* and *protected* in all circumstances.” (GC I, art. 12, para. 1 (emphasis added))
2. *Respect*: to spare, not to attack. It is “unlawful for an enemy to attack, kill, ill treat or in any way harm a fallen and unarmed soldier.” (GC I Commentary at 135). The shooting of wounded soldiers who are out of the fight is illegal. Similarly, there is no lawful justification for “mercy killings.”
3. *Protect*: to come to someone’s defense; to lend help and support. The enemy has an obligation to come to the aid of a fallen and unarmed soldier and give him such care as his condition requires. (*See* GC I Commentary at 135)
4. These duties apply “in all circumstances.” Military considerations do not permit any lesser degree of treatment.

##### B. Standard of Care. (GC I, art. 12) Protected persons “shall be treated **humanely** and cared for by the Party to the conflict in whose power they may be, without any

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<sup>4</sup> U.S. DEPT. OF ARMY, FIELD MANUAL 4-02.6, *The Medical Company Tactics, Techniques, and Procedures*, para. A-4 (August 2002) (hereinafter FM 4-02.6) (emphasis added).

adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria.” (GC I, art. 12) Thus the standard is one of humane treatment: “[E]ach belligerent must treat his fallen adversaries as he would the wounded of his own army.” (GC I Commentary at 137)

C. Order of Treatment. (GC I, art. 12)

1. **No adverse distinction** may be made in providing care, other than for medical reasons. (GC I, art. 12) Medical personnel must make the decisions regarding medical priority on the basis of their medical ethics. (*See also* AP I, art. 10)
  - a. May not discriminate against wounded or sick because of “sex, race, nationality, religion, political opinions, or any other similar criteria.” (GC I, art. 12)
  - b. Note the use of the term “adverse” permits favorable distinctions, e.g., taking physical attributes into account, such as children, pregnant women, the aged, etc.
2. “**Only urgent medical reasons** will authorize priority in the order of treatment to be administered.” (GC I, art. 12) This provision is designed to strengthen the principle of equal treatment articulated above.
  - a. Treatment is accorded using triage principles which provide the greatest medical assets to those with significant injuries who may benefit from treatment, while those wounded who will die no matter what, and those whose injuries are not life-threatening, are given lesser priority.
  - b. The U.S. applies this policy at the evacuation stage, as well as at the treatment stage. Sick, injured, or wounded enemy are treated and evacuated through normal medical channels, but can be physically segregated from U.S. or coalition patients. Subject to the tactical situation and available resources, enemy personnel will be evacuated from the combat zone as soon as possible. Only those injured, sick, or wounded enemy who would run a greater health risk by being immediately evacuated may be temporarily kept in the combat zone.
3. Triage Categories:<sup>5</sup>

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<sup>5</sup> See FM 4-02.6, para. C-3 (1 August 2002); *see also* U.S. DEPT. OF ARMY, FIELD MANUAL 8-42, *Combat Health Support in Stability Operations and Support Operations*, para. J-3 (27 October 1997).

- a. Immediate. Condition demands immediate resuscitative treatment. Generally the procedures are short in duration and economical in terms of medical resources. Example: control of a hemorrhage from an extremity. [Note: NATO divides this category into two groups: Urgent: quick short duration life saving care, which is first priority; and Immediate: which require longer duration care to save a life.]
  - b. Delayed. Treatment can be delayed for 8-10 hours without undue harm. Examples: Soft tissue injuries requiring debridement; maxillofacial injuries without airway compromise; eye and central nervous system injuries.
  - c. Minimal (or Ambulatory). Next to last priority for medical officer care; but head of the line at the battle dressing station. (Can be patched up and returned to the lines in minutes.) (Major difference with civilian triage.)
  - d. Expectant. Injuries are so extensive that even if they were the sole casualty, survival would be unlikely. Treatment will address pain and discomfort.
4. The wounded and sick “shall not willfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.” (GC I, art. 12)
- a. The first prohibition stems from a recognition that wounded personnel, who had not yet received medical treatment, were profitable subjects for interrogation. During World War II, the Germans frequently delayed medical treatment until after interrogation at their main aircrew interrogation center. Such conduct is now expressly forbidden.
  - b. The second prohibition was designed to counter the German practice of sealing off Russian POW camps once typhus or tuberculosis was discovered.
- D. Abandoning Wounded and Sick to the Enemy. (GC I, art. 12)
1. If, during a retreat, a commander is forced to leave behind wounded and sick, the commander is required to leave behind medical personnel and material to assist in their care.
  2. “[A]s far as military considerations permit” – provides a limited military necessity exception to this requirement. Thus a commander need not leave behind medical personnel if such action will leave his unit without adequate medical staff. Nor can the enemy refuse to provide medical care to abandoned

