

THE PROTECTION OF MEDICAL UNITS UNDER THE
GENEVA CONVENTIONS IN THE CONTEMPORARY
OPERATING ENVIRONMENT

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General Studies

by

MICHAEL SEAN SMITH, MAJ, U.S. ARMY
B.S., Lincoln University, Jefferson City, Missouri, 1996

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Name of Candidate: MAJ MICHAEL S. SMITH

Thesis Title: THE PROTECTION OF MEDICAL UNITS UNDER THE GENEVA
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ENVIRONMENT

Approved by:

_____, Thesis Committee Chair
Theodore Shadid, M.P.A.

_____, Member
Russell Thaden, M.M.A.S.

_____, Member
LTC Luis O. Rodriguez, J.D., LL.M.

Accepted this 12th day of February 2009 by:

_____, Director, Graduate Degree Programs
Robert F. Baumann, Ph.D.

The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

THE PROTECTION OF MEDICAL UNITS UNDER THE GENEVA CONVENTIONS IN THE CONTEMPORARY OPERATING ENVIRONMENT, by Michael S. Smith, MAJ, U.S. Army, 96 pages.

The Geneva Conventions, along with its Additional Protocols, represent the fundamental documents on which the Law of Armed Conflict (LOAC) is established. Originally established under the premise of conventional warfare, these documents have also been the cornerstone for U.S. Army doctrine in providing direction to its forces in adherence to the LOAC. Currently, the Global War on Terror (GWOT) has put many of the medical units in a dilemma; trying to care for the wounded in combat while, at the same time, attempting to provide adequate force protection for themselves, their patients and their missions essential assets.

To mitigate this, AMEDD units mostly depend on other units to meet theater directed force protection requirements, especially in the areas of base defense and security escorts. This dependency has many drawbacks. For example, medical ground evacuation missions are often delayed due to the medical elements having to wait for adequate security escorts. In addition, there are other downsides to this dependency for external security, such as synchronizing communications and battle drills, and utilizing standard operating procedures, which is difficult to do with elements from different organizations.

The intent of this thesis is to explore the possibility that the treaties of the Geneva Conventions, and/or the corresponding subordinate layers of policies from U.S. governmental agencies and the U.S. Army, may be outdated and/or over-restrictive with regards to warfare as it is being conducted on today's modern battlefield, the Contemporary Operating Environment (COE). Specifically, this thesis will explore the possibility of allowing medical units to maintain and employ weapons of increased capability, such as machine guns and crew-served weapons, and the conditions and limitations under which such weapons would be utilized.

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ACRONYMS

AIT	Advanced Individual Training
AMEDD	Army Medical Department
AMEDDC&S	AMEDD Center and School
AR	Army Regulation
CCC	Captain's Career Course
COE	Contemporary Operating Environment
DoD	Department of Defense
DoS	Department of State
FCS	Future Combat Systems
FM	Field Manual
FOB	Forward Operating Base
GWS	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed forces in the Field
GWOT	Global War on Terror
HAGA	Heavy Armored Ground Ambulance
HQDA	Headquarters, Department of the Army
JAG	Judge Advocate General
JP	Joint Publication
LOAC	Law of Armed Conflict
MEV	Medical Evacuation Vehicle
MRAP	Mine Resistant Ambush Protection
MNC-I	Multi-National Corps – Iraq
MOUT	Military Operations on Urban Terrain

NATO	National Alliance Treaty Organization
OBC	Officer Basic Course
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OSJA	Office of the Staff Judge Advocate
OTJAG	Office of the Judge Advocate General
TJAGLCS	OTJAG Legal Center and School
OTSG	Office of the Surgeon General
STANAG	Standard NATO Agreement
UN	United Nations
U.S.	United States

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CHAPTER 1

INTRODUCTION

We are engaged in a new type of warfare with a new type of enemy who does not play by the rules of civilized societies and who will exploit any real or perceived weakness to gain publicity, instill terror and advance his political agenda.

—Major General Russell J. Czerw
Commander, Army Medical Department Center and School

Introduction

In 1859, the French Army battled the Austrian Army in the Battle of Solferino, Italy. Henry Dunant, a Swiss business man, had traveled to Solferino in hopes of obtaining a business loan from Napoleon III and he witnessed the aftermath of the battle. Dunant was horrified by what he saw. Some thirty-eight thousand casualties, injured and dead, remained on the battlefield with little attempt by either side to provide care for them. As a result, Dunant wrote a book, published in 1861, entitled *A Memory of Solferino*, in which he recounted the events he had witnessed and proposed, among other things, that non combatant groups should be given protected status in order to care for the wounded and that a conference be held in which nations could reach agreement on such matters. Dunant's suggestions were widely accepted, gained momentum across Europe in the coming years and came to fruition in 1863, when the "Committee of Five" met in Geneva, Switzerland, where high-ranking delegates from five nations met with human rights experts to discuss Dunant's proposals (Cavaleri 2005, 34). The results of this meeting were the creation of the Red Cross Society, in 1863, and the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, in 1864, which was ratified by sixteen nations.

Since this inception of the Geneva Conventions, there have been numerous follow-on meetings and conventions which have resulted in four Geneva Conventions and three Additional Protocols to the Conventions, which total 429 articles designed to establish standards for international law for humanitarian concerns. Currently, the four Geneva Conventions have been ratified by 194 countries (American National Red Cross 2001, sheet 19).

Under the Geneva Conventions, all personnel assigned to the Army Medical Department (AMEDD) are considered “protected personnel.” U.S. Army Field Manual 4-02, dated February 2003, gives the following guidance to AMEDD personnel under protected status. They are:

authorized to be armed with only individual small arms . . . that these small arms consist of pistols or rifles, or authorized substitutes. These small arms may only be used for defensive purposes. The presence of machine guns, grenade launchers, booby traps, hand grenades, light antitank weapons, or mines in or around a medical unit would seriously jeopardize its entitlement to protected status under the Geneva Convention for the Amelioration of the Conditions of the Wounded and Sick in Armed Forces in the Field. The deliberate arming of a medical unit with such items could cause the medical unit to lose its protected status under the Conventions. If the local non-AMEDD commander situates a medical unit where enemy attacks may imperil its safety, then that commander should provide adequate protection for the medical unit and its personnel.

The Geneva Conventions were created under the premise of conflict between two or more nation states. In environments consisting of unconventional warfare, such as the current environments in Iraq and Afghanistan in the United States’ Global War on Terror (GWOT), the enemy does not belong to a nation state, is not easily identifiable and will often times not adhere to the Law of Armed Conflict (LOAC) and the guidelines of the Geneva Conventions. AMEDD and other “protected” elements on the battlefield often find themselves being specifically targeted because they are viewed as “soft targets.”

Presently, there are no weapon systems above the M4 rifle allowed in an AMEDD unit. This presents AMEDD personnel with a dilemma--how do you provide adequate protection for your personnel, equipment and patients against a formidable enemy who does not adhere to the LOAC, when you only have the capability of small arms?

Currently, AMEDD assets, such as Combat Support Hospitals, Brigade Support Medical Companies and Medical Brigades, find themselves depending on other units for force protection measures in the areas of base defense and convoy escort. This dependency has many drawbacks. An example of one such drawback is that medical missions are often delayed in transporting casualties due to the necessity of having to wait for adequate convoy security escorts. Another example occurs when the non-medical element assigned to provide security of the medical element receives a change of mission from its higher headquarters, the medical unit is then left temporarily unsecured while it scrambles to coordinate for another force to assist. There is also the issue that trying to coordinate communications, standard operating procedures (SOPs) and battle drills with these “temporary” security forces is difficult even under the best of circumstances.

The issue of what kinds of weapons are and are not authorized for medical units under the Geneva Conventions is not a new one. There is documented dialogue, between national and international leaders of all levels of authority, debating the real meaning and intent of the articles of the Geneva Conventions. Even today, dispute exists among senior leaders as to what the appropriate level of arming is for medical units while still conforming to the provisions of the Geneva Conventions (Weightman 2004).

The intent of this thesis is to explore the possibility that the policies from U.S. governmental agencies and the U.S. Army may need to be adjusted in protecting medical units in the changing nature of warfare in the COE. Specifically, the possibility of allowing AMEDD units to own and operate increased weapon types within their formations may be a viable option under the GWS. It may be possible to empower medical units to provide themselves with better force protection measures and still adhere to the spirit of the guidelines of the Geneva Conventions.

Structure

The main body of this thesis will be broken down into five chapters and the supporting sections will include a table of contents, a glossary, an appendix and a reference section.

Chapter 1 will provide an introduction to the thesis and some ancillary information regarding administrative data and supporting information on the thesis. Chapter 1 also provides current and historical context with regards to the Geneva Conventions and how they apply to the security of AMEDD elements operating in the current GWOT theaters. It will also provide information on the specific research questions that will be explored, along with facts, assumptions, limitations and delimitations that are relevant for this topic.

Chapter 2, Literature Review, will provide a review of relevant research and literature as it applies to this study. The chapter identifies the most current and important policies, facts and scholarly opinions on the topic and explores how they affect what medical units can and cannot do, both legally and morally, when conducting their military mission.

Chapter 3, Methodology, will describe the qualitative content analysis methodology used to examine the research products obtained. The research investigated three elements to obtain research products. First, the research will look for established policies and procedures at different echelons of national government and within the international community. Second, the research will focus on an historical analysis of the LOAC and the treaties of the Geneva Conventions' interpretation and implementation. Finally, examples of issues relating to the topic, both past and present, will be provided that examine how units have dealt with the topic in a war-time environment.

Chapter 4, Analysis, organizes and interprets the evidence produced in chapter 3 to answer the research questions. Chapter 4 brings together all aspects of the research data obtained, analyzes it and provides a comprehensive answer to the research questions.

Lastly, chapter 5 will contain the conclusions and recommendations that emerge from the analysis. The ultimate goal of chapter 5 is to present a sound course of action to advise medical units in balancing the constraints of the Geneva Convention and its implementing policy with providing adequate force protection to both themselves and their patients.

Primary Research Question

Are the constraints placed on how medical personnel can protect themselves and their patients under the Geneva Conventions still relevant, and are they being applied appropriately by the DoD and/or the U.S. Army in the Contemporary Operating Environment (COE)?

Secondary Research Questions

To further investigate the primary research question, the following secondary questions will need to be addressed:

1. How are the provisions of the Geneva Conventions transformed into doctrine, policy, and authorization documents?
2. What are the specific provisions prescribed for the protection of medical units under the Geneva Convention?
3. Has the Department of Defense (DoD) and/or the U.S. Army imposed any additional and or different constraints on medical units with regards to the Geneva Convention?
4. Are there any constraints set forth in the Geneva Conventions, or any of the resulting DoD, Army, or AMEDD policies, which are irrelevant, overly restrictive or ill applied in the COE?
5. In the COE, today's modern battlefield, has the prevalence of deliberate attacks on protected elements, such as medical assets, increased?
6. What challenges are units having with the constraints placed on them under the Geneva Conventions and U.S. Army policy?
7. How are medical units responding to attacks on them in the current COE?
8. What are some potential solutions to updating the Geneva Conventions or subordinate policies and or force structure in order to afford better protection to medical assets on the COE battlefield?

Assumptions

The following assumptions are seen as being valid for this thesis:

1. Unconventional warfare in the COE will be the predominant type of conflict that the United States will be engaged in the foreseeable future.
2. Unconventional enemy forces will continue to target and attack “soft” targets on a 360 degree battlefield (non-linear), as their method of conducting operations on an asymmetrical battlefield.
3. The United States will continue to support, and be a signatory of, the Geneva Conventions and the LOAC for the foreseeable future.

Limitations

The first limitation in this thesis will be that the examination of the topic will be limited to that of ground medical units. Another area of limitation for this thesis will be that it will focus only on the aspect of what types of weapons AMEDD assets are authorized and how they may be employed within the guidelines of the Geneva Conventions and subsequent United States policy and doctrine.

Finally, while I am excited about exploring this subject area, I acknowledge that I will need to guard against my own biases and opinions when it comes to conducting the research and analyzing the findings.

Delimitations

Although aero-medical evacuation assets fall under generally the same guidelines of the Geneva Conventions as ground components do, there are some specific differences that we will not discuss in this thesis. Another delimitation is that other, currently more

popular, subject areas within the Geneva Conventions, such as the treatment of prisoners of war and providing care to enemy and civilian casualties will not be explored in this document. Also, classified information and documents are not included in this research.

