International Review of the Red Cross (2026), 1–20.
doi:10.1017/S1816383126101052

IRRC

When loss of protection does not permit attack: Distinguishing acts harmful to the enemy from the notion of military objectives

Thibaud Jourdan*
PhD Student, Université de Liège and Université Libre de Bruxelles, Brussels, Belgium
Email: thibaud.jourdan@uliege.be

Abstract

This article examines the relationship between acts harmful to the enemy (AHTTE) – the first criterion for the loss of special protection for medical units and transports under international humanitarian law – and the requirements for classification as a military objective, which governs the loss of general protection for civilian objects. The analysis begins by clarifying the articulation between special and general protection,

* The author would like to thank Professors Christophe Deprez and Vaios Koutroulis for their trust and support in the conduct of this research, as well as the editorial team at the *Review* for their valuable assistance and comments.

then outlines the legal consequences of losing special protection alone. The definition of AHTTE is examined, with particular attention to hospital shielding, and it is then assessed whether such acts always meet the cumulative conditions of Article 52(2) of Additional Protocol I for becoming military objectives: effective contribution to military action and definite military advantage. The article argues that AHTTE do not always meet these conditions, and that certain acts contribute too indirectly or speculatively to justify targeting. The conclusion emphasizes that this analysis does not preclude the application of other rules governing the conduct of hostilities.

Keywords: international humanitarian law, medical units, acts harmful to the enemy, military objective.

Introduction

In times of armed conflict, a special protection regime[1] considered to be among the most robust in international humanitarian law (IHL)[2] is afforded to both civilian and military[3] medical units and transports[4] – provided they are authorized

1 See Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) (GC I), Arts 19, 35; Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) (GC IV), Arts 18, 21; Protocol Additional (I) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978) (AP I), Arts 12, 21; Protocol Additional (II) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609, 8 June 1977 (entered into force 7 December 1978) (AP II), Art. 11(1); Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1: *Rules*, Cambridge University Press, Cambridge, 2005 (ICRC Customary Law Study), Rules 28–29, available at: https://ihl-databases.icrc.org/en/customary-ihl/rules (all internet references were accessed in January 2026).

2 Supriya Rao and Alexander Breitegger, "Reaffirming IHL's Specific Protection of Hospitals", *Humanitarian Law and Policy Blog*, 27 May 2025, available at: https://blogs.icrc.org/law-and-policy/2025/05/27/reaffirming-ihl-s-specific-protection-of-hospitals/; Fritz Allhoff and Keagan Potts, "Medical Immunity, International Law and Just War Theory", *Journal of the Royal Army Medical Corps*, Vol. 165, No. 4, 2019, p. 258; Annyssa Bellal and Stuart Casey-Maslen, *The Additional Protocols to the Geneva Conventions in Context*, Oxford University Press, Oxford, 2022, p. 126.

3 AP I, Art. 8(e), (g); ICRC, *Commentary on the Fourth Geneva Convention: Convention (IV) relative to the Protection of Civilian Persons in Time of War*, 2nd ed., Geneva, 2025 (ICRC Commentary on GC IV), Art. 18, para. 1774.

4 As defined in AP I, Art. 8:

> (e) "medical units" means establishments and other units, whether military or civilian, organized for medical purposes, namely the search for, collection, transportation, diagnosis or treatment – including first-aid treatment – of the wounded, sick and shipwrecked, or for the prevention of disease. The term includes, for example, hospitals and other similar units, blood transfusion centres, preventive medicine

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

and recognized by a party to the conflict.[5] In order to ensure continuity of care in wartime, this protection regime prohibits misuse of and attacks against medical units and transports through an obligation on the parties to the conflict to "respect and protect"[6] such units and transports. It is applicable during both international and non-international armed conflicts.[7]

This protection is one of the core principles of IHL and was first enshrined[8] in the original Geneva Convention of 1864.[9] Moreover, "[i]ntentionally directing attacks against … hospitals and places where the sick and wounded are collected", as well as "against buildings, material, medical units and transport … using the distinctive emblems of the Geneva Conventions in conformity with international law", constitutes a war crime under the Rome Statute.[10] However, despite the importance of this rule, those entitled to its protection have never ceased to be targeted during armed conflicts.[11] In 2024 alone, the Safeguarding Health in Conflict Coalition reported 1,111 incidents involving damage or destruction of health facilities. The Coalition also notes that these figures likely represent an undercount.[12]

This apparent contradiction between a supposedly highly protective legal framework and a reality in which attacks against medical units and transports are frequent can partly be explained by the fact that this protection is not unconditional. The special protection of medical units may cease when they are used for military purposes – if "they are used to commit, outside their humanitarian duties,

---

centres and institutes, medical depots and the medical and pharmaceutical stores of such units. Medical units may be fixed or mobile, permanent or temporary; …
(g) "medical transports" means any means of transportation, whether military or civilian, permanent or temporary, assigned exclusively to medical transportation and under the control of a competent authority of a Party to the conflict.

While medical personnel benefit from a comparable protection (see GC I, Art. 24; AP I, Art. 15; AP II, Art. 9; ICRC Customary Law Study, above note 1, Rule 25), this will not be covered here as this paper compares the notion of acts harmful to the enemy (AHTTE) to that of military objectives, the latter being exclusive to objects – i.e., medical units and transports.

5 See AP I, Arts 8(g), 12. Unauthorized medical units or transports still benefit from the general protection owed to civilian objects, however. Robert Kolb and Fumiko Nakashima, "The Notion of 'Acts Harmful to the Enemy' under International Humanitarian Law", *International Review of the Red Cross*, Vol. 101, No. 912, 2019, p. 1175.

6 See GC I, Arts 19, 35; GC IV, Arts 18, 21; AP I, Arts 12, 21; AP II, Art. 11(1); ICRC Customary Law Study, above note 1, Rules 28–29.

7 ICRC Customary Law Study, above note 1, Rules 28–29, pp. 93–94, 98–99.

8 Éric David, *Principes de droit des conflits armés*, 6th ed., Bruylant, Brussels, 2019, p. 389.

9 Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, 22 August 1864, Art. 1.

10 Rome Statute of the International Criminal Court, UN Doc. A/CONF.183/9, 17 July 1998 (entered into force 1 July 2002), Art. 8(2)(b)(ix), (xxiv), 8(2)(e)(ii), (iv).

11 Duncan McLean, "Medical Care in Armed Conflict: Perpetrator Discourse in Historical Perspective", *International Review of the Red Cross*, Vol. 101, No. 911, 2019; Neve Gordon and Nicola Perugini, "'Hospital Shields' and the Limits of International Law", *European Journal of International Law*, Vol. 30, No. 2, 2019, p. 443.