enemy wounded on the grounds that the enemy failed to leave behind medical personnel. The detaining power ultimately has the absolute respect and protect obligation. (*See GC I Commentary at 142*)

E. Search for Casualties.

1. Search, Protection, and Care. (GC I, art. 15)

- a. “At all times, and particularly after an engagement,” Parties have an ongoing obligation to search for the wounded and sick as conditions permit. The commander determines when it is possible to do so. This mandate applies to all casualties, not just friendly casualties.
  - i. The drafters recognized that there were times when military operations would make the obligation to search for the fallen impracticable. (*See GC I Commentary at 151*)
  - ii. By way of example, U.S. policy during Operation Desert Storm was not to search for casualties in Iraqi tanks or armored personnel carriers because of concern about unexploded ordnance.
  - iii. Similar obligations apply to maritime operations. (GC II, art. 18) “Following each naval engagement at sea, the belligerents are obligated to take all possible measures, consistent with the security of their forces, to search for and rescue the shipwrecked.”<sup>6</sup>
- b. The protection requirement refers to preventing pillage of the wounded by the “hyenas of the battlefield.”
- c. Care refers to the requirement to render first aid.
- d. Note that the search obligation also extends to searching for the dead, again *as military conditions permit*.

2. Suspensions of Fire and Local Agreements. (GC I, art. 15)

- a. Suspensions of fire are agreements calling for ceasefires that are sanctioned by the Convention to permit the combatants to remove, transport, or exchange the wounded, sick and the dead. Such exchanges of wounded and sick between parties did occur to a limited extent during World War II. (*See GC I Commentary at 155*)

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<sup>6</sup> THE COMMANDER’S HANDBOOK ON THE LAW OF NAVAL OPERATIONS, NWP 1-14M, para. 11.4 (2007).

- b. Suspensions of fire were not always possible without negotiation and, sometimes, the involvement of staffs up the chain of command. Consequently, local agreements, an innovation in the 1949 Convention to broaden the practice of suspensions of fire by authorizing similar agreements at lower command levels, are sanctioned for use by local on-scene commanders to remove or exchange wounded and sick from a besieged or encircled area, as well as the passage of medical and religious personnel and equipment into such areas. GC IV, art. 17, contains similar provisions for civilian wounded and sick in such areas. It is this type of agreement that was used to permit the passage of medical supplies to the city of Sarajevo during the siege of 1992.

F. Identification of Casualties. (GC I, arts. 16-17)

1. Parties are required, as soon as possible, to record the following information regarding the wounded, sick, and the dead: name, identification number, date of birth, date and place of capture or death, and particulars concerning wounds, illness, or cause of death.
2. Forward the information to the Information Bureau required by GC III, art. 122. Information Bureaus are established by Parties to the conflict to transmit and to receive information/personal articles regarding Prisoners Of War to/from the International Committee of the Red Cross' (ICRC's) Central Tracing Agency. The U.S. employs the National Prisoner of War Information Center (NPWIC) in this role.
3. In addition, Parties are required to forward the following information and materials regarding the dead:
  - a. Death certificates.
  - b. Identification disc.
  - c. Important documents, e.g., wills, money, etc., found on the body.
  - d. Personal property found on the body.
4. Handling of the Dead.
  - a. Examination of bodies (a medical examination, if possible) is required to confirm death and to identify the body. Such examinations can play a dispositive role in refuting allegations of war crimes committed against

individuals. Thus, they should be conducted with as much care as possible.

- b. No cremation (except for religious or hygienic reasons).
- c. Honorable burial. Individual burial is strongly preferred; however, there is a military necessity exception which permits burial in common graves, e.g., if circumstances, such as climate or military concerns, necessitate it. (See GC I Commentary at 177)
- d. Mark and record grave locations.