Significance of Study

Based on the premise that the United States has no current peer threat, potential adversaries will avoid a toe-to-toe fight in open terrain. Future operations will therefore consist of a complex mix of offensive, defensive, and stability missions against an irregular enemy who rarely adheres to the Law of Armed Conflict. Evidence shows that the AMEDD is not only struggling with this issue currently, but has grappled with it throughout the past as well. Conclusions drawn from this study are provided to assist in developing better ways to cope with this dilemma. If it is found that the Geneva Conventions are indeed too restrictive with regards to medical elements being able to adequately defend themselves against the current enemy tactics in the COE, senior leaders at the policy-making level may consider updating the U.S. policies as they pertain to the Geneva Conventions. If it is found that those policies are still appropriate, then the result might be to update the Army's current policies of how to apply those guidelines more suitably. Regardless of outcome, a better understanding of the policies and documents and how they relate to non-state enemy actors in irregular warfare would be of great benefit to the Army community.

CHAPTER 2

LITERATURE REVIEW

Would it not be possible to found and organize, in all civilized countries, permanent societies of volunteers which in time of war would render succor to the wounded without distinction of nationality?

—Henry Dunant
Founder of the Red Cross Society, 1863

In chapter 1, an overview was given on this thesis project, which gave a synopsis of why this topic was chosen, what this thesis will cover, and how this thesis will be structured. Chapter 1 also gave a brief historical introduction to the Geneva Conventions, of which chapter 2 will expound on. The purpose of chapter 2 is to compile the literature used throughout this project and organize it so that readers can easily grasp how research data was obtained and provide a historical context for the analysis.

There was ample material to get a thorough understanding of both the fundamentals and specifics of the Geneva Conventions and how the military has incorporated those guidelines into its doctrine. Chapter 2 is organized in four categories:

1. history of the Geneva Conventions and associated documents
2. standard policies, doctrine and other official documents
3. professional opinion on the issue
4. data collected from a survey

History of the Geneva Conventions

The documents of the Geneva Conventions and the associated additional Protocols will serve as the foundational documents of this research project. They include the four treaties of the Geneva Conventions, which were updated in 1949, and the three

Additional Protocols that have been added since then. The introduction section in chapter 1 told the story of how Henry Dunant organized the initial convening of the first Geneva Conventions in 1863, and how that led to the creation of the International Red Cross and the first treaties of International Humanitarian Law (IHL). The following paragraphs will build upon that historical journey and also detail some basic principles of the treaties of the Geneva Conventions.

The Geneva Conventions fall under the Law of Armed Conflict (LOAC), which is basically derived from two sources: official treaties and customs (FM 4-02 2003, 4-1). Examples of the treaties include the Geneva and Hague Conventions and results from legal actions, such as the Nuremberg War Trials and the International Criminal Tribunal for the former Yugoslavia. Customs represent those principles which have not been incorporated in any treaty or convention but are firmly established by the custom of nations and well defined by recognized authorities on international law (Cavaleri 2005, 11).

The Geneva Conventions consist of four treaties: the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in Field (GWS); the Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked Members of the Armed Forces at Sea (GWS Sea); the Geneva Convention Relative to the Treatment of Prisoners of War (GPW); and the Geneva Convention Relative to the Protection of Civilian Persons in Time of War (GC) (International Committee of the Red Cross 2006). Additionally, there have been three additional protocols added, the first two in 1977 and the last one in 2005. Protocol I addresses international conflicts, the Protocol II addresses non-international conflicts and

Protocol III addresses additional distinctive emblems. Most pertinent to the topic of this thesis is the GWS and Protocol I, which specifically address the status and protection of medical personnel, their patients and military units during armed conflict.

The International Committee of the Red Cross (ICRC), founded in 1863, acts as the custodian of the Geneva Conventions. The ICRC is a private Swiss institution and acts as a neutral party in matters of human suffering related to, among other things, international conflicts. Headquartered in Geneva, Switzerland, it comprises over 600 employees to run the headquarters, and another several thousand field workers who operate world-wide. Also, there are two primary sub-branches to the ICRC, the International Federation of Red Cross and Red Crescent Society, which oversee several regions around the world, and the Red Cross and Red Crescent National Society, which comprise more than 180 agencies that represent their respective nations and are organized under regional Federations. When referring to the ICRC, the Federations and the National Societies as a whole, the term International Red Cross and Red Crescent Movement is used (American Red Cross 2006, 6).

Official U.S. Documents and Policies

This section will focus on the second category of research information obtained, the important documents which make up U.S. and subsequent agencies' policies. From the Geneva Conventions, the United States developed DoD Directive 2311.01E, entitled *DoD Law of War Program*, which provides guidance to the subordinate organizations within the DoD in adhering to the Geneva Conventions. Subordinate to the DoD, the Joint Chiefs of Staff (JCS) have produced several Chairman of the Joint Chiefs of Staff Instructions (CJSIs), which provide subordinate elements with directives and guidance on

carrying out specific programs. The JCS also produces field manuals, called Joint Publications (JP), which provide general guidelines on standard practices and procedures. One such manual pertaining to this thesis topic is JP 4-02, titled *Health Service Support*, which contains its own appendix dedicated to conducting medical operations in accordance with the Geneva Conventions. U.S. Army policy makers use these documents to produce their own internal manuals and regulations.

U.S. Army policy pertaining to the Geneva Conventions originates from two sources, the Office of the Judge Advocate General (OTJAG) and the Office of the Surgeon General (OTSG), who also serves as the Medical Command (MEDCOM) Commander. There are several fundamental documents that serve as the cornerstones for Army doctrine and policy with regards to the LOAC and the Geneva Conventions. AR 27-53, which focuses on the legality of weapons under international law, is one of the long standing documents used in this process. As part of the AR 27-53 process, OTJAG reviews proposed weapon systems and their intended use for compliance with the LOAC, which includes the treaties of the Geneva Conventions and Hague Regulations. The AR 71-32 is another important document regarding weapons authorizations. It prescribes policies and responsibilities for the development, documentation, authorization and approval for organizational documents for Army personnel and equipment authorizations. FM 27-10, *The Law of Land Warfare*, serves as a handbook for DA PAM 27-1, *Treaties Governing Land Warfare*, and contains important elements of international law documents, such as the Hague Regulations and Geneva Conventions, so that leaders can reference specific elements of those documents in an abridged format. The AMEDD has produced numerous FMs and handbooks that provide guidance on the Geneva

Conventions and the Law of War, but perhaps the most comprehensive is FM 4-02, *Force Health Protection in a Global Environment*, which has an entire chapter devoted to the effects of the law of land warfare on delivering medical care on the battlefield.

Professional Opinion and Debate

The third area of concentration for literature found is historical memorandums and letters that show dialogue between senior leaders on this issue. Dating as far back as 1976, the senior leaders of the AMEDD have drafted several memos and letters to each other regarding the protecting of AMEDD units during conflicts. There is correspondence between President Reagan, the Joint Chiefs of Staff and the Senate debating whether or not to ratify Additional Protocols I and II of the Geneva Conventions based on the unconventional enemy. More recently, the debate over whether to arm the new Heavy Armored Ground Ambulance (HAGA), with a machine gun has sparked correspondence at the highest levels of Army leadership. The HAGA is the medical variant to the Mine Resistant Ambush Protected (MRAP) family of vehicles, which the Army has recently begun fielding in theaters such as Operation Iraqi Freedom (OIF) and Operations Enduring Freedom (OEF) (GlobalSecurity.org 2008).

AMEDD Force Protection Survey

The final category of information collected while conducting this research project is the results of a survey of Army medical professionals who have led AMEDD elements in deployed theaters of the GWOT. It was difficult to find real world examples of how medical units dealt with protecting themselves within the confines of Geneva Conventions against an unconventional threat in previous conflicts. There are, however,

numerous examples of recent events, specifically from OIF and OEF, of medical units that were specifically targeted and attacked in the COE. As a result, I designed a survey under the supervision of the CGSC Quality Control office and sent it to AMEDD leaders who have been involved in such action. Through the survey, I was also able to solicit general experiences, trends and numerous recommended solutions to the primary thesis question, which will be further explored in chapters 4 and 5. Please refer to Appendix A for a more detailed explanation of the survey. The data collected from the survey will be analyzed in chapter 4 of this thesis.

CHAPTER 3

RESEARCH METHODOLOGY

Today's military conflicts are substantially wars of ideas, played in words or images. Our leaders preach this, our enemies confirm it. For better or worse, U.S. forces and policy makers are held to an extraordinary standard for adherence to international law, regardless of the threat and illegal tactics we face.

—Office of the Staff Judge Advocate
Multi-National Corps-Iraq

The purpose of this thesis is to establish as much clear interpretation where possible of the provisions of the Geneva Conventions and then answer the question of what are the appropriate capabilities and authorities that should be provided to medical units and personnel so that they can best protect themselves and their patients against an unconventional enemy threat in conformity with the Geneva Conventions and the LOAC. The debate over this topic is not a new one, and has been addressed and revisited numerous times throughout the years. The problem seems to lie in the fact that the issue is not easily definable, because much of the answer lies in the interpretation of the treaties of the Geneva Conventions and the accompanying commentaries.

In chapter 2, the resources used for this thesis were discussed. Four major areas of effort were involved in the research:

1. history of the Geneva Conventions and its associated documents
2. standard policies, doctrine and other official documents
3. professional opinion on the issue
4. data collected from a survey

Chapter 3 explains the research methods used to acquire pertinent information on the subject and how that information was assembled and analyzed in order to answer the research questions. The primary methodology used to examine this thesis was qualitative; however, there will be a small percentage of quantitative research conducted as well. Qualitative research focuses on the “why” and “how” of a topic area. It is not concerned with facts and figures, but rather, attempts to explain the reasons behind a specific issue. This is different than quantitative research, in which data, such as facts and figures, are gathered, computed and analyzed in order to evaluate factors which can be measured.

Qualitative research began with a detailed investigation of professional literature and official documents pertaining to the subject area, including a comprehensive search through the Combined Arms Research Library at Fort Leavenworth, Kansas, which maintains over two million documents and books locally and has access to an extensive array of professional external databases worldwide. Assisted by the research technicians, I identified previous literature on the research topic. Key words and phrases used for this search were: “Geneva Conventions,” “protection of medical,” “defense or defending medical,” “attack(s) on medical,” “targeting of medical,” “weapon(s) allowed or authorized in medical units,” and “crew-served weapon and medical.” This search provided a good foundation of historical documents, such as the treaties of the Geneva Conventions themselves and other Law of War related international policies. It also provided some professional literature, in the form of journal articles, speeches and even a previous MMAS thesis, which added to laying the foundation of understanding what already exists pertaining to the subject area. The commentaries to the Geneva

Conventions, as well as the actual treaties, proved to be a great use in determining what the convention members' intent was in deciding on the language used throughout the documents.

The next step was to seek out assistance from official organizations that govern this topic area for the U.S. Army. The primary sources for this search included the AMEDD CALL, the AMEDD Center and School (AMEDDC&S), the DA OTSG and the DA OTJAG. The author contacted these offices directly, either by a personal visit or email correspondence, and requested information pertaining to the primary and secondary research questions. At each of the above offices, the author was able to dialogue directly with the subject matter expert in the topic areas of this thesis.

This effort proved to be extremely helpful in obtaining relevant information, including numerous memorandums, letters and other historical documents that provided valuable insight on how senior leaders at multiple levels - military, civilian, political and international - interpreted the problems associated with protecting medical units in accordance with the Geneva Conventions. These documents spanned from 1976 to the present and helped to show how long-standing the debate over this issue is. Also, I was able to personally talk to the subject matter experts on both the legal and medical sides of the house on this topic. By doing this, I was able to tap into their extensive research on this topic, acquire their opinions on the issue and understand the process of how international agreements, such as the Geneva Conventions, get processed and staffed into subsequent national and governmental documents, and then transformed into military policy.

In an effort to add a quantitative aspect of this research, a survey was conducted aimed at two things:

1. to identify how often AMEDD leaders have experienced problems with protecting their personnel and their patients in the COE under the GWS
2. to identify what procedures they are implementing or would recommend implementing in order to provide increased protection to themselves, their medical unit and their patients

This survey was developed and approved through the Combined General Staff College's (CGSC) Quality Assurance Office and then distributed to the target participants. The sampling method used for the survey was "purposive," which means that the people chosen to be surveyed were those that were most likely to have pertinent information on the topic. In a typical AMEDD unit, the personnel most likely to struggle with the issue of force protection in accordance with the GWS are those in direct leadership positions, such as commanders and their NCO counterparts and leaders of staff surgeon sections. With this premise in mind, those AMEDD personnel who have served or are currently serving in those specified leadership positions were invited to complete the survey (Appendix A). In all, the survey was sent out to 239 prospective participants, of which 75 successfully completed the survey.