12 Safeguarding Health in Conflict Coalition, "Epidemic of Violence: Violence against Health Care in Conflict", 2024, p. 7, available at: https://insecurityinsight.org/wp-content/uploads/2025/04/2024-SHCC-Annual-Report.pdf.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

acts harmful to the enemy", to quote treaty law.[13] As for medical transports, their protection covers them "in the same way as mobile medical units"[14] and ceases in the same circumstances.[15] These exceptions are regularly invoked by States to justify attacks against specially protected objects.[16]

However, caution is required when linking such attacks to the legal limits of special protection, as being used for acts harmful to the enemy (AHTTE) does not necessarily render medical units or transports lawful targets. First, the loss of special protection caused by AHTTE can only happen "after a due warning has been given, naming, in all appropriate cases, a reasonable time limit[,] and after such warning has remained unheeded".[17] This entails that the party considering an attack needs to provide an opportunity and a time frame that would "allow for termination of the act or, failing that, the safe evacuation of the wounded and sick".[18]

Second, medical units and transports[19] also benefit from the general protection afforded to civilian objects, as both fall under the definition laid down in Article 52 of Additional Protocol I (AP I).[20] This general protection entails that "the Parties to the conflict shall at all times distinguish … between civilian objects and military objectives".[21] Its main consequence is that direct attacks against the former are prohibited,[22] unless and for such time as they qualify as the latter.[23]

Because special protection neither derogates from nor extinguishes general protection, both apply cumulatively, and it follows that the loss of special

13 GC I, Art. 21; GC IV, Art. 19; AP I, Art. 13.

14 GC I, Art. 35; GC IV, Art. 21; AP I, Art. 21.

15 ICRC, *Commentary on the First Geneva Convention: Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 2nd ed., Geneva, 2016 (ICRC Commentary on GC I), Art. 35, para. 2389; ICRC Commentary on GC IV, above note 3, Art. 21, para. 1959.

16 For example, on 9 March 2022, Maternity Hospital No. 3 in Mariupol, Ukraine, was bombed by Russian armed forces. The attack was justified by allegations that members of the Azov battalion were present in the hospital. Alan Cullison, "Russian Airstrike Hits Maternity Hospital in Ukrainian City of Mariupol", *Wall Street Journal*, 10 March 2022, available at: www.wsj.com/world/europe/russia-presses-offensive-as-ukrainians-try-to-evacuate-11646819525. On 15 November 2023, the Israel Defense Forces conducted a large-scale operation in Al-Shifa hospital in Gaza, claiming that the operation was lawful due to the "continued military use by Hamas" of the hospital, which allegedly "compromised its protected status under international law". Israel Defense Forces (@IDF), "A precise and targeted operation is being carried out against Hamas in a very specific area of the Shifa Hospital", *X* (previously *Twitter*), 15 November 2023, 10:19 AM, available at: https://x.com/IDF/status/1724718737389965402.

17 GC I, Art. 21; GC IV, Art. 19; AP I, Art. 13(1); AP II, Art. 11(2).

18 ICRC Commentary on GC I, above note 15, Art. 21, para. 1850. For further development on the warning requirement, see ICRC Commentary on GC IV, above note 3, Art. 19, paras 1851–1859; R. Kolb and F. Nakashima, above note 5, pp. 1181–1184; Tom Haeck, "Loss of Protection", in Andrew Clapham, Paola Gaeta and Marco Sassòli (eds), *The 1949 Geneva Conventions: A Commentary*, Oxford University Press, Oxford, 2015, p. 848, paras 32–33.

19 For the rest of this article, medical transports will be conflated with mobile medical units, given that their protection and the circumstances under which it ceases are identical.

20 ICRC Commentary on GC I, above note 15, Art. 19, paras 1794–1796; R. Kolb and F. Nakashima, above note 5, p. 1175.

21 AP I, Art. 48.

22 *Ibid.*, Art. 52(1).

23 ICRC Customary Law Study, above note 1, Rule 10; AP I, Art. 52(2).

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

protection does not in itself permit attack, unless the general protection is also lost.[24] Accordingly, if the AHTTE that led to the loss of special protection do not also fulfil the criteria required to qualify the medical facility concerned as a military objective, they cannot justify targeting it.[25] The opposite is also true: even when a hospital qualifies as a military objective, the conditions for the loss of special protection – notably issuing a prior warning – must still be met before an attack may be conducted. To summarize, attacks against medical units may only be permissible if both their special and general protections have been lost, each according to their own conditions.

Although the cumulative nature of special and general protection is generally accepted,[26] the differences and connexions between the criteria for their loss are rarely examined in detail.[27] The International Committee of the Red Cross (ICRC) Commentary on Geneva Convention I (GC I) notes that "it is hard to conceive of circumstances in which the commission of an act harmful to the enemy would not transform the facility in question into a military objective",[28] thereby illustrating the perceived proximity between the two concepts. In terms of State practice, military manuals often fail to distinguish clearly between the loss of special protection and the loss of general protection.[29]

This article argues that the distinction between the conditions for the loss of special and general protection remains both conceptually and practically significant, and that this distinction has important implications for the legality of attacks against medical units and transports. It focuses in particular on the circumstances under which AHTTE may lead to the loss of special protection without, however, permitting direct targeting.

24 Andrew Clapham, *War*, Oxford University Press, Oxford, 2021, p. 400; Marco Sassòli, *International Humanitarian Law: Rules, Controversies and Solutions to Problems Arising in Warfare*, 2nd ed., Edward Elgar, Cheltenham, 2024, p. 264, para. 8.029; Vaios Koutroulis, "Loss of Protection of Medical Personnel in Armed Conflict", *Military Law and the Law of War Review*, Vol. 57, No. 2, 2017, p. 230; Nils Melzer, *International Humanitarian Law: A Comprehensive Introduction*, ICRC, Geneva, 2016, p. 145; R. Kolb and F. Nakashima, above note 5, p. 1177; S. Rao and A. Breitegger, above note 2.

25 ICRC Commentary on GC I, above note 15, Art. 21, para. 1794; S. Rao and A. Breitegger, above note 2.

26 ICRC Commentary on GC I, above note 15, Art. 21, para. 1847; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1836, and Art. 19, para. 1852; ICRC, *Global Initiative to Galvanize Political Commitment to International Humanitarian Law: Progress Report*, 2025, p. 42; V. Koutroulis, above note 24, pp. 230–231; M. Sassòli, above note 24, p. 264, para. 8.029; S. Rao and A. Breitegger, above note 2; R. Kolb and F. Nakashima, above note 5, p. 1172. *Contra*, see Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds), *Commentary on the Additional Protocols*, ICRC, Geneva, 1987 (ICRC Commentary on AP I/AP II), AP I, Art. 13, para. 555: "If the medical unit is used to commit acts which are harmful to the enemy, it actually becomes a military objective which can legitimately be attacked, and even destroyed."

27 The more in-depth contribution known to the author is the one by R. Kolb and F. Nakashima, above note 5, pp. 1192–1194.