G. Voluntary Participation of Local Population in Relief Efforts. (GC I, art. 18)

- 1. Commanders may appeal to the charity of local inhabitants to collect and care for the wounded and sick. Such actions by the civilians must be voluntary. Similarly, commanders are not obliged to appeal to the civilians.
- 2. Spontaneous efforts on the part of civilians to collect and care for the wounded and sick are also permitted.
- 3. Ban on the punishment of civilians for participation in relief efforts. This provision arose from the fact that the Germans prohibited German civilians from aiding wounded airmen.
- 4. Continuing obligations of occupying power. Thus, the occupant cannot use the employment of civilians as a pretext for avoiding their own responsibilities for the wounded and sick. The contribution of civilians is only incidental. (See GC I Commentary at 193)
- 5. Civilians must also respect the wounded and sick. This is the same principle discussed above (GC I, art. 12) vis-à-vis armed forces. This is the only article of the Convention that imposes a duty directly on civilians. (See GC I Commentary at 191)

## V. STATUS AND PROTECTION OF PERSONNEL AIDING THE WOUNDED AND SICK

- A. There are **three categories** of persons who are protected for their work in aiding the wounded and sick.
  - 1. First category: Medical 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; chaplains attached to the armed forces (GC I, art. 24); and personnel of national Red Cross/Red Crescent Societies and other recognized relief organizations. (GC I, art. 26)

- a. Respect and protect “in all circumstances.” (GC I, art. 24) This means that they must not knowingly be attacked, fired upon, or unnecessarily prevented from discharging their proper functions. The accidental killing or wounding of such personnel, due to their presence among or in proximity to combatant elements actually engaged, by fire directed at the latter, gives no just cause for complaint. (FM 27-10, para. 225)
- b. Status upon capture: **Retained Personnel**, not POWs. (GC I, art. 28)
  - i. This was a new provision in the 1949 convention. The 1864 and 1906 conventions required immediate repatriation. The 1929 convention also required repatriation, absent an agreement to retain medical personnel. During World War II, the use of these agreements became extensive, and very few medical personnel were repatriated. Great Britain and Italy, for example, retained 2 doctors, 2 dentists, 2 chaplains, and 12 medical orderlies for every 1,000 POWs.
  - ii. The 1949 convention institutionalized this process. Some government experts proposed making medical personnel regular POWs, the idea being that wounded POWs prefer to be cared for by their countrymen who speak the same language. The other camp, favoring repatriation, cited the traditional principle of inviolability—that medical personnel were non-combatants. What resulted was a compromise: medical personnel were to be repatriated, but if needed to treat POWs, they were to be retained and treated at least as well as POWs. (See GC I Commentary at 238–40)
  - iii. Note that medical personnel may only be retained to treat POWs. Under no circumstances may they be retained to treat *enemy* personnel. While the preference is for the retained persons to treat POWs of their own nationality, the language is sufficiently broad to permit retention to treat **any** POW. (See GC I Commentary at 241)
- c. Repatriation of Medical Personnel. (GC I, arts. 30–31)
  - i. Repatriation is the rule; retention the exception. Medical personnel are to be retained only so long as required by the health and spiritual

needs of POWs and then are to be returned when retention is not indispensable.<sup>7</sup>

- ii. GC I, art. 31, states that selection of personnel for return should be irrespective of race, religion or political opinion, preferably according to chronological order of capture—first-in/first-out approach.
  - iii. Parties may enter special agreements regarding the percentage of personnel to be retained in proportion to the number of prisoners and the distribution of the said personnel in the camps. The U.S. practice is that retained persons will be assigned to POW camps in the ratio of 2 doctors, 2 nurses, 1 chaplain, and 7 enlisted medical personnel per 1,000 POWs. Those not required will be repatriated.<sup>8</sup>
- d. Treatment of Medical Personnel. (GC I, art. 28)
- i. Medical personnel and chaplains may only be required to perform medical and religious duties.
  - ii. They will receive at least all benefits conferred on POWs, e.g., pay, monthly allowances, correspondence privileges.
  - iii. They are subject to camp discipline.
- e. Relief. Belligerents may relieve doctors retained in enemy camps with personnel from the home country. (GC I, art. 28) During World War II some Yugoslavian and French doctors in German camps were relieved. (See GC I Commentary at 257)
- f. Continuing obligation of detaining power. (GC I, art. 28) The detaining power is bound to provide, free of charge, whatever medical attention the POWs require.
2. Second category: *Auxiliary* medical support personnel of the Armed Forces. (GC I, arts. 25 and 29)