The survey was constructed by the CGSC's Quality Assurance Office, who then published it on a secure website belonging to CGSC. The participants were sent a personal email through the Army Knowledge Online website, which contains a secured email browser, inviting them to complete the survey. The email contained a link to the

website containing the survey, in which the participant would have to login with his/her username and password in order to be allowed access to the survey.

In chapter 4, all of the obtained information, described in chapter 3, will be consolidated and analyzed in order to answer the primary and secondary research questions. By combining both qualitative and quantitative research processes, the recommended solution to the problem of protecting medical units while maintaining adherence to the GWS and supporting U.S. policies will be both more comprehensive and sound.

CHAPTER 4

ANALYSIS

The realities of the modern battlefield, which place medical personnel and their patients at greater risk, necessitate a reexamination of the types of weapons authorized for use by medical units for their protection.

—Major General George Weightman
Commander, Army Medical Department Center and School

Introduction

The goal of this chapter is to utilize the information obtained through the research described in chapter 3 to answer the primary and secondary research questions. The overall purpose of this thesis is to examine if the restrictions placed on medical personnel in protecting themselves and their patients under the Geneva Conventions is being applied appropriately by the DoD and or the U.S. Army in the Contemporary Operating Environment (COE).

First, we will examine the answers to the secondary research questions. Then, we will analyze the results of the survey. Chapter 4 will conclude by combining the answers to the secondary research questions with the analysis from the survey, to explore the primary research question.

Secondary Research Question #1

How are the provisions of the Geneva Conventions transformed into doctrine, policy, and authorization documents?

To answer this question, the historical analysis of chapter 2 will be built upon. The focus is on how the international process works at the Geneva Conventions and how that process translates to U.S. policy.

Every four years, representatives from each component of the International Red Cross and Red Crescent Movement, along with representatives from each nation that is party to the Geneva Conventions, meet at the International Conference of the Red Cross and Red Crescent, in Geneva, Switzerland, to discuss issues of humanitarian concern (American Red Cross 2006, 11). As a result of these deliberations, certain resolutions may be proposed that the participants of the conference must decide whether or not to adopt as a whole. The representatives at the conference are given a prescribed time limit to take these proposed resolutions back to their respective nations and obtain a decision on whether or not that nation will support, whether whole-heartedly, or conditionally. The United States will typically send a representative of the President, usually an International Humanitarian Law (IHL) expert from the State Department, to accomplish this task at the conference (American Red Cross 2006, 11). This representative will take the resolution, treaty or other pertinent documents resulting from the conference, and forward it to the U.S. government executive branch to be reviewed. The DoD and DoS are two of the more important elements within the executive branch who will review the document. Once reviewed, it will be forwarded, along with recommendations, to the President for his review. After analyzing it, the President will forward it to the Senate for ratification, along with a document that explains his position on the resolution and any recommended changes. The Senate will then decide on ratification and will include documents that explain any required exceptions or further clarification, called “understandings” or “reservations” (Jackson 2008).

Once the documents, whether a treaty, resolution or protocol, are ratified by the U.S. government, the U.S., as a signatory to the Geneva conventions, takes on the

additional responsibility of ensuring that its constituents are aware of and act in compliance with the documents. This has to be done by each signatory because although the ICRC is the governing body of the Geneva Conventions, it has no power to enforce compliance. By signing the conventions, nations agree to enact their own internal laws in support of the Geneva Conventions. As an official signatory, the U.S. is responsible to build into its laws, regulations, and policies ways to insure compliance and adherence to those Geneva Conventions (American Red Cross 2006, 11).

In order to ensure compliance to the Geneva Conventions by all U.S. governmental agencies the U.S. government enacts laws and directives to all of its subordinate elements. After ratification by the Legislative branch, the Executive branch of the U.S. government enacts legal documents, such as updates to the U.S. Code, in which direction is given to all of the subordinate agencies of the U.S. government. Relevant to this topic, Title 18 of the U.S. Code specifically addresses war crimes and Title 10 of the U.S. Code provides directives for the Secretary of Defense in managing the military. In turn, the Secretary of Defense publishes guidance and rules in the form of DoD Directives. These directives establish policy, tasks and responsibility for each of the subordinate organizations within the DoD.

The Joint Chiefs of Staff, which serves as the governing authority for the military forces, are one such organization within the DoD which would receive the various directives, and staff them for analysis and processing. After staffing these DoD Directives, the Joint Chiefs of Staff publishes subsequent directives, called Chairman of the Joint Chiefs of Staff Instructions, or CJSIs, to each of the subordinate armed services branches. For the Army's part in this process, the Headquarters of the Department of the

Army (HQDA) will staff and analyze the CJSIs, and then subsequently publish guidance in the form of Army Regulations (ARs), Field Manuals (FMs), DA Pamphlets (DA PAM) and the like, which interpret the higher echelon's requirements into Army specific directives. Within the Army, several agencies can be called upon to have input into the staffing process before these documents are finalized.

With respect to the topic of the Geneva Convention, the Department of the Army relies heavily on the input from the Army Medical Department (AMEDD) and the Army Judge Advocate General (OTJAG). In most instances, HQDA delegates that these agencies serve as the proponent for various documents which address their respective subject areas. For example, the Army Medical Department Center and School (AMEDDC&S) is the proponent for all of the medical series of FMs (4-), while the proponent for the legal series of FMs (27-) is the Judge Advocate General's Legal Center and School (TJAGLCS).

In order to be provide more clarity to this process, the following details an example of how a recent DoD Directive was processed through the subordinate channels to ensure that the policies of the Geneva Conventions were captured and adhered to by the U.S. Army, and its subcomponents. In DoD Directive 2311.01E, dated May 9, 2006, the DoD established clear language pertaining to the Law of War Program, stating that "members of the DoD Components comply with the law of war during all armed conflicts, however such conflicts are characterized, and in all other military operations." Furthermore, the directive establishes responsibilities for various levels within the military, from the CJCS down to the combatant commanders in the field. To ensure compliance, the DoD Directive states that:

[the] Secretaries of the Military Departments shall develop internal policies and procedures consistent with this directive in support of the DoD Law of War Program [and that they shall] provide directives, publications, instructions and training so the principles and rules of the law of war will be known to members of their respective departments.

In order to accomplish this task, the Army turns to the Office of the Judge Advocate General (OTJAG) for Law of War Matters, which advises the Army's policy makers on how and what to capture in the various documents to ensure that the requirements of the Geneva Conventions are appropriately translated into policies and procedures (Jackson 2008). Additionally, Judge Advocates assigned to TRADOC and the Judge Advocate General's Legal Center and School (TJAGLCS) also assist in reviewing and producing doctrine, ensuring that pertinent aspects of the Geneva Conventions are incorporated into Army FMs, ARs, DA PAMs and other official documents (Jackson 2008).

The AMEDD assists with certain parts of this process as well. While the Office of the Surgeon General (OTSG) is ultimately responsible for AMEDD specific doctrine and policy, the task of researching and developing these documents is the AMEDD Center and School (AMEDDC&S), which serves as the proponent for establishing the policies and procedures for all medical personnel within the Army. By working in conjunction with the OTJAG, they have published numerous FMs, ARs and other documents that ensure AMEDD personnel conduct operations within the scope of the Geneva Conventions.

It is important to note that although these agencies, the OTJAG and the OTSG, serve as subject matters experts in matters of the Geneva Conventions and the Law of War, neither of them are authorized to make official changes to ARs, authorization

documents or the like, as these decision are reserved for official policy makers within Headquarters, Department of the Army (HQDA), which is the executive part of the Department of the Army at the seat of Government (Headquarters Department of the Army 2008). Another aspect of this process is that the AMEDD and the OTJAG must collaborate to produce certain documents. This is the case with many of the Law of War documents, particularly the ones that deal with the Geneva Conventions and medical operations within the LOAC.

Secondary Research Question #2

What are the specific provisions prescribed for the protection of medical units under the Geneva Convention?

To better answer this question, we will start by establishing what constitutes “protected” personnel. Article 24 of the Geneva Convention for the Amelioration of the Condition of the Sick and Wounded in Armed Forces in the Field (GWS) provides special protection for “medical personnel exclusively engaged in the search, collection, transport or treatment of the wounded or sick, or in the prevention of disease, and staff exclusively engaged in the administration of medical units and establishment.” The deciding factor in whether a person or a unit is considered “protected” or not under the Geneva Convention is a matter of that person being “exclusively engaged” in providing or assisting in the administration of medical care (FM 4-02 2003, 4-5). In the commentaries to the 1949 GWS, the plenary explained their understanding of the language “exclusively engaged” to mean all personnel permanently assigned to the medical unit, which includes not only the health care providers themselves, but also the administrators and support personnel (ICRC Commentaries 1949).

Despite the large number of nations and organizations (each with their own unique views and interests) involved with the development of the Geneva Conventions and its Protocols, definitive principles which have been agreed upon unanimously by all parties regarding the protection of medical personnel have remained constant throughout the Geneva Conventions' development. First, medical personnel are authorized to carry arms to defend themselves, their patients and their facilities. Second, that protected personnel are to use those weapons in a strictly defensive nature, and only against those that are acting in violation of the LOAC (Solf 1977). The GWS uses terms such as "marauders," "pillagers," and "bandits" to describe those personnel whom protected personnel might have to defend themselves against. Lastly, protected personnel cannot physically defend themselves from capture if the opposing force is acting within the LOAC. This is to say, that if an enemy force attempts to occupy the medical facility or detain medical personnel and they do so without violating the LOAC, the protected personnel may not resist (Solf 1977).

Even with these fundamental principles firmly established in the LOAC, one issue has remained a source of contention, the issue of what kinds of weapons "protected" personnel are authorized to maintain. From the deliberations of the Geneva Conventions of 1929, and continuing through to the present, the debate over what type of weapons protected personnel are allowed to carry and use has been highly controversial.

Although the GWS of 1906 makes no direct mention of the kinds of weapons and ammunition that protected personnel are authorized to carry, it does recognize the need for those personnel to be armed for self defense purposes. It also makes mention that the facility cannot lose its protected status if weapons and ammunition are found on the

premises due to them being evacuated with the wounded. Article 8, from the 1906 GWS states with reference to the presence of weapons and ammunition in medical facilities:

The following facts are not considered to be of a nature to deprive a medical unit or establishment of the protection guaranteed by Article 6:—

1. That the personnel of the unit or of the establishment are armed, and that it uses its arms for its own defense or for that of the sick and wounded under its charge.
2. That in default of armed orderlies the unit or establishment is guarded by a piquet or by sentinels furnished with an authority in due form.
3. That weapons and cartridges taken from the wounded and not yet handed over to the proper department are found in the unit or establishment.

The debate over the weapons types began with the 1929 Geneva Conventions conference, where the significant discussion occurred between many of the delegates over the issue. The Italian delegate suggested that the terms “portable arms” be used to define the types of weapons that protected personnel could carry, and added that this included rifles. The Swiss delegate asked for clarification on this proposal, specifically asking whether or not “portable arms” included machine guns, to which the Italian delegate stated that machine guns were not included. Another delegate voiced concern that there is a need to specify that the weapon type be an “individual” weapon. After some deliberation, the plenary concluded that this is not necessary, because the weapons utilized by protected personnel are only to be defensive in nature and also, that it is not feasible for the wounded to be evacuated with crew-served weapons (Solf 1977). This dialogue shows that as far back as 1929, the delegates had a difficult time establishing exactly what type of weapons medical personnel and units are authorized to use. This discussion also suggests that, according to the train of thought of the 1929 Geneva

Conventions delegates, the mere presence of a crew-served weapon might endanger the medical unit's protected status, as there would be no legitimate reason for it to be there.

The 1949 Geneva Conventions produced several revisions to the treaties. World War II had brought to light new challenges to the protection of medical units, such as the advances in weapons technology. In the commentary on the deliberations of Protocol I of 1977, the ICRC recalls the discussions of the 1949 Geneva Convention conference by stating:

It is clear that when medical personnel were granted the right to bear arms in 1949, the views regarding the lawful use that these personnel could make of these arms implied that they must be light weapons. However, it was not considered necessary to specify this in Article 22 of the First Convention. (ICRC Commentaries 1978)

This suggests that prior to the 1949 conventions; the mere thought of arming medical personnel was highly controversial. Even though the 1906 GWS clearly states that medical personnel are authorized to be armed, the fact that only five of the fifty-two state delegates actually signed the treaty suggests that this issue was very much unfinished.