28 ICRC Commentary on GC I, above note 15, Art. 21, para. 1847.

29 US Department of Defense, *Law of War Manual*, 2023, pp. 510–511; Danish Ministry of Defence and Defence Command Denmark, *Military Manual on International Law Relevant to Danish Armed Forces in International Operations*, 2016, p. 262; French Ministry of Armed Forces, *Manuel de droit des opérations militaires*, 2022, p. 125; New Zealand Defence Force, *Manual of Armed Forces Law*, Vol. 4, 2nd ed., 2017, p. 11-21, para. 11.6.4.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

The first part of the article begins by clarifying the legal consequences arising from the loss of special protection alone, before turning to the definition of AHTTE. The notion of AHTTE is then examined in light of the case of hospital shields. The second part assesses the extent to which AHTTE may fail to meet the criteria for the loss of general protection under Article 52(2) of AP I, focusing first on the requirement of an effective contribution to military action, and then on that of a definite military advantage, and finally returns to the issue of shielding in that context. The conclusion underscores that the analysis is limited to the qualification of medical units as military objectives and does not extend to the additional constraints that govern the lawfulness of attacks under IHL.

The loss of special protection

This article argues that there are circumstances under which medical units lose their special protection but may still not be attacked. Clarification is thus needed regarding what legal consequences such a scenario has for the medical unit, and the definition of AHTTE.

Legal consequences of the loss of special protection

Special protection obliges the parties to conflict to "respect and protect"[30] medical units. The obligation to respect entails not only a prohibition against attack, but also a duty to refrain from interfering with the humanitarian function of such units.[31] The obligation to protect adds the requirement to take positive measures – to "lend help and support"[32] – to ensure the effective functioning of medical units and to prevent them from being exposed to danger.[33]

When a medical unit loses its special protection, the parties to the conflict are released from their obligation to respect and protect that unit.[34] As a result, the enemy "is no longer obliged to refrain from interfering with the work"[35] of the

30 See GC I, Arts 19, 35; GC IV, Arts 18, 21; AP I, Arts 12, 21; AP II, Art. 11(1); ICRC Customary Law Study, above note 1, Rules 28–29.

31 ICRC Commentary on GC I, above note 15, Art. 19, para. 1799; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1794.

32 Jean Pictet (ed.), *Commentary on the Geneva Conventions of 12 August 1949*, Vol. 1: *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, ICRC, Geneva, 1952 (Pictet Commentary on GC I), Art. 12, p. 135.

33 ICRC Commentary on GC I, above note 15, Art. 19, para. 1805; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1800; Gilles Giacca, "The Obligations to Respect, Protect, Collect, and Care for the Wounded, Sick, and Shipwrecked", in A. Clapham, P. Gaeta and M. Sassòli (eds), above note 18, pp. 784–785; Supriya Rao and Alexander Breitegger "Reaffirming the Obligation to Protect Medical Facilities and Support Their Functioning", *Humanitarian Law and Policy Blog*, 20 November 2025, available at: https://blogs.icrc.org/law-and-policy/2025/11/20/reaffirming-the-obligation-to-protect-medical-facilities-and-support-their-functioning/.

34 ICRC Commentary on GC IV, above note 3, Art. 19, para. 1859.

35 *Ibid.*

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

medical units concerned, nor, *a fortiori*, to take measures to facilitate its functioning.[36] This means that, in situations where a medical unit loses its special protection but does not qualify as a military objective, the adverse party may take measures that do not amount to acts of violence to bring the AHTTE to an end. Indeed, such measures would not be considered attacks under Article 49 of AP I[37] and would therefore be allowed against civilian objects still benefiting from the general protection afforded to them.

Permissible non-violent measures may include seizing a medical transport used for military intelligence-gathering, taking control of a medical unit in order to relocate it away from a military objective, conducting search operations to seize unlawfully stored military materiel, or disrupting military communications being transmitted from a facility. However, the methods chosen must remain effective in inducing the termination of the AHTTE, and must be proportionate to the AHTTE.[38]

Most importantly, the loss of the unit's special protection does not affect the protection owed to the wounded and sick present in the facility,[39] nor to its medical personnel – provided they are not the ones committing AHTTE. The party taking action against the unit must therefore continue to respect and protect the wounded and sick[40] as well as the medical staff,[41] and must avoid, even while taking lawful measures, exposing them to harm.

Defining acts harmful to the enemy

Although AHTTE are not defined in treaties,[42] the Geneva Conventions and AP I provide examples of acts that shall not be considered as such.[43] This non-exhaustive[44] list includes the personnel of the unit carrying light personal weapons for self-defence or the protection of the wounded, the presence of sentries or escorts, the temporary holding of weapons taken from the wounded, and the presence of combatants solely for medical reasons. These are acts which, although they could

36 ICRC Commentary on GC I, above note 15, Art. 21, para. 1854.

37 AP I, Art. 49(1): "'Attacks' means *acts of violence* against the adversary, whether in offence or in defence" (emphasis added).

38 R. Kolb and F. Nakashima, above note 5, p. 1182.

39 ICRC Commentary on GC I, above note 15, Art. 21, para. 1854; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1859; Alexander Breitegger, "The Legal Framework Applicable to Insecurity and Violence Affecting the Delivery of Health Care in Armed Conflicts and Other Emergencies", *International Review of the Red Cross*, Vol. 95, No. 889, 2013, p. 118.

40 GC I, Art. 12; AP I, Art. 10; AP II, Art. 7; ICRC Customary Law Study, above note 1, Rules 110–111.

41 GC I, Art. 24; GC IV, Art. 20; AP I, Art. 15; AP II, Art. 9; ICRC Customary Law Study, above note 1, Rule 25.

42 ICRC Commentary on GC I, above note 15, Art. 21, para. 1840; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1845; ICRC Commentary on AP I, above note 26, Art. 13, para. 550.

43 See GC I, Art. 22(2); Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950), Art. 35(3); GC IV, Art. 19(2); AP I, Art. 13(2).

44 ICRC Commentary on GC I, above note 15, Art. 22, para. 1860.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

be regarded as harmful, or hostile, to the opposite forces, have been considered necessary to permit the proper functioning of medical units.[45]

In the absence of a legal definition of AHTTE, the applicable standard has been inferred *a contrario* from the conditions under which the protection is granted. The protection afforded to medical actors is subsidiary: it is given in order to enable them to perform their humanitarian function.[46] It is therefore lost when the unit no longer exclusively[47] fulfils that function and is used to make a military contribution in favour of, or against, a party to the conflict. As the ICRC notes, "[w]hen medical facilities are used to interfere directly or indirectly in military operations, and thereby cause harm to the enemy, the rationale for their specific protection under IHL is removed".[48]

The justification for the loss of protection is thus well established[49] and has guided the literature in defining acts that may qualify as AHTTE. These have been described as acts that "have the aim or effect, by favouring or impeding military operations, of being detrimental to one of the belligerents".[50] Accordingly, any use of medical establishments for military purposes by a party to the conflict may fall under AHTTE.[51] No threshold of severity is considered necessary.[52]

However, this broad interpretation remains limited by the requirement that the act in question must fall outside the humanitarian function of the unit concerned.[53] This has been illustrated by the scenario in which an ambulance, travelling in accordance with its medical function, breaks down accidentally in the middle of a crossroad or on a bridge of military importance and obstructs it; in such a case, the ambulance does not lose its special protection.[54]

45 ICRC Commentary on AP I, above note 26, Art. 13, para. 557.

46 ICRC Commentary on GC I, above note 15, Art. 19, para. 1172; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1772; A. Breitegger, above note 39, p. 108; Peter De Waard and John Tarrant, "Protection of Military Medical Personnel in Armed Conflicts", *University of Western Australia Law Review*, Vol. 35, 2010, p. 161.