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<sup>7</sup> See GC I Commentary, supra note 2, at 260–262. Since World War II, this is one of the least honored provisions of the convention. U.S. medical personnel in Korea and Vietnam were neither repatriated nor given retained person status. See Memorandum of W. Hays Parks to Director, Health Care Operations *reprinted in* THE ARMY LAWYER, April 1989, at 5.

<sup>8</sup> See Army Regulation 190-8/OPNAVINST 3461.6/AFJI 31-304/MCO 3461.1, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees (1 October 1997).

- a. These are personnel who have received special training in other medical specialties (e.g., orderlies, stretcher bearers) in addition to performing other military duties. (While Article 25 specifically refers to nurses, nurses are Article 24 personnel if they meet the “exclusively engaged” criteria of that article.)
  - b. Respect and protect: when acting in their medical capacity. (GC I, art. 25)
  - c. Status upon capture: POWs; however, must be employed in medical capacity insofar as a need for their special training arises. (GC I, art. 29)
  - d. Treatment. (GC I, art. 29)
    - i. When not performing medical duties, shall be treated as POWs.
    - ii. When performing medical duties, they remain POWs, but receive treatment under GC III, art. 32 as retained personnel; however, they are not entitled to repatriation.
    - iii. Auxiliaries are not widely used.<sup>9</sup>
    - iv. The U.S. Army does not have any personnel who *officially* fall into the category identified in Article 25.<sup>10</sup>
3. Third category: Personnel of aid societies of neutral countries. (GC I, art. 27 and 32)
- a. Nature of assistance: procedural requirements. (GC I, art. 27)
    - i. Consent of neutral government.
    - ii. Consent of party being aided.
    - iii. Notification to adverse party.

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<sup>9</sup> *But see* W. Hays Parks memorandum, *supra* note 7, for discussion of certain U.S. personnel, who *de facto*, become auxiliary personnel. *See also* ATTP 4-02 at para. 4-21 (discusses this same issue and points out that Article 24 personnel switching between medical and non-medical duties **at best** places such individuals in the auxiliary category).

<sup>10</sup> *See* W. Hays Parks memorandum, *supra* note 7. Air Force regulations do provide for these personnel. *See* Bruce T. Smith, *Air Force Medical Personnel and the Law of Armed Conflict*, 37 A. F. L. REV. 242 (1994).

- b. Retention prohibited: must be returned “as soon as a route for their return is open and military considerations permit.” (GC I, art. 32)
- c. Treatment pending return: must be allowed to perform medical work. (GC I, art. 32)

## VI. MEDICAL UNITS AND ESTABLISHMENTS

### A. Protection.

1. Fixed Establishments and Mobile Medical Units. (GC I, art. 19)
  - a. May not be attacked, provided they do not abrogate their status.
  - b. Commanders are encouraged to situate medical units and establishments away from military objectives. *See also* AP I, art. 12, which states that medical units will, in no circumstances, be used to shield military objectives from attack.
  - c. If these units fall into the hands of an adverse party, medical personnel will be allowed to continue caring for wounded and sick, as long as the captor has not ensured the necessary care.
  - d. GC I does not confer immunity from search by the enemy on medical units, establishments, or transports. (FM 27-10, para. 221)
2. Discontinuance of Protection. (GC I, art. 21)
  - a. Medical units/establishments lose protection if committing “acts harmful to the enemy.” Acts harmful to the enemy are not only acts of warfare proper, but also any activity characterizing combatant action, such as setting up observation posts, or the use of the hospital as a liaison center for fighting troops. (*See* FM 27-10, para. 258) Other examples include using a hospital as a shelter for combatants, or as an ammunition dump. (*See* GC I Commentary at 200–201)
  - b. Protection ceases only after a warning has been given, and it remains unheeded after a reasonable time to comply. A reasonable time varies depending on the circumstances, e.g., no time limit would be required if fire is being taken from the hospital. (*See* GC I Commentary at 201)
  - c. AP I, art. 13, extends this same standard to civilian hospitals.