The issue resurfaced again in 1977 Geneva Conference, in which 168 nation state representatives gathered to update the 1949 Geneva Convention treaties. Debate again surfaced over the types of weapons that could be used by medical personnel, which was addressed in an Additional Protocol to the treaties. During discussion on Article 13 of the Additional Protocol, the Mexican delegate suggested using the terms "light individual weapons." The Uruguay delegate agreed, adding that "an ambulance, for example, could not be mounted with a machine gun on its roof." The U.S. delegate suggested that the same language be used from Article 22 of the 1949 GWS, which states "small arms and

ammunition”, so as to eliminate confusion. The Swiss delegate pointed out that by specifying “individual weapons” it would ensure that no “collectively operated weapons,” or crew-served, be authorized for use (Solf 1977). The Hungarian representative also suggested mentioning the word “individual” in Article 13 of Protocol I because it would “make it clear that individual weapons were carried” by medical personnel. Ultimately, a compromise was reached in which both the terms “light individual” and “for their own defense” were incorporated in the Article 13, by a vote of 35 to none. According to the commentary notes from the 1977 Geneva Conventions conference on Protocol I, the intent with using the term “light individual” refers to:

weapons which are generally carried and used by a single individual. Thus not only hand weapons such as pistols are permitted, but also rifles or even sub-machine guns. On the other hand, machine guns and any other heavy arms which cannot easily be transported by an individual and which have to be operated by a number of people are prohibited. [And that] Pistols should certainly be sufficient to carry out the tasks specified, but it makes little difference in the end if the personnel prefer rifles, provided that they stay strictly within their competence. (ICRC Commentaries 1978)

In summary, Protocol I to the 1949 GWS provides much more specificity on particular types of weapons which may be used in medical units, but still focuses more on the purpose for the weapon’s use rather than the type. This language is still rather ambiguous and leaves much to be interpreted by the parties when considering what weapon types are appropriate for their respective armed forces. It is also noteworthy to mention that only five of the 168 delegates signed this Protocol, and the U.S. still has not ratified it.

Secondly, articles 18-22 of the GWS states the following about how personnel and units can be physically defended and still maintain their unique status:

Fixed establishments and mobile medical units of the Medical Service may in no circumstances be attacked, but shall at all times be respected and protected by the Parties to the conflict. Should they fall into the hands of the adverse Party, their personnel shall be free to pursue their duties, as long as the capturing Power has not itself ensured the necessary care of the wounded and sick found in such establishments and units. The responsible authorities shall ensure that the said medical establishments and units are, as far as possible, situated in such a manner that attacks against military objectives cannot imperil their safety. . . . The protection to which fixed establishments and mobile medical units of the Medical Service are entitled shall not cease unless they are used to commit, outside their humanitarian duties, acts harmful to the enemy. Protection may, however, cease only after a due warning has been given, naming, in all appropriate cases, a reasonable time limit, and after such warning has remained unheeded. . . . The following conditions shall not be considered as depriving a medical unit or establishment of the protection guaranteed by Article 19:

- (1) That the personnel of the unit or establishment are armed, and that they use the arms in their own defense, or in that of the wounded and sick in their charge.
- (2) That in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort.
- (3) That small arms and ammunition taken from the wounded and sick and not yet handed to the proper service, are found in the unit or establishment.

In 1977, Protocol I was added to the Geneva Conventions and further refined the language that was used to describe the protection of medical units and personnel.

Articles 12 and 13 of Protocol I state the following:

Medical units shall be respected and protected at all times and shall not be the object of attack. . . . Under no circumstances shall medical units be used in an attempt to shield military objectives from attack. Whenever possible, the Parties to the conflict shall ensure that medical units are so sited that attacks against military objectives do not imperil their safety. The following shall not be considered as acts harmful to the enemy:

- (a) that the personnel of the unit are equipped with *light individual weapons* for their own defense or for that of the wounded and sick in their charge; [emphasis added]
- (b) that the unit is guarded by a picket or by sentries or by an escort;
- (c) that small arms and ammunition taken from the wounded and sick, and not yet handed to the proper service, are found in the units;
- (d) that members of the armed forces or other combatants are in the unit for medical reasons.

Secondary Research Question #3

Has the Department of Defense (DoD) and or the U.S. Army imposed any additional and or different constraints on medical units with regards to the Geneva Convention?

As mentioned in the answer to question 1, the U.S. governmental agencies, which include the DoD, do not give specific guidance to their subordinate agencies, other than to direct them to create programs and policies that ensure adherence to the IHL and the LOAC.

The U.S. Army, being one such subordinate to the DoD, has adhered to the stipulations of the Geneva Conventions in its doctrine and policies, almost verbatim. Within the guidelines of Article 24 of the GWS, all personnel regimentally affiliated with the Army Medical Department (AMEDD) or assigned to an AMEDD unit are considered “protected personnel” (FM 4-02 2003, 4). Simply by their nature, all AMEDD units are considered exclusively engaged in providing health care, and as such, all personnel assigned to those units are considered protected, whether they are an AMEDD affiliated person or not. However, there may be cases where AMEDD personnel are assigned to positions in units where they are not exclusively engaged in the delivery of health care on the battlefield. Under these cases, they lose their protected status and become combatants. For example, AMEDD personnel are commonly assigned to non-medical units such as Brigade Support Battalions, Sustainment Brigades, Combined Arms Battalions and Military Transition Teams (MiTTs), and most often are assigned to a non-medical position. If the unit is a non-medical unit and the position in which these personnel are assigned is a non-medical position, than these personnel are not considered “protected,” but rather “combatants” (FM 4-02 2003, 4-6).

FM 4-02 and FM 27-10 are the documents that best capture the Army's interpretation and guidance on this aspect of the Geneva Conventions. FM 27-10, *The Law of Land Warfare*, is a comprehensive manual which covers all things associated with the legal aspects of conducting military operations on land. One drawback with FM 27-10 is that it was last updated in 1956. To compensate for this, the TJAGLCS has published the Law of War Documentary Supplement, completed in 2007, which includes all the pertinent international law of war documents published since 1956 and also some important U.S. documents produced that are currently in effect. FM 4-02, *Force Health Protection in a Global Environment*, represents the AMEDD's best source document for summarizing the Army's directives to AMEDD personnel for providing medical care in a military operation. The following is an excerpt from FM 4-02 regarding the protection of AMEDD personnel and facilities (notice how similar the guidance in FM 4-0 is to the actual language in the articles of the Geneva Conventions):

[They are] authorized to be armed with only individual small arms . . . that these small arms consist of pistols or rifles, or authorized substitutes. These small arms may only be used for defensive purposes. The presence of machine guns, grenade launchers, booby traps, hand grenades, light antitank weapons, or mines in or around a medical unit would seriously jeopardize its entitlement to protected status under the Geneva Convention for the Amelioration of the Conditions of the Wounded and Sick in Armed Forces in the Field. The deliberate arming of a medical unit with such items could cause the medical unit to lose its protected status under the Conventions. If the local non-AMEDD commander situates a medical unit where enemy attacks may imperil its safety, then that commander should provide adequate protection for the medical unit and its personnel. AMEDD personnel are permitted to fire only when they or their patients are under direct attack in violation of the Geneva Conventions. Use of arms by AMEDD personnel for other than protection of themselves or their patients violates the Geneva Conventions' provisions governing the protected status of AMEDD personnel and results in the loss of protected status. Army Regulation 350-41 states the AMEDD personnel and non-AMEDD personnel in medical units will not be required to train or qualify with weapons other than individual or small arms weapons.

Secondary Research Question #4

Are there any constraints set forth in the Geneva Conventions, or any of the resulting DoD, Army, or AMEDD policies, which are irrelevant, overly restrictive or ill applied in the COE?

While the large majority of provisions in the GWS are unequivocally accepted and adhered to, there is one area that has been a long-standing point of contention among the senior leadership in the OTJAG and the AMEDD proponents: the issue of what types of weapons a medical unit is authorized to maintain and use.

In a memo sent to HQDA, dated December 1976, LTC Tom Edwards, from the Academy of Health Sciences (which is now the AMEDD Center and School) requested authorization for the use of more lethal weapon types, which included specifically the M60 machine gun, grenades and claymore mines, by medical units for defensive purposes. Two months later, in February 1977, the OTJAG responded to the request as HQDA's representative on the matter. In the response, drafted by Waldemar A. Solf, Chief of International Affairs Division, OTJAG concluded that the "deliberate arming" of such weapon types would "constitute an act harmful to the enemy" and jeopardize the "entitlement of protected status" for the medical unit under the 1949 GWS (Solf 1977, 1).

Some ten years later, the issue was revisited by the AMEDDC&S as debate between senior AMEDD leaders within the organization ultimately lead to the Army Surgeon General publishing a memo in October of 1988 with a subject line titled *Status of Medical Personnel and Defense of Medical Units Under the Provisions of the Geneva Conventions*. For the most part, the memo reiterated the 1949 GWS provisions, almost verbatim. It reinforced that only individual small arms are authorized and that medical

personnel must only use force for purely defensive purposes and only against violators of the LOAC. However, the memo did address some specific weapon types that would not be authorized for medical units. In paragraph 2c of the letter, the OTSG states:

The deliberate arming of medical units with machine guns (crew-served or other), grenade launchers, hand grenades, light anti-tank weapons, mines of any kind, or booby traps (to include warning type devices) could constitute an act harmful to the enemy and cause the unit to lose its protected status.

In the 1988 memo, the OTSG makes it clear that the responsibility to protect the medical unit beyond what they are authorized under the Geneva Conventions falls on the tactical commander, stating in paragraph 2c that the “tactical commander (non-AMEDD) should provide adequate protection for the medical unit and its personnel.” To conclude the memo, in paragraph three, the OTSG gives the directive to the AMEDD C&S to “ensure that all AMEDD doctrine and training literature, programs of instruction, and exportable training packages reflect the implementation of the GWS.” It is important to note that prior to publishing the memorandum, the OTSG sent the memo to the OTJAG for analysis and approval. This decisive action by the OTSG seemed to have put the issue to rest; that is until recently.

With the onset of military operations after the terrorist attacks of September 11, 2001, the U.S. Army found itself engaged in counterinsurgency (COIN) operations in Iraq and Afghanistan, in a new battlefield termed the Contemporary Operating Environment (COE). The topic of defending medical units and weapon types arose yet again; and like the previous times, a request was initiated in the form of a memorandum. In November 2004, Major General George Weightman, who was serving as Commander of the AMEDDC&S, sent a memorandum to the OTSG requesting a “reevaluation of policy that limits the types of weapons medical units and personnel are permitted to

possess for self defense and defense of patients in their care” (Weightman 2004, 1). In the memo, Weightman states that “the realities of the modern battlefield, which place medical personnel and their patients at greater risk, necessitate a reexamination of the types of weapons authorized for use by medical units for their protection.” He goes on to suggest that:

The currently authorized individual small arms (pistols and rifles) do not afford adequate protection from the increased threat. Other weapons, such as the squad automatic weapon (M249) or crew-served weapons currently in the Army inventory, would provide medical units an adequate defense during movement operations. If used solely for defensive purposes as prescribed in the Geneva Conventions, the issuance of these weapons to medical units would be in consonance with the intent of the Conventions.

For reasons that are as yet undetermined, his request went unanswered. Then, in October 2006, a new AMEDDC&S commander, Major General Russell Czerw followed up his predecessor’s request with another memorandum. This time, Czerw took it a step further, asking that the OTSG consider a “policy change,” rather than a “reevaluation,” as Weightman had requested two years earlier (Czerw 2006, 2).

MG Czerw emphasized in his memo that there are increased threats to medical assets in the COE and that action should be taken to increase their protection. He states, “Medical Soldiers on today’s non-contiguous battlefield face an asymmetric threat that does not respect nor adhere to the law of war” and that this threat “employs tactics and techniques which capitalize on the limited protection status of medical forces.” Czerw suggests that the individual small arms authorized for medical personnel to carry, which is outlined in AR 71-32 do not provide “even a minimal level of defense” to medical personnel. In recommending that medical units be authorized a more effective weapon type, namely the M249 SAW, Czerw notes that the GWS does not specifically prohibit

certain weapon types but focuses rather on the intent for which the weapon is to be used. Czerw suggests to the OTSG that increasing the capability of the medical assets by authorizing the M249 SAW only provides the ability for the medical forces to adequately defend themselves in the COE (Czerw 2006, 2).

This request resulted in a much more thorough and expedient response from the OTSG. After receiving the request, the OTSG sought out the advice of the OTJAG. On 20 October 2006, the OTSG received an analysis of the request from the office of the Law of War Matters within OTJAG. They concluded that because the M249 SAW is classified as a sub-machine gun, it would not be in violation of the provision of “light individual weapons,” which is established in Article 13 of Protocol I to the Geneva Conventions, which was discussed previously in this chapter. The OTJAG elaborated on this topic by warning the OTSG that any larger weapon than the M249 would violate the Law of War and the vehicle and personnel would lose their protective status. Finally, the OTJAG advised the OTSG that if the medical unit felt that the threat to them demanded a larger weapon system for protection, they could petition the Combatant Commander as the authority for such a decision, but that such an action would result in a forfeiture of their protected status (email with OTSG 2008).