47 Wording found in GC I, Art. 24; ICRC Customary Law Study, above note 1, Rules 28–29.

48 ICRC, *Public International Humanitarian Law and the Challenges of Contemporary Armed Conflicts: Building a Culture of Compliance for IHL to Protect Humanity in Today's and Future Conflicts*, 34IC/24/10.6, Geneva, September 2024, p. 35.

49 ICRC Commentary on GC I, above note 15, Art. 21, para. 1841; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1846; A. Breitegger, above note 39, p. 110.

50 Jean Pictet, "The Medical Profession and International Humanitarian Law", *International Review of the Red Cross*, Vol. 25, No. 247, 1985, p. 204.

51 ICRC Commentary on GC I, above note 15, Art. 21, para. 1842; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1846.

52 R. Kolb and F. Nakashima, above note 5, p. 1188.

53 GCI, Art. 21; GC IV, Art. 19; AP I, Art. 13; ICRC Commentary on GC I, above note 15, Art. 21, para. 1844; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1850.

54 ICRC Commentary on GC I, above note 15, Art. 21, para. 1844; P. De Waard and J. Tarrant, above note 46, p. 175.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

The case of hospital shields and AHTTE

The first sentence of Article 12(4) of AP I provides that "[u]nder no circumstances shall medical units be used in an attempt to shield military objectives from attack". Shielding, accordingly, can be defined as deliberately siting a medical unit and a military objective in the same vicinity "in the hope that the adverse Party would hesitate to attack these objectives for humanitarian reasons",[55] and is characterized by intentional proximity and shielding intent.[56] Claims alleging that the unit is harbouring or hiding a legitimate target[57] fall outside of this definition, as such misuse is better identified as misuse through repurposing.[58] Shielding is clearly prohibited, but one may question whether it also leads to the loss of special protection of the medical unit concerned.

By itself, the disrespect of Article 12(4) of AP I cannot release the adverse party from its obligation to respect and protect the medical unit concerned. This conclusion is supported in the ICRC Commentary on this provision,[59] which refers to Article 51(7) of AP I. This article contains a similar prohibition in relation to the civilian population,[60] and the Commentary notes that in that case, the subsequent paragraph expressly states that "[a]ny violation of these prohibitions shall not release the Parties to the conflict from their legal obligations".[61] One could argue that no such clarification appears in Article 12. It is nonetheless certain that a *tu quoque* argument invoking the enemy's breach of this provision to justify one's own non-compliance would fail, as IHL is non-reciprocal in nature.[62] Moreover, the placement of this rule in Article 12 ("Protection of Medical Units") rather than in Article 13 ("Discontinuance of Protection of Civilian Medical Units") underscores its protective nature. It is a rule directed at the defending party, not a basis for that party's opponents to claim that protection has been lost.

However, the same conduct may still qualify as AHTTE, as suggested by the ICRC Commentary on GC I, which gives as examples of acts amounting to AHTTE, based on State practice,

55 ICRC Commentary on AP I, above note 26, Art. 12, para. 538.

56 *Ibid.*; ICRC Commentary on GC I, above note 15, Art. 21, para. 1842; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1847.

57 See the examples cited in above note 16.

58 Whereas shielding deters attack by altering the legal parameters of the targeting decision without changing the unit's humanitarian function, repurposing involves an alteration of that function, often through physical change – for example, use as weapons or ammunition storage, or as a command or observation post. Supporting this division, the ICRC Commentary on GC I, above note 15, lists such acts separately from shielding as examples of AHTTE. Because there is no doubt that misuse through repurposing qualifies as AHTTE, the rest of this section addresses shielding only.

59 ICRC Commentary on AP I, above note 26, Art. 12, para. 539.

60 AP I, Art. 51(7): "The presence or movements of the civilian population or individual civilians shall not be used to render certain points or areas immune from military operations, in particular in attempts to shield military objectives from attacks or to shield, favour or impede military operations."

61 *Ibid.*, Art. 51(8).

62 ICRC Customary Law Study, above note 1, Rule 140; ICRC Commentary on GC I, above note 15, Art. 1, para. 188; International Criminal Tribunal for the former Yugoslavia (ICTY), *Prosecutor v. Kupreškić et al.*, Case No. IT-95-16-T, Judgment (Trial Chamber), 14 January 2000, para. 517.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

> 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*.[63]

Similar wording is found in the ICRC Commentary on Geneva Convention IV (GC IV).[64] Shielding may therefore lead to the loss of special protection – after a warning has been given and remained unheeded. It is however not the breach of Article 12(4) *per se* that leads to the cessation of protection, but the fact that the same conduct may also amount to AHTTE.

It must first be recalled that shielding intent is required for proximity between a medical unit and a military objective to amount to AHTTE,[65] thereby excluding cases of mere co-location.[66] Admittedly, intention is difficult to prove,[67] but the warning requirement may assist in establishing it.[68] If the attacker notifies the unit that its proximity to a military objective impedes operations, the latter may explain the placement, including any temporary humanitarian necessity. A failure to respond or to relocate, depending on the context, could support an inference of intent, with the proviso that "in case of doubt as to whether a particular type of conduct amounts to an 'act harmful to the enemy', it should not be considered as such".[69]

Second, in the author's view, two distinct forms of shielding should be distinguished. The first, active shielding, involves placing or relocating a medical unit or transport near a military objective. The second, passive shielding, concerns the opposite: positioning or moving a military objective in the vicinity of a medical unit. This distinction also implies a corresponding difference in the type of medical units concerned.[70] The first scenario will typically involve mobile medical units or transports, which are, to varying degrees, capable of being moved, while the second applies mainly to fixed medical units, which cannot ordinarily be relocated and

63 ICRC Commentary on GC I, above note 15, Art. 21, para. 1842 (emphasis added). A similar example was already present in the Pictet Commentary on GC I, above note 32, Art. 21, p. 201: "the deliberate siting of a medical unit in a position where it would impede an enemy attack".

64 ICRC Commentary on GC IV, above note 3, Art. 19, para. 1847: "Other scenarios that may be regarded as 'acts harmful to the enemy' in relation to civilian hospitals include placing a medical unit close to a military objective with the specific intention of shielding the military objective."

65 *Ibid.*, Art. 18, para. 1836, and Art. 19, para. 1847.

66 *Ibid.*, Art. 18, para. 1835, and Art. 19, para. 1848. Co-location here describes situations where shielding intent is absent but there is proximity between medical units and military objectives (as can be common in urban settings: see Nicholas W. Mull, "A Critique of the ICRC's Updated Commentary to the First Geneva Convention: Arming Medical Personnel and the Loss of Protected Status", *Georgia Journal of International and Comparative Law*, Vol. 45, No. 3, 2017, p. 504). This would not constitute AHTTE, because the unit's conduct remains within its humanitarian function.