3. Conditions **not** depriving medical units and establishments of protection: (GC I, art. 22)
  - a. Unit personnel armed for their own defense against marauders and those violating the law of armed conflict, e.g., by attacking a medical unit. Medical personnel thus may carry small arms, such as rifles or pistols for this purpose. In contrast, placing machine guns, grenade launchers, mines, light antitank weapons, etc., around a medical unit **would** cause a loss of protection.<sup>11</sup>
  - b. Self-Defense Defined. Although medical personnel may carry arms for self-defense, they may not employ such arms against enemy forces acting in conformity with the law of armed conflict. These arms are for their personal defense and for the protection of the wounded and sick under their charge against persons violating the law of armed conflict. Medical personnel who use their arms in circumstances not justified by the law of armed conflict expose themselves to penalties for violation of the law of armed conflict and, provided they have been given due warning to cease such acts, may also forfeit the protection of the medical unit or establishment of which they form part or which they are protecting. (*See* FM 27-10, para. 223)
  - c. Unit guarded by sentries. Normally medical units are guarded by their own personnel. It will not lose its protection, however, if a military guard attached to a medical unit guards it. These personnel may be regular members of the armed force, but they may only use force in the same circumstances as discussed in the previous paragraph.<sup>12</sup>
  - d. Small arms and ammunition taken from wounded may be present in the unit. However, such arms and ammunition should be turned in as soon as practicable and, in any event, are subject to confiscation. (FM 27-10, para. 223)
  - e. Presence of personnel from the veterinary service.
  - f. Provision of care to civilian wounded and sick.

B. Disposition of Captured Buildings and Material of Medical Units and Establishments.

1. Mobile Medical Units. (GC I, art. 33)

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<sup>11</sup> ATTP 4-02, *supra* note 3, at para. 4-35.

<sup>12</sup> *Id.* at para. 4-35.

- a. Material of mobile medical units, if captured, need not be returned. This was a significant departure from the 1929 Convention which required mobile units to be returned.
  - b. But captured medical material must be used to care for the wounded and sick. First priority for the use of such material is the wounded and sick in the captured unit. If there are no patients in the captured unit, the material may be used for other patients.<sup>13</sup>
2. Fixed Medical Establishments. (GC I, art. 33)
- a. The captor has no obligation to restore this property to the enemy—he can maintain possession of the building, and its material becomes his property. However, the building and the material must be used to care for wounded and sick as long as a requirement exists.
  - b. Exception: “in case of urgent military necessity,” they may be used for other purposes.
  - c. If a fixed medical establishment is converted to other uses, prior arrangements must be made to ensure that wounded and sick are cared for. Medical material and stores of both mobile and fixed establishments “shall not be intentionally destroyed.” **No military necessity exception.**

## VII. MEDICAL TRANSPORTATION

- A. Medical Vehicles—Ambulances. (GC I, art. 35)
1. Respect and protect: Medical vehicles may not be attacked if performing a medical function.
  2. These vehicles may be employed permanently or temporarily on such duties, and they need not be specially equipped for medical purposes. (*See* GC I Commentary at 281). As ambulances are not always available, any vehicles may be adapted and used temporarily for transport of the wounded. During that time they will be entitled to protection, subject to the display of the distinctive emblem. Thus military vehicles going up to the forward areas with ammunition may bring back the wounded, with the important reservation the emblem must be detachable, e.g., a flag, so that it may be flown on the downward journey. Conversely military vehicles may take down wounded and bring up military

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<sup>13</sup> *See* GC I Commentary, *supra* note 2, at 274; *see also* ATTP 4-02, *supra* note 3, at para. 4-25.

supplies on the return journey. The flag must then be removed on the return journey.