Upon receiving the OTJAG opinion, Lieutenant General Kevin Kiley, the Army Surgeon General at the time, responded to MG Czerw’s request with a memorandum expressing his support of the idea to authorize the use of the M249 SAW by AMEDD personnel. He relayed the OTJAG’s opinion that the SAW was an authorized weapon for medical units to maintain and instructed the AMEDDC&S to determine the requirements for SAWs in authorization documents, such as AR 71-32, and to “have the SAWs

documented as a requirement” for medical units. LTG Kiley reiterated that the SAW was to be used strictly for defensive purposes and that the AMEDDC&S should coordinate with command surgeons in the OIF theater to request that the Commander of U.S. Central Command, a combatant commander, allow medical units in theater to maintain and utilize the SAW for their protection (Kiley 2007).

In addition to authorizing the use of the SAW by medical personnel, the OTSG also suggested that the AMEDDC&S and the field surgeons give some significant consideration to mounting the SAW on standard medical evacuation vehicles (ambulances), which would be clearly marked with the distinctive Geneva Convention emblem of the red cross with white background. This directive specifically suggested mounting the SAW on the newly fielded Heavy Armored Ground Ambulance (HAGA). The HAGA is the medical evacuation vehicle variant of the MRAP family of vehicles, which the Army developed and began fielding in 2007 in order to provide better protection from the enemy tactics of IEDs and RPGs in theaters such as OIF and OEF.



Figure 1. The Heavy Armored Ground Ambulance (HAGA)
Source: Mr. Greg Rathbun, AMEDD Center for Army Lessons Learned.

Response to this request from the OIF theater, the Office of the Staff Judge Advocate (OSJA), Multi-National Corps-Iraq (MNC-I) drafted a detailed memorandum dated February 2008. The OSJA MNC-I referenced the 1949 Geneva Conventions treaties, Protocol I of 1977 and the commentaries that accompany them. They reiterated that the decision to allow “sub-machine guns” during the conferences was very controversial, and that one must consider the types of weapons the plenary was referring to when attempting to adhere to the spirit of the provisions (Ayres 2008). The OSJA MNC-I memo states the following about this topic:

In truth, both the written description of the M249 [SAW] and the practical experience with the weapon speak to its use as an individual weapon, carried and employed by a single person and firing the same caliber round as the M16. Nevertheless, few would deny that the M249 possesses significantly more firepower and offensive capability than the 1970’s era “sub-machine gun”-- such as the famous Thompson version--that was clearly contemplated by the Additional Protocol I commentary. (Ayres 2008)

The OSJA MNC-I also strongly opposed the mounting of such weapons on medically marked vehicles. In their words:

both the language and official commentary to Protocol I to the Geneva Conventions strongly suggests that mounting an M249 on a marked ambulance is inconsistent with Geneva protection [and that] by placing an M249 on an ambulance, its personnel would be subjecting themselves to an unnecessary risk of attack from a loss of protected status. (Ayres 2008)

As a result of this most recent OSJA MNC-I recommendation, the topic is still under debate, and presently, there are no weapon systems above the M4 rifle allowed in an AMEDD unit and no ambulances mounted with an M249. Since neither the AMEDD nor the OTJAG proponents have the authority to direct these types of changes or actions, the combatant commander, or his designated representative, in this case the MNC-I commander, will have to decide on what is appropriate for his tactical situation.

This recommendation to arm the HAGA with the M249 also sparked debate within the AMEDD, as several senior leaders have openly opposed this decision. COL Michael Brumage, who Commands a Health Center at Schofield Barracks, submitted a memorandum for record criticizing this recent decision. He concluded that the policy change to allow the use of the M249 SAW is “tactically limited and strategically flawed” and that “the failure to remain beyond reproach [on the provision of the GWS] may well have unforeseen lethal consequences in the present and future battlefields by supplying our enemies with recruitment fodder on par with the Abu Ghraib, Haditha or Blackwater incidents” (Brumage 2008). COL Patricia Hastings, Director of the Emergency Medical Services at Fort Sam Houston, Texas signed in support of COL Brumage’s memo and also forwarded it through her chain of command.

Secondary Research Question #5

In the COE, today’s modern battlefield, has the prevalence of deliberate attacks on protected elements, such as medical assets, increased?

This is the one research question listed in chapter 1 which was not conclusively answered through this research effort. While it was possible to determine that some attacks have happened in various conflicts, the ability to determine the prevalence of these types of occurrences was not achievable. In MG Weightman’s 2004 memo to the OTSG, as mentioned in chapter 4, he states, “The realities of modern battlefield which place medical personnel and their patients at greater risk, necessitate a reexamination of the types of weapons” [emphasis added] (Weightman 2004, 2). Are medical units really at a greater risk in the modern battlefield, or COE? The problem with trying to answer this is that my research found no database that annotates each attack on a “protected”

asset during an operation or a systematic analysis from which to draw from to compare one conflict to another. For example, are medical units in OIF more at risk to deliberate attack than the medical units in the Vietnam War were? While the answer may be “yes,” the researcher could find no quantifiable evidence to prove this. Obtainable data shows clearly that medical units have always been the victims of deliberate targeting in U.S.-involved conflicts, dating as far back as World War I (Anderson 1988). What could be verified with respect to this issue is that the amount of deliberate attacks on medical elements in the COE is significant enough to warrant a high level of attention. As the answers to survey question #1 showed, on average, 33 percent of AMEDD leaders responded that they had experienced at least one attack on their medical assets during their experiences in the COE.

AMEDD Force Protection Survey Results

Answers to Secondary Research Questions 6, 7 and 8

In order to gain more perspective from relevant leaders across the AMEDD on this topic, a survey was conducted to determine how prevalent the problem of securing medical assets in the COE actually is and also to solicit ideas on how to mitigate this risk. The following section breaks down the questions on that survey and reports the responses.

The survey that was conducted as part of this research was an attempt to capture information pertaining to two areas: (1) to determine the prevalence of the problem of securing medical assets on the battlefield is and (2) to solicit ideas from a specific population amongst AMEDD leaders on ways to mitigate the problem. The answers to the survey assisted in answering the following secondary research questions:

Question 6: What challenges are units having with the constraints placed on them under the Geneva Conventions and U.S. Army policy?

Question 7: How are medical units responding to attacks on them in the current COE?

Question 8: What are some potential solutions to updating the Geneva Conventions or subordinate policies and or force structure in order to afford better protection to medical assets on the COE battlefield?

Chapter 3 outlined what how the survey was developed and conducted, and also explained how the sample population was selected. In all, 239 invitations to participate in the survey were sent out to select AMEDD leaders, of which 75 successfully completed it, resulting in a completion percentage of 31 percent. The survey consisted of only five questions and two of those were optional, depending on the participant's answers to certain questions. Please see Appendix A for the details on the structure of the actual survey.

In the following paragraphs, each survey question, along with the answers, will be discussed and analyzed in order to determine any trends or consensuses among the respondents.

Survey question #1 asked: As an appropriately marked AMEDD element, have you, your medical assets or your patients ever been deliberately attacked (by regular or irregular forces) while conducting military operations in the COE? Of the 75 respondents, 21 of them reported that they had experienced at least one deliberate attack on medical assets in the COE. This means that 1 out of every 3 medical leaders surveyed had been exposed to deliberate enemy attacks by enemy forces in the COE during their

rotations in either OIF or OEF. Figure 1 below graphically depicts the results from that question.

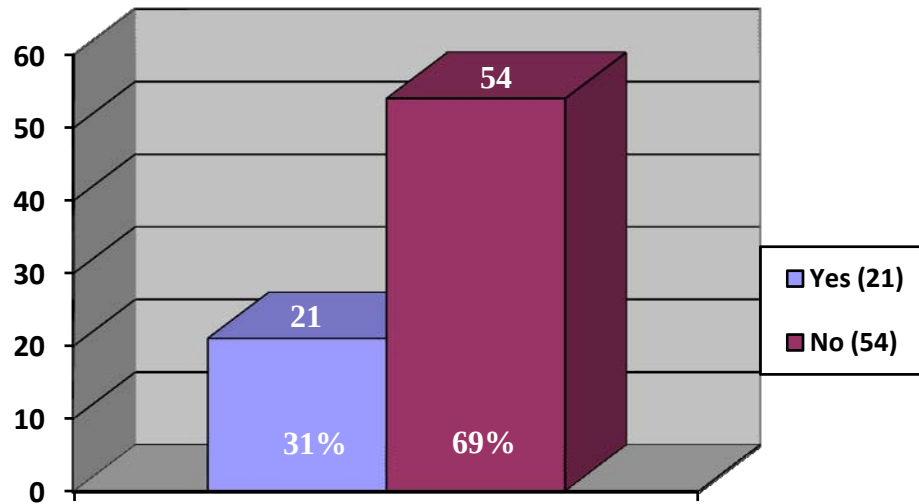


Figure 2. Responses from Survey Question #1

Source: Created by author from survey.

For those respondents who answered “Yes” to question one, they were then prompted to answer survey question #2, which was: You indicated your AMEDD element had been deliberately attacked, briefly describe the nature of the attack(s). From their answers, five distinct categories for the method of attacks were identified. The first three categories were “small arms,” “rocket propelled grenade” (RPG), “improvised explosive devise” (IED), and the final two dealt with indirect fire and were termed “indirect (confirmed)” and “indirect (unconfirmed).” Figure 3 depicts the categories described above and the number of incidences in each category as described by the respondents in survey question #2.

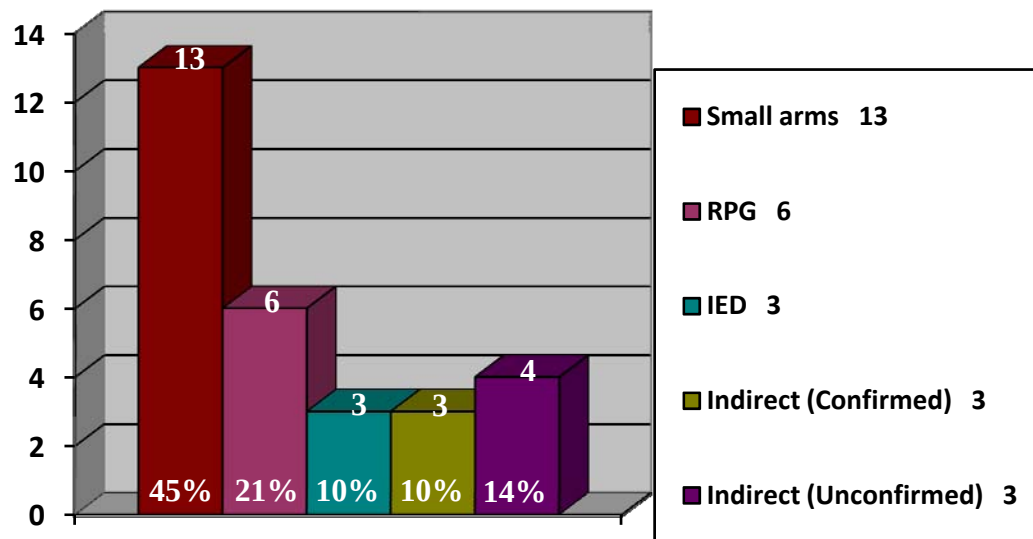


Figure 3. Responses from Survey Question #2

Source: Created by author from survey.

With regards to the attacks mentioned in question two, the majority of them occurred to either large, stationary medical facilities, such as a CSH, or to elements conducting medical evacuation missions.

Survey question #3 was answered by all the participants; it read as follows: As an AMEDD leader, have you ever had difficulties with providing adequate force protection to your unit and or your patients during a military operation? In response to question three, the respondents indicated that 27 percent of them had had difficulties in providing adequate force protection. Figure 4 depicts the results from survey question #3.

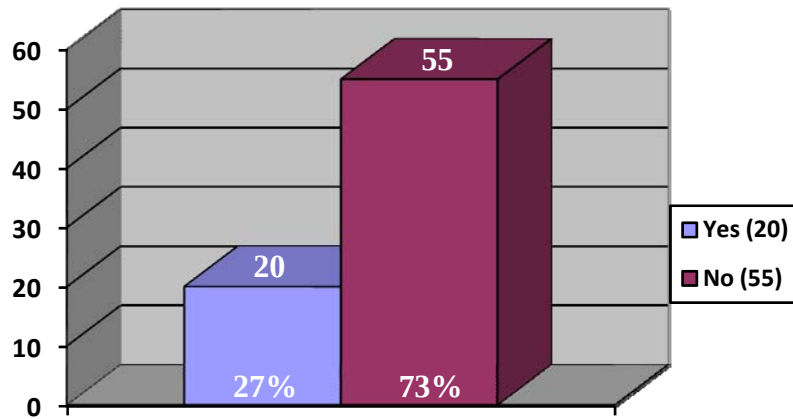


Figure 4. Responses from Survey Question #3

Source: Created by author from survey.