67 ICRC Commentary on AP I, above note 26, Art. 12, para. 540.

68 N. W. Mull, above note 66, p. 504.

69 ICRC Commentary on GC I, above note 15, Art. 21, para. 1844.

70 Fixed medical units "consist of buildings built to remain where they are", while mobile medical units "are structures or establishments which can be moved according to needs". ICRC Commentary on AP I, above note 26, Art. 8, para. 370.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

can only serve a shielding function if a military objective is brought near them.[71] The author concludes that the first form of shielding falls within the prohibition of Article 12(4) of AP I and qualifies as AHTTE, while the second does not fall within that provision and does not amount to AHTTE, but nonetheless breaches the obligation to respect and protect the medical unit concerned.

Both scenarios produce the same outcome: deterring attack on a nearby military objective by altering the proportionality assessment of a strike on that objective. The justification for distinguishing these types of shielding therefore lies elsewhere. It is found in the wording of the conditions for loss of protection, which require that medical units "*are used* to commit"[72] AHTTE, as well as in the language of Article 12(4), which states that "medical units [shall not] *be used* in an attempt to shield military objectives".[73] In both cases, the verb "to use" is employed in the passive voice, with "medical units" as its subject. According to its ordinary meaning,[74] "to use" means "to do something with a machine, a method, an object, etc. for a particular purpose".[75] AHTTE, as well as the conduct prohibited by Article 12(4), therefore presupposes a purposive[76] act in which the unit is actively employed.

In the active shielding scenario, the medical unit is the object being acted upon: it is moved or positioned close to a military objective, thus being used to shield it and to commit AHTTE. In the passive shielding scenario, by contrast, nothing is done with the medical unit to achieve the shielding; what is acted upon is the military objective. This underscores that AHTTE depends not on a misuse of the special protection afforded to medical units – for in both scenarios that protection is exploited to deter attack – but on a conduct that misuses the unit itself. In a case of passive shielding, the unit is therefore not used in violation of Article 12(4) of AP I, nor to commit AHTTE. In addition, in the author's view, this interpretation is consistent with the protective logic of the special protection regime. The unit is already exposed to increased risk through no act attributable to it, due to the presence of a nearby military objective that remains a lawful target; a loss of protection would lack a clear legal basis in the absence of any conduct involving the unit itself.

71 The case where a fixed unit is built next to an existing military objective with shielding intent would still fall under the first scenario. Moreover, regardless of shielding intent, building a medical unit close to a military objective may often be in contradiction with the second sentence of Art. 12(4) of AP I ("Whenever possible, the Parties to the conflict shall ensure that medical units are so sited that attacks against military objectives do not imperil their safety"), which "should already have been taken into consideration … in time of peace, for example by avoiding the construction of a hospital next to a barracks". ICRC Commentary on AP I, above note 26, Art. 12, para. 544. Articles 19(2) of GC I and 18(5) of GC IV both contain similar provisions, also to be already taken in peacetime: see Elżbieta Mikos-Skuza, "Hospitals", in A. Clapham, P. Gaeta and M. Sassòli (eds), above note 18, p. 213, para. 19.

72 GC I, Art. 21; GC IV, Art. 19; AP I, Art. 13 (emphasis added).

73 AP I, Art. 12(4) (emphasis added).

74 Vienna Convention on the Law of Treaties, 1155 UNTS 331 (entered into force 27 January 1980), Art. 31(1).

75 "Use (Verb)", *Oxford Learner's Dictionaries*, available at: www.oxfordlearnersdictionaries.com/definition/english/use_1.

76 This conclusion is also supported by Nicholas W. Mull when he explains that AHTTE "must be purposeful with the specific intent to cause harm to the enemy". N. W. Mull, above note 66, p. 504.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

Furthermore, the ICRC Commentaries provide examples of misuse only corresponding to active shielding: "the placing of a medical unit in proximity to a military objective with the intention of shielding it",[77] "situations where a hospital is positioned with the intent to shield a military objective from attack",[78] "placing a medical unit close to a military objective with the specific intention of shielding the military objective"[79] and "intentionally plac[ing] medical units on the periphery of military objectives".[80] Although the Commentaries do not aim to provide an exhaustive list of AHTTE, the exclusive focus of the examples concerning shielding on the deliberate positioning of medical units near a military objective, and not on the reverse situation, supports the view that AHTTE and shielding require an active use of the unit.

To conclude, only active shielding may amount to AHTTE. This does not imply, however, that passive shielding is permitted: such conduct neither entails a loss of protection nor falls under Article 12(4), but remains prohibited. Because the nearby military objective remains a lawful target, it endangers the medical unit and thus breaches the obligation to respect and protect it, which requires that "proactive measures be taken … against various dangers arising in armed conflicts".[81] This obligation applies to both parties to the conflict.[82]

The gaps between AHTTE and the definition of a military objective

In order to identify circumstances in which AHTTE do not simultaneously permit direct targeting, it must first be recalled that this notion applies exclusively to medical units and transports.[83] By contrast, the definition of military objectives may apply to any object, regardless of its initial protection status.

Under Article 52(2) of AP I, which reflects customary law,[84] an object becomes a military objective only if it satisfies two cumulative conditions. First, the object must, by its nature, location, purpose or use, make an effective contribution to military action. Second, its total or partial destruction, capture or neutralization, in the circumstances ruling at the time, must offer a definite military advantage.

77 ICRC Commentary on GC I, above note 15, Art. 21, para. 1842.

78 ICRC Commentary on GC IV, above note 3, Art. 18, para. 1836.

79 *Ibid*., Art. 19, para. 1847.

80 ICRC Commentary on AP I, above note 26, Art. 12, para. 538.

81 G. Giacca, above note 33, p. 784, para. 10. See also ICRC Commentary on GC I, above note 15, Art. 19, para. 1805; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1800.

82 ICRC Commentary on GC I, above note 15, Art. 19, paras 1798, 1806; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1801.

83 Medical personnel have also seen this standard applied to them *mutatis mutandis* (ICRC Commentary on GC I, above note 15, Art. 24, para. 1996; M. Sassòli, above note 24, p. 261, para. 8.021; Stuart Casey-Maslen, "Medical and Religious Personnel", in A. Clapham, P. Gaeta and M. Sassòli (eds), above note 18, p. 817, para. 32), as they lose their special protection when they are no longer "exclusively assigned" to medical duties (GC I, Art. 24).