3. Key issue for these vehicles is the display of the distinctive emblem, which accords them protection.
    - a. Camouflage scenario: Belligerents are only under an obligation to respect and protect medical vehicles so long as they can identify them. Consequently, absent the possession of some other intelligence regarding the identity of a camouflaged medical vehicle, belligerents would not be under any obligation to respect and protect it.<sup>14</sup>
    - b. Display the emblem only when the vehicle is being employed on medical work. Misuse of the distinctive symbol is a war crime. (*See* FM 27-10 at para. 504)
  4. Upon capture, these vehicles are subject to the laws of armed conflict.
    - a. Captor may use the vehicles for any purpose. However, the *material* of mobile medical units falling into the hands of the enemy must be used only for the care of the wounded and sick, and does not constitute war booty, until GC I ceases to be operative. (*See* FM 27-10, para. 234)
    - b. If the vehicles are used for non-medical purposes, the captor must ensure proper care of the wounded and sick they contained, and, of course, ensure that the distinctive markings have been removed.
- B. Medical Aircraft. (GC I, art. 36)
1. Definition: Aircraft exclusively employed for the removal of wounded and sick and for the transport of medical personnel and equipment.
  2. Protection.
    - a. Marked with protected emblem.
    - b. However, **protection ultimately depends on an agreement**: medical aircraft are not to be attacked if “flying at heights, times and on routes specifically agreed upon between the belligerents.” (GC I, art. 36) The differing treatment accorded to aircraft, as opposed to ambulances, is a function of their increased mobility and consequent heightened fears about

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<sup>14</sup> *See* ATTP 4-02, *supra* note 3, at para. 4-26.

their misuse. Also the speed of modern aircraft makes identification by color or markings useless. Only previous agreement could afford any real safeguard.

- c. Without such an agreement, belligerents use medical aircraft at their own risk.<sup>15</sup>
- d. Aircraft may be used permanently or temporarily on a medical relief mission; however, to be protected it must be used “exclusively” for a medical mission during its relief mission. (*See* GC I Commentary at 289) This raises questions as to whether the exclusivity of use refers to the aircraft’s entire round trip or to simply a particular leg of the aircraft’s route. The point is overshadowed, however, by the ultimate need for an agreement in order to ensure protection. The GC I Commentary also says “exclusively engaged” means flying without any armament.<sup>16</sup>
- e. Reporting information acquired incidentally to the aircraft’s humanitarian mission does not cause the aircraft to lose its protection. Medical personnel are responsible for reporting information gained through casual observation of activities in plain view in the discharge of their duties. This does not violate the law of armed conflict or constitute grounds for loss of protected status. For example, a Medevac aircraft could report the presence of an enemy patrol if the patrol was observed in the course of their regular mission and was not part of an information gathering mission outside their humanitarian duties.
- f. Flights over enemy or enemy-occupied territory are prohibited unless agreed otherwise.

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<sup>15</sup> *See* GC I Commentary, *supra* note 2, at 288; ATTP 4-02, *supra* note 3, at para. 4-24. This was certainly the case in Vietnam where “any air ambulance pilot who served a full one year tour could expect to have his aircraft hit at least once by enemy fire. . . . Most of the Viet Cong and North Vietnamese clearly considered the air ambulances just another target.” PETER DORLAND AND JAMES NANNEY, *DUST OFF: ARMY AEROMEDICAL EVACUATION IN VIETNAM 85-86* (1982). Medical aircraft (and vehicles) took fire from Panamanian paramilitary forces (DIGBATS) during OPERATION JUST CAUSE in 1989. CENTER FOR ARMY LESSONS LEARNED, *OPERATION JUST CAUSE: LESSONS LEARNED*, p. III-14, (October 1990). By contrast, in the Falklands each of the hospital ships (four British and two Argentinean) had one dedicated medical aircraft with Red Cross emblems. Radar ID was used to identify these aircraft because of visibility problems. Later it was done by the tacit agreement of the parties. Both sides also used combat helicopters extensively, flying at their own risk. No casualties occurred. SYLVIE-STOYANKA JUNOD, *PROTECTION OF THE VICTIMS OF THE ARMED CONFLICT IN THE FALKLANDS 26-27* (1984).

<sup>16</sup> *See also* Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims on International Armed Conflicts (Protocol I). Geneva, June 8, 1977, art. 28(3). Dept. of Army, Field Manual 8-10-6, *Medical Evacuation in a Theater of Operations – Tactics, Techniques, and Procedures*, para. A-4 (14 April 2000) (the mounting or use of offensive weapons on dedicated Medevac vehicles and aircraft jeopardizes the protection afforded by the Conventions. Offensive weapons include, but are not limited to, machine guns, grenade launchers, hand grenades, and light antitank weapons).