Only those respondents who answered “Yes” to question three were then prompted to answer survey question #4, which was: You indicated that as an AMEDD leader, you had difficulties with providing adequate force protection to your unit and or your patients during a military operation. Please describe the difficulty you had with providing force protection for the medical element(s).

Although there were many differing answers to question four, the researcher was able to organize them into categories of similar schools of thought. In an effort to quantify the responses and identify any major themes, the answers were organized into the following categories:

1. Security assets unavailable
2. Inadequate weapon types
3. Inadequate vehicular armor
4. Inadequate cantonment facilities

Of the twenty respondents who indicated that they had had difficulties in providing adequate force protection to their medical assets, almost half of them, 48 percent, stated that it was due to difficulties in resourcing security forces. This difficulty ranged from the security forces being simply unavailable, to situations where the security assets were “pulled” away unexpectedly from the medical element due to competing requirements. The next most occurring category that led to difficulties in providing force protection to medical assets was inadequate weapon type. The respondents indicated that because of the restriction that AMEDD elements utilize the M-4 rifle or below weapon types, their ability to internally resource and conduct operations outside of the cantonment areas was greatly inhibited. Depending on the tactical situation and enemy threat, the tactical commander’s requirement might be as little as the presence of an M249 or as great as a fully armored, combat vehicle escort. The third most prevalent category was inadequate vehicle armament. One of the biggest threats to medical assets in the COE is from high explosive or penetrating munitions, such as IEDs and RPGs, which are commonly used to attack convoys by enemy forces in Iraq and Afghanistan. Because the large majority of the medical evacuation vehicles within the AMEDD are “soft-skinned,” meaning they have no vehicle armor, they are highly vulnerable to these types of attacks. This has become so much of a problem in the OIF theater that several AMEDD leaders indicated on the survey that they never took their ambulances out of the FOBs, and would use non-standard armored cargo vehicles and configure them into make-shift ambulances instead. The last category that the respondents indicated they had difficulty with in providing adequate force protection was inadequate cantonment facilities. All three of the answers in this category indicated that the facility in which

their unit conducted medical operations did not provide adequate protection to their staff and their patients from indirect fire and RPG attacks. The respondents suggested that it may not be feasible to provide the medical units with suitable reinforced facilities, but that at least an adequate bunker complex should be established for the majority of the staff and patients. Figure 5 graphically depicts the answers from survey question #4.

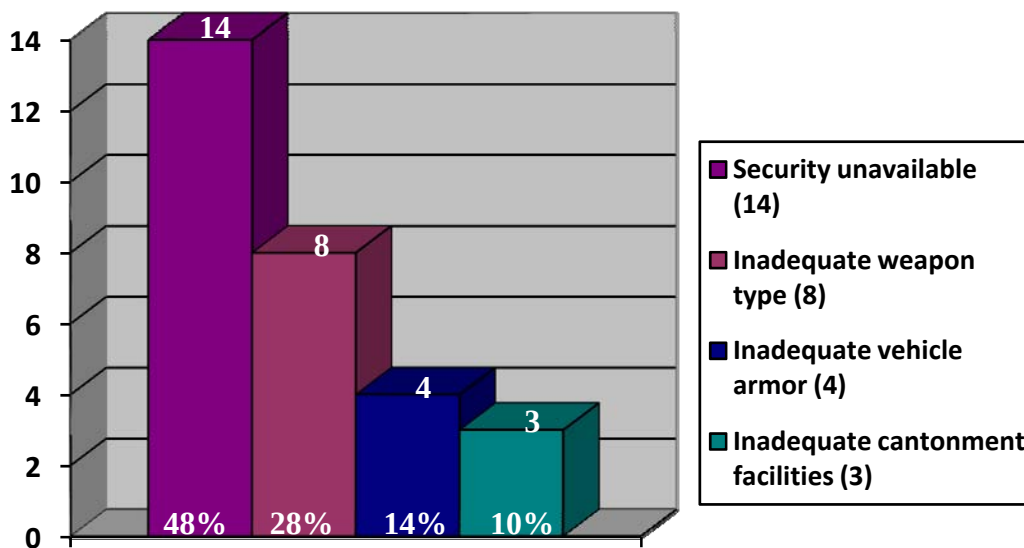


Figure 5. Responses from Survey Question #4
Source: Created by author from survey.

Survey question #5 was available for all of the participants to answer. This question was an attempt to solicit ideas from the respondents on what solutions or ideas they would suggest to improve the protection of medical assets, specifically in the COE. It read as follows: What recommendation(s) do you have for providing adequate protection for medical elements in the Contemporary Operating Environment (COE)?

This answer section was simply a blank text box, in which the respondent could type in any way they wished. Similar to what was done in survey question #4, the answers were grouped into categories in order to quantify like responses.

For survey question #5, the responses were grouped into six distinct categories:

1. No change to policies but improved leader education required
2. Increase weapon capability
3. Increase vehicle armor
4. Increase training
5. Assign permanent security
6. Remove distinctive markings

Sixty-nine survey participants answered survey question #5 with enough detail to successfully group them into one of the six categories. Figure 6 graphically depicts the answers given in survey question #5 into the six established categories.

The most popular opinion on how to improve the security of medical assets in the COE was to keep the policies as they are, but focus more energy on educating the operational and tactical commanders on the medical element's limitations and security requirements to ensure that adequate force protection measures are taken. Of the 69 respondents, 27 (39 percent) proposed this idea and also provided some thought provoking remarks to go along with this premise. Some of those comments include, "we need to support the Geneva Conventions . . . not change the definitions to cover new environments" and "the geographical combatant commander must understand the responsibilities and liabilities of the medical unit in their footprint, close coordination and

communication must take place between the senior medical commander and the tactical commander”

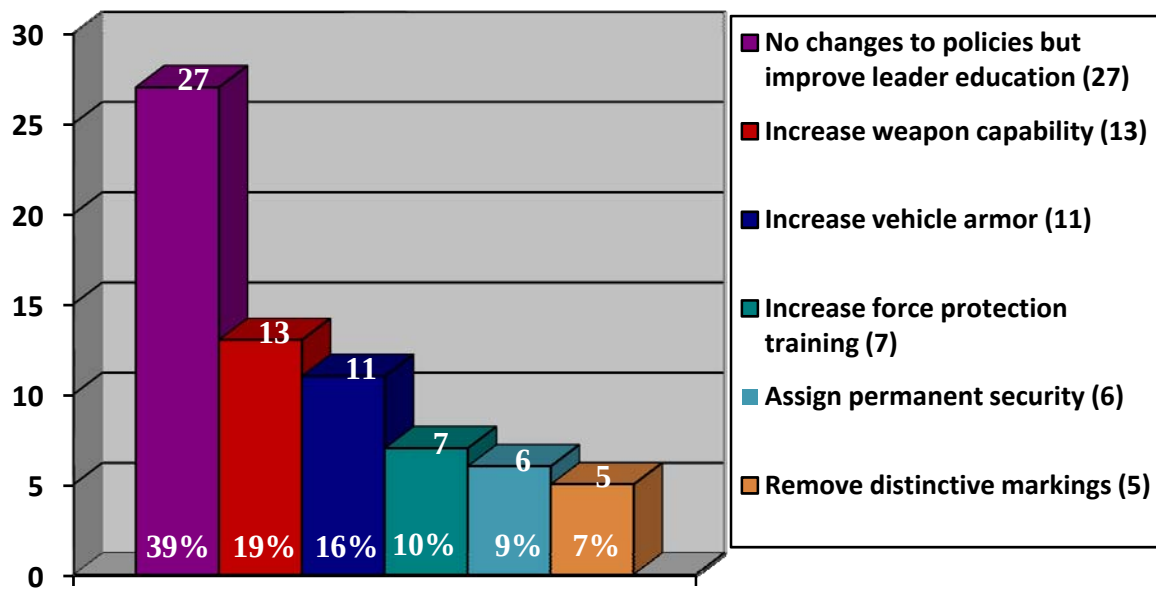


Figure 6. Responses from Survey Question #5

Source: Created by author from survey.

The second most recommended solution was to increase the weapon capabilities of the AMEDD units. Thirteen of the respondents (19 percent) suggested that the limitation of the AMEDD in using only the M4/M16 series and below weapon types was insufficient to provide adequate force protection in the COE. Some of their specific comments included: “medical units must be allowed to use the SAW in defense” and “continue to progress toward fielding all ambulances with M249s.” While the vast majority of these comments do not directly violate the provisions of the GWS, there were

some responses that suggest a direct violation to the GWS, such as “the inability for a medical element to have crew-served weaponry assigned . . . is outrageous today.”

The next most recommended category was to simply increase the vehicle armor on the standard medical evacuation vehicles. Eleven of the sixty-nine answers (16 percent) fell into this group. All of these answers expressed frustrations in having to “park” their standard wheeled evacuation assets and conduct operations from more heavily armored vehicle types. Sometimes these were a non-standard variety, such as a 5-ton cargo truck, in which the unit fitted the vehicle with armor and created a patient compartment, and other times the unit was fielded an upgraded medical vehicle, such as the Medical Evacuation Vehicle (MEV) from the Stryker family of vehicles.

The fifth most suggested idea was to increase the training requirements for AMEDD personnel in the areas of individual and collective force protection. Seven (10 percent) respondents offered up this option. Three of the suggestions indicated a need to increase weapons training for all AMEDD personnel, and conduct it on a regular basis, rather than just a few weeks prior to deploying, which can often happen to AMEDD personnel under the professional filler, or PROFIS, system. Many of the respondents in this category suggested that Soldiers rely heavily on “muscle memory in dealing with combat situations” and that continued training over extended periods of time is a necessity, rather than “a few weeks prior to deploying.”

The least suggested category, proposed by five of the respondents, in response to question five was to remove the distinctive markings from the medical assets in the COE. This means that all the standard ‘red cross on a white background’ markings on the medical vehicles and facilities would be removed and they would essentially look the

same as all the other Army assets around them. Reasons for suggesting this option included: “removing the markings gives the medical personnel the same ability to defend themselves as any other Soldier” and “remake all medical evacuation platforms casualty evacuation (CASEVAC) platforms and make CASEVAC a METL task for the tactical commanders.” One note on this category is that removing the distinctive markings is now and has always been a legitimate option for the tactical commander. Standard NATO Agreement (STANAG) #2931 give the authority for a NATO commander (usually at the Brigade level or above) to “temporarily” remove or camouflage the red cross or red crescent emblem due to the possibility that the presence of such a marking might jeopardize the overall camouflaging of the accompanying non-medical units (STANAG 2931).

Summary

In chapter 4, the answers to the research questions were discussed and analyzed. By comparing the actual Geneva Convention treaties and protocols with current Army doctrine and policy, definitive answers were obtained in showing how closely associated Army doctrine is in adhering to the provisions of the Geneva Conventions. What is not clear, and is currently still often debated, are the exact weapon types that should be authorized for AMEDD personnel to employ in their force protection efforts within the provisions of the Geneva Conventions and the LOAC. Also, the results of the survey provided valuable information in obtaining the experiences of other seasoned AMEDD leaders in protecting medical assets in the COE, and gaining their insight on some possible solutions to improve this effort in future operations.

In chapter 5, the researcher will expound upon the findings detailed in chapter 4 in an attempt to provide further meaning and implications to the data. Additionally, by incorporating the answers to the various research questions, the researcher will propose some possible course of action which might be taken to improve efforts on the subject of defending medical units in the COE.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this study is to explore the possibility that the policies from U.S. governmental agencies, and subsequent U.S. Army documents implementing said policies, may need to be adjusted in the area of the protection of medical units considering the changing nature of warfare in the COE. Furthermore, this is an attempt to explore the possibility of increasing the capability of medical units to provide themselves with better force protection measures, while at the same time maintaining adherence to pertinent provisions of the Geneva Conventions. Conclusions drawn from this study could greatly assist in developing better ways to cope with this dilemma.

The goal of chapter 5 is to draw conclusions and recommendations about the primary research question by further analysis of the answers to the secondary research questions discussed in chapter 4. Chapter 5 will begin with a brief synopsis of the more important findings from chapter 4, and will then move into an exploration of possible solutions to the problems identified. Chapter 5 will conclude with recommendations on what future researchers might consider for further exploration of this topic.