84 ICRC Customary Law Study, above note 1, Rule 8.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

Effective contribution to military action through nature, location, purpose or use

The requirement of a contribution to military action is where the conceptual proximity between AHTTE and military objectives is most evident. Both notions rely on the existence of a military nexus and a contribution that either favours or impedes military action.[85]

The threshold for AHTTE is nonetheless slightly lower than that applicable to military objectives. While the qualification of an object as a military objective has been described as requiring a direct link[86] between the object and the contribution to military action, AHTTE can encompass both direct and indirect forms of contribution;[87] acts that favour or interfere with military operations in an indirect manner may therefore qualify as AHTTE without simultaneously transforming the medical unit concerned into a military objective.[88] For example, if the policy of a hospital requires its staff to distribute documents encouraging patients to join the armed forces, this may support recruitment efforts, therefore indirectly favouring military operations, and could thus constitute AHTTE. However, the contribution would remain indirect and insufficient to meet the threshold required for qualification as a military objective.[89]

Under Article 52(2) of AP I, four criteria may establish such a military contribution: nature, purpose, location or use. The nature criterion is not applicable to medical units, which do not have "inherent attributes"[90] that would contribute to military operations. The same reasoning applies *prima facie* to purpose, understood as the enemy's intended future use of the object[91] – a hospital's purpose is, by definition, medical. One might nonetheless consider the case of a party to the conflict systematically converting ambulances or hospitals into means of military transport or storage, thereby diverting them from their designated role. In such circumstances,

85 Agnieszka Jachec-Neale, *The Concept of Military Objectives in International Law and Targeting Practice*, Routledge, London, 2015, p. 84; R. Kolb and F. Nakashima, above note 5, p. 1188.

86 Gloria Gaggioli and George Dvaladze, "Military Objectives", in Dražan Djukić and Niccolò Pons (eds), *The Companion to International Humanitarian Law*, Brill, Leiden, 2018, p. 501; Robert Kolb, *Advanced Introduction to International Humanitarian Law*, Edward Elgar, Cheltenham, 2025, p. 184; A. Jachec-Neale, above note 85, p. 91.

87 ICRC Commentary on GC I, above note 15, Art. 21, para. 1841; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1846.

88 R. Kolb and F. Nakashima, above note 5, p. 1193.

89 Even if one were to argue that a direct link is not required for an object to qualify as a military objective, the same result would likely follow from the second cumulative condition of Article 52(2) of AP I – i.e., the requirement of a *definite* military advantage, discussed below. Indeed, any advantage from an attack would be speculative, resting on uncertain assumptions about the recruitment impact of the documents, the effect of the hospital's destruction, and the overall military gain, which would likely be minimal.

90 Yoram Dinstein, "Legitimate Military Objectives under the Current *Jus in Bello*", in Andru E. Wall (ed.), *Legal and Ethical Lessons of NATO's Kosovo Campaign*, Naval War College, Newport, RI, 2002, p. 146.

91 ICRC Commentary on AP I, above note 15, Art. 52, para. 2022; M. Sassòli, above note 24, p. 378, para. 8.306; G. Gaggioli and G. Dvaladze, above note 86, p. 501.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

the units or transports may fall under the purpose criterion.[92] However, a specific medical unit that has not yet been used for such aims is not being used for AHTTE and thus cannot be attacked. This conclusion is supported by the requirement to issue a warning[93] before special protection can be lost: since the warning is intended to allow for the termination of the AHTTE,[94] it presupposes that such acts are ongoing.[95] A future use cannot be terminated. It follows that an anticipated or intended use – i.e., purpose – does not amount to AHTTE; if it could, the warning requirement would be deprived of its rationale.

The location criterion refers to areas whose strategic position may justify their classification as military objectives, such as elevated terrain, mountains passes or major access routes.[96] A hospital may be situated in such an area and thus potentially meet the first condition for classification as a military objective. This fact alone, however, does not entail the loss of its special protection: the presence of a medical unit in an area of military relevance does not, by itself, involve conduct beyond the unit's humanitarian function.[97] On the contrary, often, the location will have been chosen to enable that function.[98] Moreover, even if "the presence or activities of a medical unit might interfere with tactical operations",[99] such interference does not suffice to characterize the unit's conduct as harmful to the enemy.[100] The above discussion on shielding also confirms that AHTTE requires active use of the unit, not mere siting. Accordingly, presence alone, even if tactically disadvantageous to the enemy, does not constitute AHTTE.[101]

To illustrate this point, consider a variation on the previous ambulance example:[102] a medical transport or a mobile medical unit stops on a bridge and blocks access to a strategic location. If that stop is accidental, or required by medical necessity, it does not amount to AHTTE. If, however, the stop is deliberate and outside the unit's humanitarian function, it may constitute AHTTE. In such circumstances, the unit would also fall within the first condition of Article 52(2) of AP I, since it effectively contributes to one party's military action by hampering that of the other party. Even then, the decisive element is use rather than location: it is the deliberate employment of the unit to obstruct a strategic position that may constitute AHTTE, not the mere fact of being situated there.

92 With the caveat that this purpose must be established or proven for it to be able to make an effective military contribution, and not only deduced from assumptions or suspicions. G. Gaggioli and G. Dvaladze, above note 86, p. 501; Y. Dinstein, above note 90, p. 148.

93 GC I, Art. 21; GC IV, Art. 19; AP I, Art. 13(1); AP II, Art. 11(2).

94 ICRC Commentary on GC I, above note 15, Art. 21, para. 1850; N. W. Mull, above note 66, p. 507.

95 ICRC Commentary on GC IV, above note 3, Art. 19, para. 1853.

96 M. Sassòli, above note 24, p. 378, para. 8.306; G. Gaggioli and G. Dvaladze, above note 86, p. 500; Y. Dinstein, above note 90, p. 150.

97 ICRC Commentary on GC IV, above note 3, Art. 18, para. 1835, and Art. 19, para. 1848.

98 *Ibid.*

99 Pictet Commentary on GC I, above note 32, Art. 21, p. 201.

100 *Ibid.*; P. De Waard and J. Tarrant, above note 46, p. 175; R. Kolb and F. Nakashima, above note 5, p. 1180.

101 A. Breitegger, above note 39, p. 111.

102 See the paragraph attached to above note 54.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

The last criterion through which an object can make an effective military contribution is use. Any civilian object can become a military objective under this criterion,[103] which refers to the current function of an object and is indifferent to the object's original nature, purpose or location.[104] AHTTE, by definition, also encompass scenarios in which a medical unit is used for military purposes. Having excluded the three other criteria, a medical unit can therefore only fall under both the definition of AHTTE and that of a military objective – the only set of circumstances in which an attack may be lawful – on account of its (mis-)use outside of its humanitarian function.