3. Summons to land.
  - a. Means by which belligerents can ensure that the enemy is not abusing its use of medical aircraft—**must be obeyed**.
  - b. Aircraft must submit to inspection by the forces of the summoning Party.
  - c. If not committing acts contrary to its protected status, medical aircraft may be allowed to continue.
  
4. Involuntary landing.
  - a. Occurs as the result of engine trouble or bad weather. Aircraft may be used by captor for any purpose. Materiel will be governed by the provisions of GC I, arts. 33 and 34. (*See GC I Commentary at 293*)
  - b. Personnel are Retained or POWs, depending on their status.
  - c. Wounded and sick must still be cared for.
  
5. The inadequacy of GC I, art. 36, in light of growth of use of medical aircraft, prompted an overhaul of the regime in AP I. (AP I, arts, 24–31)
  - a. Establishes three overflight regimes:
    - i. Land controlled by friendly forces (AP I, art. 25): No agreement between the parties is required for the aircraft to be respected and protected; however, the article recommends that notice be given, particularly if there is a SAM threat.
    - ii. Contact Zone (disputed area) (AP I, art. 26): Agreement required for absolute protection. However, enemy is not to attack once aircraft identified as medical aircraft.
    - iii. Land controlled by enemy (AP I, art. 27): Overflight agreement required. Similar to GC I, art. 36(3) requirement.
  - b. Bottom line: *Known* medical aircraft shall be respected and protected when performing their humanitarian functions.

- c. Optional distinctive signals, e.g., radio signals, flashing blue lights, electronic identification, are all being employed in an effort to improve identification. (AP I, Annex I, Chapter 3)
- C. Hospital ships. Military hospital ships, which are to be marked in the manner specified by GC II, art. 43, may in no circumstances be attacked and captured but must be respected and protected, *provided* their names and descriptions have been notified to the Parties to the conflict ten days before those ships are employed. (GC I, art. 20; GC II, art. 22)
1. Hospital ships must be used exclusively to assist, treat, and transport the wounded, sick, and shipwrecked. The protection to which hospital ships are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy. (GC II, art. 34)
  2. Traditionally, hospital ships could not be armed, although crew members could carry light individual weapons for the maintenance of order, for their own defense, and that of the wounded, sick, and shipwrecked. However, due to the changing threat environment in which the Red Cross symbol is not recognized by various hostile groups and actors as indicating protected status, the United States views the manning of hospital ships with defensive weapons systems, such as point defense anti-missile systems or crew-served weapons to defend against small boat threats, as prudent force protection measures, analogous to arming crew members with small arms, and consistent with the humanitarian purpose of hospital ships and the duty to safeguard the wounded and sick.<sup>17</sup>
  3. GC II, art. 34 provides that hospital ships may not use or possess “secret codes” as means of communication, so that belligerents could verify that hospital ships’ communications systems were being used only in support of their humanitarian function and not as a means of communicating information that would be harmful to the enemy. However, subsequent technological advances in encryption and satellite navigation, while recognized as problematic, have not been specifically addressed by treaty. As a practical matter, modern navigational technology requires that the traditional rule prohibiting “secret codes” be understood to not include modern encryption communication systems.<sup>18</sup>
  4. Coastal Rescue Craft. Small craft employed by a State or by the officially recognized lifeboat institutions for coastal rescue operations are to be respected and protected, so far as operational requirements permit. (GC II, art. 27)

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<sup>17</sup> NWP 1-14M, *supra* note 6, at para. 8.6.3.

<sup>18</sup> *Id.*

5. Any hospital ship in a port which falls into the hands of the enemy is to be authorized to leave the port. (GC II, art. 29)
6. Retained Personnel and Wounded and Sick Put Ashore. The religious, medical, and hospital personnel of hospital ships retained to care for the wounded and sick are, on landing, subject to GC I. (GC II, art. 37) Other forces put ashore become subject to GC I. (GC II, art. 4)