Summary of Research Findings

Chapter 4 laid out the relevant data collected from the research in three main topic areas. Several important aspects of the Geneva Conventions were identified as the foundation for the protection of medical assets in the LOAC. First, the treaties to the Geneva Convention make no distinction between the type of warfare and what provisions

protected personnel should adhere to in IHL. Whether it is a conventional fight with established force-on-force state actors or an unconventional conflict with both state actors and non-state actors, the provisions governing what capabilities and measures medical assets can take to protect themselves are the same. Secondly, medical units currently have the right to bear arms with “light individual weapons,” which encompass all weapons at the sub-machine gun level and below. For the U.S. Army, this permits use of the M249, which is classified as a sub-machine gun, and below. Third, medical elements can use these weapons in a strictly defensive manner, and only against those enemy forces and personnel who are acting in violation of the LOAC. Protected personnel cannot employ their arms in self-defense while being captured or detained by an enemy force that is acting in accordance with the LOAC, nor can they utilize their weapons in the defense of other, non-protected, assets within their military forces.

This last statement is important and requires further explanation. For instance, a medical company operating in a Forward Operating Base (FOB) in the current theater of OIF is located close to a non-medical unit. If enemy forces, conventional or unconventional, attacked the FOB and were in the process of assaulting the unit in proximity to the medical company, members of that medical company would not be authorized, under the provisions of the GWS and current U.S. Army policy, to engage the enemy attacking their sister unit and at the same time maintain their unique, protected status under the GWS. To do so would be a violation of the provisions of the GWS and those personnel would lose their protected status under the GWS.

Another example of this dynamic would be an appropriately marked medical vehicle, such as the M997 Army ambulance, traveling as part of a convoy which is

ambushed by an insurgent force. Unless the ambulance, its crew or one of its patients is directly fired upon, the medical personnel would not be authorized to engage the enemy force in support of defending the other elements of the convoy. To do so would violate the provisions of the GWS, and would cause those personnel to lose their protected status. In both examples given above, it is important to note that the tactical commander, at the brigade level or higher, could authorize the *temporary* removal of the distinctive marking of the Geneva Conventions emblem (for instance, the Red Cross with the white background) and the personnel would not lose their protected status under the GWS.

Another critical area of information obtained in the research and detailed in chapter 4, and perhaps the most relevant to this thesis, is the fact that even though the parties to the Geneva Conventions agreed that medical personnel should be armed, the topic of what type of weapons they should be limited to was always highly debated. The language describing these weapon types went from “portable arms” in 1929, to “small arms” in 1949, to “light individual” in 1977. As described in chapter 4, the commentaries that accompany the articles of the Geneva Conventions show that in each conference in which updates to the Geneva Convention treaties were produced, the delegates rarely agreed upon exactly what weaponry medical personnel would be authorized to maintain under the Geneva Convention.

The subject of how the U.S. governmental and military agencies have interpreted the provisions of the GWS was another important finding from chapter 4. The research indicated that documents, particularly DoD Directives and CJCSIs, are produced at the policy-making levels that give direction and guidance to the subordinate military agencies in adherence to the Geneva Conventions. Evidence showed that these national

level documents do little more than tell the Army to follow and support the provisions of the Geneva Conventions. In turn, the preponderance of responsibility in developing exact policy and guidance for Army forces in delivering health care in the LOAC lies in the OTJAG and OTSG agencies.

Analysis in chapter 4 concluded that in most instances U.S. Army policy and doctrine is very much in line with the actual language used in the treaties of the Geneva Conventions. The language is not where the differences between the Geneva Conventions and U.S. Army doctrine differ; rather, the differences lie in the interpretation of that language. As with the delegates who participated in the actual Geneva Conventions, U.S. Army policy makers have wrestled with this issue throughout the past, and the struggle continues today.

Perhaps the most controversial example of this struggle is the constant debate on the topic of what weapons Army medical units should be allowed to maintain and operate under the provisions of the Geneva Conventions. Dialogue and correspondence show that senior leaders within OTJAG and the AMEDD have had differing views on this issue for some time. Questions from the field stimulated a thorough examination of the issue by the AMEDDC&S and the OTSG in 1976-77, which included a detailed analysis performed by the OTJAG to support the AMEDD senior leaders' position. In 1988, the issue resurfaced again and it compelled the OTSG, again with OTJAG input, to publish an official policy letter regarding the topic. The issue was reenergized in 2004, when the recommendation to increase the weapon capability of medical units to the M249 SAW sparked polarizing and on-going debate within AMEDD and OTJAG.

Chapter 4 also included the analysis of survey results given to select leaders across the AMEDD on the topic of the protection of medical assets in the COE.

Important trends identified in the survey respondents' answers included the following:

1. One out of every three officers served in medical units which were deliberately targeted and or attacked while conducting operations in the COE

2. Of the medical elements deliberately attacked, almost half of them (45 percent) were from small arms fire, outside of the cantonment areas

3. One out of every four AMEDD leaders indicated that they have experienced problems with providing adequate force protection for their medical assets

4. Among the difficulties indicated in providing adequate force protection to medical assets, 48 percent consisted of the unavailability of security forces, 28 percent of the time it was due to inadequate weapon capabilities of the medical personnel another 14 percent was from inadequate vehicular armor and the remaining 10 percent was due to inadequate cantonment facilities

In recommending ways to improve the force protection of medical assets in the COE, the following data was obtained in the survey:

1. Thirty-nine percent of the AMEDD leaders indicated that no major changes are necessary in policies or doctrine, but that better coordination and education is required amongst Army leadership

2. Nineteen percent recommended increasing the weapons capability of medical units; 16 percent advised that the Army should increase the vehicle armor on standard medical evacuation vehicles

3. Ten percent stated that an increase in force protection training would be the best option
4. Nine percent recommended assigning permanent security elements within the AMEDD units; and
5. Seven percent indicated that removing the distinctive markings would help in providing better force protection to medical assets

Answer to the Primary Research Question

Are the constraints placed on how medical personnel can protect themselves and their patients under the Geneva Conventions still relevant, and are they being applied appropriately by the DoD and or the U.S. Army in the Contemporary Operating Environment (COE)?

After analyzing all of the answers for the secondary research questions, this study finds that the provisions of the Geneva Conventions are still relevant to the modern battlefield, and that the U.S. governmental agencies, and subsequently the U.S. Army, are appropriately applying the provisions of the Geneva Conventions on the force protection of medical units in the COE.

The treaties of the Geneva Conventions and the accompanying Protocols are still relevant because the principles on which the provisions are founded make no distinction about the nature of the conflict, nor does it matter what type of forces are involved. The commentaries to the treaties are very clear in that medical personnel are only to employ their weapons when faced with forces who are acting in violation of the LOAC. Whether it is a conventional war between two nation states with uniformed forces, or an unconventional war between guerilla forces, the guiding principles that provide special

protection to medical assets apply equally. Furthermore, the documents of the Geneva Conventions offer adequate options for commanders to utilize when faced with security dilemmas, such as temporarily removing the distinctive Red Cross or Red Crescent markings and thereby forfeiting their protected status and allowing the use of increased weapons capabilities.

This research also finds that current U.S. Army doctrine is in line with the limits of these provisions, being neither too restrictive, nor too permissive. U.S. Army doctrine and policy use almost the same language as the actual Geneva Conventions documents with reference to how medical units can employ force protection measures. Nevertheless, there are two areas of concern that should be addressed to ensure future compliance with the spirit of the Geneva Conventions by U.S. forces:

1. the education of AMEDD leaders on the Geneva Conventions and its application, and
2. the decision to arm medical units with the M249

First Area of Concern

Despite the U.S. Army's efforts in ensuring compliance to the Geneva Conventions thus far, more education, particularly in the AMEDD institutional system, needs to be implemented. In order to effectively lead Soldiers and properly advise tactical commanders, AMEDD personnel must possess a comprehensive understanding of the Geneva Conventions and how to apply the same in various situations in the LOAC. Evidence from the survey conducted as part of this project indicated that many AMEDD leaders lack a thorough understanding of the fundamental principles of the Geneva Conventions, as many of the respondents offered suggestions that would be in direct

violation of the Geneva Conventions. Furthermore, many of the participants recommended more training and education be mandated for AMEDD leaders. Currently, the AMEDD only briefly addresses the Geneva Conventions and the LOAC in the professional education courses offered to its officers and NCOs. The AMEDD should increase the amount of time devoted to educating leaders on the Geneva Conventions and how they apply to medical personnel in its professional education courses.

An additional effort which could improve the education and training of AMEDD personnel would be to incorporate more instruction from the Judge Advocate General (JAG) Corps in preparing units for operational deployments. As part of home station training prior to any major deployment, all participating personnel, AMEDD elements included, receive a battery of instructional classes surrounding the legal aspects of their deployment. Among these classes are basic refreshers on the LOAC and rules of engagement. In addition to the standard, basic instruction in these areas, AMEDD units should receive more in depth instruction on the Geneva Conventions and the LOAC. Because of the unique status medical personnel receive under the Geneva Conventions during military operations, it would be highly beneficial to have subject matter experts in these areas provide a level of education that would enable medical personnel to fully understand all the ramifications of their status as “protected” personnel. The JAG Corps is probably the best proponent to conduct such pre-deployment training. JAG Corps personnel are generally available in-theater and could also provide refresher training as needed during deployment. This additional instruction would provide AMEDD leaders with a more thorough understanding of the principles of the Geneva Conventions and better prepare them for operational deployments.

Second Area of Concern

The recommendation to arm medical units with the M249 SAW may be a viable option, but should be pursued with extreme caution. This study has determined that while the arming of medical personnel with the M249 and their ability to employ it in a defensive nature would not be a violation of the provisions of the Geneva Conventions, it does enter into a “grey area.” Medical assets should not be allowed to operate such weapons from vehicles or facilities clearly marked with the Red Cross, such as the current initiative to mount the M249 on the HAGA. To do so, would be a clear violation of the Geneva Conventions.

There are multiple reasons why the arming of distinctively marked medical assets with machine guns should not be allowed. First, the arming of medical vehicles with machine guns will send a mixed message to the international community about U.S. commitment to the principles of the Geneva Conventions. OTJAG put it best in their legal opinion regarding the arming of the HAGA with a mounted M249, which stated in part, “it is important, though not {a} legal {question}, to consider how a picture of a medical transport with SAWs mounted would look on the front page of papers around the world” (Jackson 2008). Second, if we allow AMEDD personnel to employ weapons such as the M249 from clearly marked medical vehicles and facilities, we are potentially burdening them with the ethical dilemma of having to make a split second decision when engaging a target of whether they are acting in self-defense or not, in accordance with the spirit of the Geneva Conventions. It is important to recall that, regarding what measures a medical unit can take to defend itself, both U.S. policy and the GWS state that they can only employ purely defensive measures, and only against violators of the LOAC,

marauders or attacking wildlife (Additional Protocol I 1977). Lastly, if the tactical situation is such that the enemy force is specifically targeting our medical assets in spite or because of their status, the tactical commander can always make the decision to allow the medical unit to employ increased weapon capabilities by taking the distinctive marking off of medical assets and mounting crew-served weapons on them. This would not be a violation of the LOAC; it would only mean that the medical element would lose its protected status under the Geneva Conventions.

In the final analysis, the key issue is how the unit commander assesses the nature of the enemy threat and whether or not he wants Geneva Conventions' protected status for medical units with regards to that threat. If the medical element wants to maintain its protected status, then it cannot mount the M249 (or any greater weapon system) on medically marked vehicles or facilities. If the unit feels that the enemy threat warrants an increased security posture, it can forfeit its protected status, remove the distinctive markings, and employ any defensive measures and weapon systems it chooses within the constraints of any other unit on the battlefield.

Recommendations from Survey Question #5

Survey question #5 asked the respondents to provide specific recommendations on how to improve the force protection for medical elements in the COE. This section explores survey recommendations for their validity as potential courses of action for the AMEDD and the U.S. Army to consider. This section will address each of six recommendations in turn. The summary of survey responses from survey question #5 is at figure 6 on page 48.

1. The first suggestion we will address, to increase the vehicle armament of the U.S. Army's standard medical evacuation platforms, was made by eleven respondents (16 percent). This issue is already being investigated by the Army in various, on-going programs. There are currently three specific programs designed to increase both the armament and overall capability of medical vehicles in the U.S. Army, the Heavy Armored Ground Ambulance (HAGA), the Stryker Medical Evacuation Vehicle (MEV) and the Medical Vehicle-Evacuation (MVE).

The HAGA, as described and illustrated in chapter 4, represents the Army's most significant effort to increase the vehicle armor of medical evacuation vehicles. The HAGA is in the MRAP family of vehicles, and is already being fielded in the theaters of OIF and OEF (Globalsecurity.org 2008).