Finally, Article 52(2) of AP I adds the requirement that the contribution to military action be effective – that is, real and discernible, not merely theoretical or speculative.[105] One way to assess this element is to establish that "an object that was earlier identified to be militarily significant … is actually used in a way that makes the required contribution".[106] If not, the effectiveness criterion is not met. For example, a fortress which, by its nature, could contribute to military action no longer does so effectively if it has been converted into a museum. The relevance of effectiveness is, however, limited in the case of medical units. Because it is only through its use that a medical facility can both fulfil the first prong of the definition of a military objective and be liable to lose its special protection due to AHTTE, if those two criteria are met, the identified facility will be used in a way that makes the required contribution. Still, the effectiveness requirement will not be fulfilled if the contribution in question remains theoretical or speculative.[107]

Definite military advantage obtained through total or partial destruction, capture or neutralization, in the circumstances ruling at the time

The second limb of Article 52(2) of AP I requires that, for an object to qualify as a military objective, its total or partial destruction, capture or neutralization must offer, at the time of the attack, a definite military advantage. An advantage may be understood as "everything which facilitates military operations",[108] but to qualify as military, it must involve "a clear belligerent nexus or other connection to ongoing or planned military operations in a specific armed conflict".[109] The benefit cannot be solely political, psychological, economic or otherwise non-military in nature.[110] The term "definite" further requires that the advantage be clearly defined, rather than

103 A. Bellal and S. Casey-Maslen, above note 2, p. 117; G. Gaggioli and G. Dvaladze, above note 86, p. 501.
104 Y. Dinstein, above note 90, p. 149; A. Jachec-Neale, above note 85, p. 65.
105 A. Jachec-Neale, above note 85, p. 83.
106 *Ibid.*, p. 84.
107 See the following section, "Are Hospital Shields Military Objectives?"
108 R. Kolb, above note 86, p. 184.
109 A. Jachec-Neale, above note 85, pp. 117, 126.
110 G. Gaggioli and G. Dvaladze, above note 86, p. 502; R. Kolb, above note 86, p. 184; A. Jachec-Neale, above note 85, pp. 117, 126.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

vague, general, potential or indeterminate.[111] Finally, the reference to "the circumstances ruling at the time" anchors the assessment of the advantage to the moment of the attack.[112]

The definite military advantage requirement is cumulative with that of an effective contribution to military action.[113] This narrows the scope of the definition of a military objective, as "a much wider pool of objects would be effectively contributing to the defender's military action, but only some of them might offer a real military advantage in concrete circumstances".[114] There can therefore be circumstances where a medical object is used for AHTTE and thereby contributes effectively to military action, but still fails to fulfil the second criterion of Article 52(2).

By definition, AHTTE involve a military nexus and, admittedly, bringing an end to AHTTE will often produce a definite military advantage. This may, however, not always be the case: if an attack is not "necessary in order to reach a permissible operative goal",[115] there would be no advantage. Consider a medical outpost located far from active hostilities, used to conceal a cache of outdated communications equipment belonging to an armed group. Intelligence confirms the equipment is passive, not in use, and unrelated to current or planned operations. Although the concealment may constitute AHTTE, the destruction of this equipment would yield no military advantage in those circumstances.

The ICRC Commentary on Article 34 of Geneva Convention II offers another example. It refers to AHTTE as including "the interrogation of enemy prisoners of war on board hospital ships, when the said interrogation seeks to acquire information beyond what they are required to disclose on the basis of Article 17 of the Third Convention".[116] By analogy, if prisoners are interrogated in a military hospital beyond these limits, the facility may be regarded as being used for AHTTE.[117] However, such misconduct would not necessarily entail the existence of a military advantage to be gained from an attack on the medical unit. Such an advantage would indeed depend on the concrete circumstances at hand – for example, the importance of the prisoners concerned, the value of the information they possess, or their capacity to re-engage in hostilities after their liberation. The existence of AHTTE does not, therefore, predetermine the outcome of the separate assessment required to establish whether an attack on a medical unit having lost its special protection would yield a military advantage.

111 ICRC Commentary on AP I, above note 26, Art. 52, para. 2024; A. Jachec-Neale, above note 85, p. 124.

112 R. Kolb, above note 86, p. 185.

113 ICRC Commentary on AP I, above note 26, Art. 52, para. 2018.

114 A. Jachec-Neale, above note 85, pp. 115–116.

115 Stefan Oeter, "Methods of Combat", in Dieter Fleck (ed.), *The Handbook of International Humanitarian Law*, 4th ed., Oxford University Press, Oxford, 2021, p. 179.

116 ICRC, *Commentary on the Second Geneva Convention: Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea*, 2nd ed., Geneva, 2017, Art. 34, para. 2375.

117 R. Kolb and F. Nakashima, above note 5, p. 1187.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

Overly distant, highly indirect or speculative advantages are also excluded through the definiteness requirement.[118] Intelligence plays a central role in this assessment: as noted in the literature, "speculation regarding the advantage may be connected to the issue of the credibility, volume and relevancy of the information on which the decision is made",[119] and "[t]hose ordering or executing the attack must have sufficient information available to take [the definiteness] requirement into account".[120]

Consider, for example, a situation in which a party to the conflict confirms the presence of communications equipment in the basement of a functioning medical facility in an area controlled by its opponents. Intelligence indicates that similar materiel was used in a previous conflict by the same adversary to coordinate front-line operations from underground locations. On this basis, the attacking party suspects that the basement is currently being used as an operational liaison centre.[121] However, no additional evidence confirming its current use is available, and the same communication equipment is also often used by medical facilities. In this situation, the expected military advantage of destroying the basement remains speculative and therefore not definite.

Lastly, the temporal clause "in the circumstances ruling at the time" further restricts the qualification of an object as a military objective.[122] It ensures that the required military advantage must exist at the moment of the attack, highlighting that "military objectives do not exist once and for all".[123] However, this requirement has limited implications in the case of medical units. As discussed, a medical unit can only become liable to attack through its use for military purposes, and this necessarily already reflects the circumstances prevailing at a specific point in time. If the use – i.e., the AHTTE – has ceased, the condition of effective contribution to military action is necessarily no longer fulfilled and the unit cannot be considered a military objective.[124]

This connects to the unresolved question of the duration of the loss of special protection. According to the ICRC Commentaries on GC I and GC IV, no definitive conclusions can be drawn regarding the permanent or temporary character of this loss[125] – although the Commentaries present several arguments supporting a temporary effect.[126] Considering both possibilities, if special protection

118 A. Jachec-Neale, above note 85, p. 126; R. Kolb, above note 86, p. 185.

119 A. Jachec-Neale, above note 85, p. 126.

120 ICRC Commentary on AP I, above note 26, Art. 52, para. 2024.

121 Such conduct would definitely qualify as AHTTE: see ICRC Commentary on GC IV, above note 3, Art. 19, para. 1847.

122 A. Jachec-Neale, above note 85, p. 145.

123 R. Kolb, above note 86, p. 185.

124 R. Kolb and F. Nakashima, above note 5, p. 1183.

125 ICC Commentary on GC I, above note 15, Art. 21, para. 1856; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1862.

126 ICRC Commentary on GC I, above note 15, Art. 21, paras 1856–1857; ICRC Commentary on GC IV, above note 3, Art. 19, para. 1862. For further support for the temporary character of the loss of protection, see N. W. Mull, above note 66, pp. 507–511.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

returns automatically and immediately upon cessation of the misuse, then the temporal clause under Article 52(2) of AP I serves a parallel but redundant function: both the special and general protection return as soon as the AHTTE end, and both prevent direct attack. Conversely, if special protection is not immediately restored – or if repeated acts of misuse are deemed to extinguish protection definitively – the temporal requirement plays a role in limiting direct targeting. Even if a medical unit had lost its special protection from previous AHTTE, the attacker would still need to determine that, at the time of attack, the unit is being misused in a way that makes it a military objective under Article 52(2).[127]

Are hospital shields military objectives?