## VIII. DISTINCTIVE EMBLEMS

- A. Emblem of the Conventions and Authorized Exceptions. (GC I, art. 38)
  1. Red Cross. The distinctive emblem of the conventions.
  2. Red Crescent. Authorized exception.
  3. Red Lion and Sun. Authorized exception employed by Iran, although it has *since been replaced by the Red Crescent*.
  4. Red Crystal. On 14 January 2007, the Third Additional Protocol to the 1949 Geneva Conventions (AP III) entered into force. **The United States is a party to AP III**, which established an additional emblem—the red crystal—for use by Governments and the International Red Cross and Red Crescent Movement. Under international law, the red crystal offers the same protection as the red cross and the red crescent when marking military medical personnel, establishments and transport; the staff of national societies; staff, vehicles and structures of the ICRC and the International Federation.
- B. Unrecognized symbols. The most well-known is the red “Shield of David” of Israel. While the 1949 diplomatic conference considered adding this symbol as an exception, it was ultimately rejected. Several other nations had requested the recognition of new emblems, and the conference became concerned about the danger of substituting national or religious symbols for the emblem of charity, which must be neutral. There was also concern that the proliferation of symbols would undermine the universality of the Red Cross and diminish its protective value. (*See* GC I Commentary at 301). As discussed above, Additional Protocol III to the Geneva Conventions also recognizes the Red Crystal. The Red Crystal replaces the Red Star of David.<sup>19</sup>
- C. Identification of Medical and Religious Personnel. (GC I, art. 40)

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<sup>19</sup> See ATTP 4-02, *supra* note 3, at para. 4-26.

1. Note the importance of these identification mechanisms. The two separate and distinct protections given to medical and religious personnel are, as a practical matter, accorded by the armband and the identification card.<sup>20</sup>
    - a. The armband provides protection from intentional attack on the battlefield.
    - b. The identification card indicates entitlement to “retained person” status.
  2. Permanent medical personnel, chaplains, personnel of National Red Cross and other recognized relief organizations, and relief societies of neutral countries. (GC I, art. 40)
    - a. Armband displaying the distinctive emblem.
    - b. Identity card: U.S. uses DD Form 1934 for the ID cards of these personnel.
    - c. Confiscation of ID card by the captor prohibited. Confiscation renders determination of “retained person” status extremely difficult.
  3. Auxiliary personnel. (GC I, art. 41)
    - a. Armband displaying the distinctive emblem in miniature.
    - b. ID documents indicating special training and temporary character of medical duties.
- D. Marking of Medical Units and Establishments. (GC I, art. 42) The distinctive flag of the Convention (e.g., the Red Cross) may be hoisted only over such medical units and establishments as are entitled to be respected under GC I. It may be accompanied by the national flag of the Party to the conflict. However, if captured, the unit will fly only the Red Cross flag.
- E. Marking of Medical Units of Neutral Countries. (GC I, art. 43)
1. Shall fly the Red Cross flag, national flag, and the flag of belligerent being assisted.
  2. If captured, will fly only the Red Cross flag and their national flag.

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<sup>20</sup> See *id.* at para. 4-22.

- F. Authority over the Emblem. (GC I, art. 39) Article 39 makes it clear that the use of the emblem by medical personnel, transportation, and units is subject to “competent military authority.” The commander may give or withhold permission to use the emblem, and the commander may order a medical unit or vehicle camouflaged. (*See* GC I Commentary at 308) While the Convention does not define who is a competent military authority, it is generally recognized that this authority is held no lower than the brigade commander (generally O-6) level.<sup>21</sup>
- G. The emblem of the red cross on a white ground and the words “Red Cross” or “Geneva Cross” may not be employed, **either in time of peace or in time of war**, except to indicate or to protect the medical units and establishments, the personnel and material protected by GC I and other Conventions dealing with similar matters. (GC I, art. 44 (which also lists exceptions to the rule). *See also* AP I, art. 38, and AP II, art. 12, which prohibit the improper use of the distinctive emblems, such as the red cross).
- H. “The use by individuals, societies, firms or companies . . . of the emblem . . . shall be **prohibited at all times.**” (GC I, art. 53)

#### **FOR FURTHER READING:**

- A. Joint Chiefs of Staff, Joint Publication 4-02, Health Service Support (26 July 2012).
- B. Dept. of Army, Field Manual 4-02.1, Army Medical Logistics (8 December 2009).

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<sup>21</sup> *See id.* at para. 4-26.

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