As discussed above, the deliberate positioning of a medical unit in the vicinity of a military objective in order to deter attacks against it amounts to AHTTE. The question remains whether such conduct also transforms the medical unit into a military objective. Applying the two prongs of Article 52(2) of AP I leads to a negative answer.

With regards to the first prong, the medical unit does not make an effective contribution to military action: the proximity between a medical unit and a military objective does not increase the adversary's firepower, protection, mobility or intelligence, nor does it degrade the attacker's capabilities.[128] Any contribution lies solely in the legal effect of the unit's presence, insofar as it may alter the proportionality assessment of a strike on the adjacent military objective by "increasing the probability that the expected incidental harm would have to be regarded as excessive in relation to the anticipated military advantage".[129] This has no "adverse impact on the capacity of the attacker to identify and destroy the shielded military objective".[130]

The alleged military contribution of the medical unit is therefore contingent on the legal appraisal of a future targeting decision and could even vanish entirely if the attack on the military objective can be conducted in a way that avoids excessive harm. For that reason, the contribution is indirect and speculative and does not meet the threshold of an "effective" contribution to military action under Article 52(2) of AP I.

Concerning the second prong, even assuming, for the sake of argument, that an effective contribution exists, the military advantage sought – namely, the removal of the medical unit so that it no longer affects the proportionality assessment – would

127 ICRC Commentary on GC I, above note 15, Art. 21, para. 1857; ICRC Commentary on GC IV, above note 3, Art. 18, para. 1836.

128 This does not apply to cases where the medical unit harbours or hides a legitimate target and becomes a physical obstacle for a strike on that target, but such conduct would be better described, as previously noted, as misuse through repurposing, and not shielding (see above note 58: "Whereas shielding deters attack by altering the legal parameters of the targeting decision without changing the unit's function, repurposing involves an alteration of that function, often through physical change – for example, use as weapons or ammunition storage, or as a command or observation post").

129 Nils Melzer, *Interpretive Guidance on the Notion of Direct Participation in Hostilities under International Humanitarian Law*, ICRC, Geneva, 2009, p. 57.

130 *Ibid.*

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

not be definite. The same considerations that render the contribution indirect and speculative apply equally to the advantage, which therefore fails the definiteness test.

Furthermore, that advantage could not be obtained through the destruction of the medical unit. Accepting the contrary would entail that, because the inclusion of the medical facility in the proportionality assessment may preclude an attack on a nearby objective, the facility could be destroyed solely to remove that legal constraint.[131] As noted by Mull, "[t]his is, of course, an absurd result".[132]

Finally, and in any case, treating a medical unit used to shield a military objective as a military objective itself is self-defeating. To paraphrase the literature on human shields, if such an assertion were indeed valid,

> the presence of [a hospital shield] would not have any legal impact on the ability of the enemy to attack the shielded objective, and an [object] that does not impact the enemy cannot possibly be classified as a [military objective].[133]

Conclusion

This article has endeavoured to demonstrate that medical units may, in certain circumstances, lose their special protection without simultaneously becoming lawful targets. It first examined the legal implications of such a scenario, concluding that adverse parties may in that case adopt non-violent measures to terminate the misuse of medical units, provided these measures are proportionate and do not endanger the wounded and sick or the medical personnel. The main condition for the loss of special protection – AHTTE – was then analyzed and applied to the case of hospital shields, emphasizing that AHTTE presupposes an active use of the medical unit itself.

The article then assessed whether AHTTE necessarily satisfy the cumulative conditions of Article 52(2) of AP I. It was concluded that this is not always the case: AHTTE may involve forms of contribution to military action that remain too indirect to meet the required threshold, or may fail to provide a definite military advantage at the time of the attack. These gaps are particularly evident in situations where both the contribution and the expected advantage are speculative or are only caused by legal effects. The case of active hospital shields illustrated these limitations.

It must be recalled that this article has focused solely on the preliminary question of whether a medical unit used for AHTTE meets the criteria to be considered a military objective. This is only the first step in determining the lawfulness

131 N. W. Mull, above note 66, p. 506.
132 *Ibid*.
133 M. Sassòli, above note 24, p. 400, para. 8.358.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press

of an attack – other applicable rules on the conduct of hostilities, in particular those governing proportionality and precautions in attack, remain fully applicable.[134]

In that regard, a further constraint lies in determining which specific part of the unit has been transformed into a military objective. Such a determination should be made narrowly, focusing on the part of the unit that is indeed used for military purposes.[135] As has been noted elsewhere, "a medical service cannot be automatically considered as a single military objective",[136] especially since hospitals often consist of several buildings serving different functions. The delimitation of military objects should thus follow the physical contours of those separate structures of the hospital.[137] This view finds support in the case law of the International Criminal Tribunal for the former Yugoslavia (ICTY),[138] which has held that even where a hospital becomes a lawful military target, the attack "must be aimed at the military objects in or around the facility".[139]

Finally, a good-faith proportionality assessment will often preclude an attack on a medical unit even if the medical unit has become a military objective and has lost its special protection.[140] Indeed, given that there would be no justification for the damage to and destruction of the civilian objects that are medical equipment and furniture,[141] and considering the presence of protected persons in the hospital[142] as well as the reverberating effects of such an attack, "the expected civilian losses will generally outweigh the concrete and direct military advantage anticipated from the attack".[143] However, because "this may be more an operational than a legal matter",[144] it remains crucial to reiterate that not all AHTTE involving medical units or transports justify a direct attack under IHL.

134 ICRC Commentary on GC IV, above note 3, Art. 18, para. 1836; ICRC, *Global Initiative*, above note 26, p. 40; A. Clapham, above note 24, p. 400; M. Sassòli, above note 24, p. 264, para. 8.029; T. Haeck, above note 18, p. 847, para. 31; A. Breitegger, above note 39, p. 113.

135 ICRC, *Global Initiative*, above note 26, p. 42; R. Kolb and F. Nakashima, above note 5, p. 1198.

136 R. Kolb and F. Nakashima, above note 5, p. 1196.

137 ICRC, *Global Initiative*, above note 26, p. 42.

138 R. Kolb and F. Nakashima, above note 5, p. 1196.

139 ICTY, *Prosecutor v. Stanislav Galić*, Case No. IT-98-29-A, Judgment (Appeals Chamber), 30 November 2006, para. 346.

140 T. Haeck, above note 18, p. 847, para. 31; ICRC, *Global Initiative*, above note 26, p. 43.

141 *Report of the Commission of Inquiry on Lebanon Pursuant to Human Rights Council Resolution S-2/1*, UN Doc. A/HRC/3/2, 23 November 2006, p. 43, para. 167.

142 ICRC, *Global Initiative*, above note 26, p. 43.

143 *Ibid.*

144 T. Haeck, above note 18, p. 847, para. 31.

https://doi.org/10.1017/S1816383126101052 Published online by Cambridge University Press