Another example of the Army's efforts to increase its vehicle protection is the Medical Evacuation Vehicle, or MEV, which is a medical variant to the Stryker family of vehicles. The MEV has the same armament and mechanical capabilities as the rest of the Stryker family of vehicles, and was fielded to some Stryker brigades as early as 2003 (Globalsecurity.org 2006). Figure 7, shows a picture of the Stryker MEV.



Figure 7. The Stryker Medical Evacuation Vehicle (MEV)

Source: Military All Scales website, <http://www.pawstrains.com/images/Trident-87091.gif>

The third area in which the U.S. Army has plans to increase the armament of its medical vehicles is in the Future Combat Systems program, which represents the next generation of U.S. Army vehicle platforms, due to be fielded around the year 2013. In this program, the Medical Vehicle-Evacuation (MVE) will have the same mechanical and armament specifications as all the other combat platforms in the program (United States Army 2008, 1).

2. The next suggestion, made by seven respondents (10 percent), was to increase the force protection training for AMEDD personnel. This too is already being thoroughly addressed by AMEDD organizations across the Army, and at multiple institutions of individual professional development. The AMEDDC&S, which is responsible for the institutional training and professional development of all AMEDD personnel, has incorporated substantial force protection training into their respective curricula, for both

officers and enlisted, and at both the individual and collective levels. Training events relevant to the COE, such as Combat Logistics Patrols (sometimes referred to as Convoy Operations) and Military Operations on Urban Terrain (MOUT), are conducted in both the AIT and OBC programs of instruction.

This increased emphasis on training AMEDD personnel in aspects of force protection has also taken place outside of the institutional courses. All AMEDD units assigned under FORSCOM must conduct a multitude of force protection training as part of their mandatory training requirements, as detailed in AR 350-1, which states that: “medical personnel [must] have the tactical and technical proficiency necessary to survive . . . on the battlefield” (AR 350-1 2007, 30).

One area specifically mentioned by the respondents on the survey as being a chronic problem area was the preparation of personnel assigned under the Medical Professional Filler System (PROFIS). This system designates qualified active U.S. Army AMEDD personnel in table of distribution and allowances (TDA) units to fill modified table of organization and equipment (MTOE) units of the U.S. Army. The objective of PROFIS is to resource MTOE units to their required level of organization with AMEDD personnel in accordance with the appropriate governing manning documents for the execution of a contingency operation, or for the conduct of mission-essential training (AR 601-142 2007, 1). The problem is that often, the PROFIS personnel do not arrive at their MTOE unit until a few weeks, sometimes just days, before the unit deploys from home station. As a result, those personnel do not conduct all the necessary pre-deployment training that the rest of the unit has completed. AMEDD needs to research and implement personnel management procedures to ensure PROFIS replacements are

assigned in a timely manner. Under PROFIS system, the TDA unit has certain training requirements that their PROFIS personnel must complete, and the respective MTOE unit will have certain training requirements that the PROFIS must complete (AR 601-142 2007, 1-3). Both parties have responsibilities in ensuring their PROFIS personnel are adequately trained. If the program is managed and adhered to appropriately, the systems in place are adequate to properly prepare PROFIS personnel for training and deploying with their units.

3. The third suggestion we will address, made by five respondents (7 percent), is to remove the Geneva Conventions' distinctive emblem markings from standard medical assets. This suggestion is not recommended for implementation or further study. The reason for this is two-fold. First, the *temporary* removal of the markings is a course of action which is already an authorized option for tactical commanders in the LOAC (FM 4-02.21 2000, A-1). Second to permanently remove the distinctive markings would violate not only the spirit of the Geneva Conventions, but also would be in direct violation of United Nations' Standard NATO Agreement (STANAG) 2931. STANAG 2931 states the following:

If failure to camouflage endangers or compromises tactical operations, the camouflage of medical facilities could be ordered by a NATO commander of at least brigade level or equivalent. Such an order is to be temporary and local in nature and is rescinded as soon as circumstances permit. (FM 4-02.21 2000, A-1)

As a signatory to the United Nations and NATO, the United States, and all its agencies, must adhere to this agreement. This above excerpt from STANAG 2931 addresses both aspects of why this recommendation is not a viable course of action.

4. The fourth category proposed in survey question #5 recommended keeping the policies and doctrine as they are while improving leader education at all levels and increasing coordination between AMEDD elements and their supported. This response represented 27 respondents, which is 39 percent of the AMEDD leaders who participated in the survey. The overarching theme from the comments was that the U.S.' national and military programs and policies are adequate for the COE, but what is needed is more education and training for both AMEDD leaders and the tactical and operational leaders whom they support. The respondents indicated that many AMEDD leaders do not fully understand the policies and the reasons they exist. As a result, they are unable to properly advise their tactical commanders on how to best operate within those constraints. The respondents indicated that there is currently insufficient instruction given in the AMEDD professional development courses, such as the Officer Basic Course, the Advanced NCO Course and the Captain's Career Course, to properly prepare AMEDD leaders for this task. In order to make themselves relevant to the tactical commander, the AMEDD leader must be well educated in the fundamental tenants and application of the Geneva Conventions. In order to ensure this happens, the AMEDD should dedicate more time in its professional development curriculums to the study of the Geneva Convention principles and provisions.

5. The fifth recommendation given from the survey on how to improve the security of medical assets in the COE was to increase the weapons capability in AMEDD units. While this option is already being explored by the AMEDD, it has yet to come to fruition, and as previously noted, has been met with significant resistance. While the arming of medical elements with crew-served or greater weapons would be a direct

violation of the Geneva Conventions, equipping them with sub-machine guns, such as the M249 SAW, would be acceptable (Jackson 2008).

There could be several advantages to this course of action. First, it would enable medical units to control their own destiny with operations, such as medical evacuations and MEDCAPs, which require a minimum security level to leave cantonment areas. A medical commander would not have to rely on external security support, thus making the mission easier to resource, synchronize and manage. Second, this would ease the burden on other units, as the medical elements would not require as much support from them, in terms of personnel and equipment.

Along with the benefits of allowing medical units to maintain and employ the M249, there are also several disadvantages. First, there would be a requirement to update the policies and doctrine so that AMEDD personnel have a reference for how to manage and utilize this increased weapon capability. Second, there would be increased training requirements that would accompany this initiative. Not only would personnel have to meet qualification standards that accompany the weapon system (stationary and mounted), but there would also be a requirement to understand how to maintain, store and account for the system and its components.

Third, there would be a materiel requirement to deal with, as the military would have to field and sustain thousands of these weapon systems, and their supporting components, across the numerous AMEDD units in the U.S. Army. And finally, but perhaps most important, the leader responsibilities that would accompany this course of action would be significant. AMEDD leaders would have to learn how to employ this new capability, both individually and collectively, and both stationary and mounted.

Also, AMEDD leaders would bear the responsibility to ensure that all their personnel operating these weapon systems fully understand and operate within the provisions of the Geneva Conventions and the LOAC. The recommendation to field the M249 (or equivalency) to medical units in the U.S. Army is certainly viable, but it would come with its share of challenges and drawbacks.

6. The sixth, and last, category of recommendations given from the survey on how to improve the security of medical assets in the COE is to assign permanent security forces within AMEDD units. Six respondents (9 percent) of respondents recommended this in one form or another. The responses that fell into this category recommended that Soldiers from non-AMEDD branches (such as MPs, ADA, Infantry, and others) be permanently assigned to AMEDD units for the purposes of providing security for the AMEDD unit.

The major advantage that this recommendation provides is that it would give the medical commander a legitimate, dedicated security force to support the medical mission. Theoretically, this security force would be able to provide more security to the medical unit than simply giving the unit an increased weapon capability. Because it would be organic to the medical unit, security for medical missions could be better resourced, synchronized and executed. Also, the medical commander would not have to worry about where his security was going to come from or when it was going to get taken away from him because of competing requirements.

While this recommendation has some substantial advantages, and is theoretically feasible, it would probably require the most significant changes and would therefore be difficult to implement. First, this recommendation would require all the changes

mentioned in the previous suggestion to increase the weapon capability. A dedicated, non-AMEDD security force would need to be fielded with at least the M249, which would infer all the necessary changes mentioned above in that course of action. Second, the U.S. Army is currently a “zero sum game” organization, meaning its total personnel strength cannot be increased. This course of action would either require that other branches to decrease slots in some organizations and shift them over to the AMEDD units or that the AMEDD would have to decrease its medical personnel slots to accommodate the non-medical security personnel. This aspect means that change would need to occur not only across the AMEDD, but also across the entire Army. With the current manpower struggles across the U.S. Army, the AMEDD would have a very difficult time selling this concept to its sister branches.

Third, this recommendation would require a significant change to the organizational structure of the U.S. Army. Manning and equipment documents, such as MTOEs and ARs, would have to be revamped and updated. Fourth, this recommendation would increase the personnel management requirement of the AMEDD unit. Even though many medical units already manage a small percentage of non-AMEDD personnel within their organizations, the addition of a security force would significantly increase the demand in this area.

In summary, the first two recommendations, increasing vehicle armament and increasing training for AMMED personnel, are already receiving significant attention from the Army and require no further emphasis. The third suggestion, removing markings from medical vehicles, is not needed or recommended by this study because it is a violation of the Geneva Conventions and tactical leaders currently have sufficient

authority to mitigate this issue at their discretion. The final three of the recommendations given by the survey respondents (improving Army coordination and leader education, improving weapons capability in AMMED units, and assigning permanent security forces to AMMED units) are recommended for additional attention and further analysis from the U.S. Army even though solutions might be resource intensive, especially for assigning security forces to medical units. Nevertheless, to study these courses of action would be a wise use of resources, because they are appropriate, feasible and, if implemented prudently, could significantly improve the overall force protection and security of medical elements on the modern battlefield.

Conclusion

The analysis from this research project suggests that the existing governing documents set forth by U.S. governmental agencies are adequate and appropriate in providing guidance to subordinate organizations on conducting military operations in adherence to the provisions of the Geneva Conventions. The research also shows that AMEDD leaders still have significant difficulties with providing medical support to their tactical commanders, while at the same time adhering to the provisions of the Geneva Conventions. From the results of the survey and the author's professional experiences, there is little doubt that more attention needs to be given to improving the education and training level of AMEDD and supported unit leaders on the understanding and application of the provisions of the Geneva Conventions. In the short term, adjusting the curriculum in AMEDD professional development courses, such as ANCOC, OBC and the CCC, by increasing the time dedicated to this topic could be accomplished relatively easily. In the long term, more Army-wide training programs could be implemented for

tactical leaders at all levels, and also more in depth, detailed training programs could be given to AMEDD leaders from subject matter experts, such as proponents from the JAG Corps.

Although the current AMEDD initiatives to improve the force protection of AMEDD assets in the COE are warranted, they might be overstepping the ethical boundary under the spirit of the Geneva Conventions. The idea of arming medical units with the M249 SAW is certainly within the limits of the letter and spirit of the Geneva Conventions. However, the mounting of such weapons on medically marked vehicles infringes upon the intent of provisions of the Geneva Conventions, and would probably have adverse consequences in the global community. This on-going course of action should be analyzed further to attain some middle ground that would be more acceptable internationally and also more easily implemented by AMEDD personnel.

GLOSSARY

- AMEDD Unit. Those units that fall under the AMEDD Regimental Affiliation, as designated by the Headquarters, Department of the Army. These units are designated with their own Table of Organization and Equipment (TO&E).
- Armed Conflict. Confrontations between two or more nations, a nation and a body other than a nation or a nation and a dissident faction or two ethnic groups within a nation.
- Combatant. Members of forces taking a direct part in the conflict. Under the LOAC, combatants are under obligation to distinguish themselves from the civilian population.
- Convention. A written treaty, pact or agreement between nations that regulates matters of common concern, thus becoming international law.
- Custom. Comprehensive and uniform repetition of behavior over a long period, in belief that such behavior is obligatory. Custom often precedes regulations and are respected by all participants. Such customs often then become part of international law.
- Law of Armed Conflict (LOAC). The LOAC regulates the conduct of armed hostilities. It aims to protect civilians, prisoners of war, the wounded, sick, and shipwrecked. LOAC applies to international armed conflicts and in the conduct of military operations and related activities in armed conflict. LOAC comes from both customary international law and treaties. Customary international law, based on practice that nations have come to accept as legally required, establishes the traditional rules that govern the conduct of military operations in armed conflict.
- Medical Personnel. Persons assigned exclusively to medical purposes, whether to search for, collect, transport, diagnose and/or treat the wounded and sick or to the administration or operation of medical units or medical transports.
- Protect. To come to someone's, or something's, defense; to lend help or support.
- Protocol. An international agreement that usually complements or expands upon an existing treaty or agreement.
- Ratify. An act of government that legally binds the nation to a treaty already signed by that government's representative.
- Small Arms. Those weapon systems that fire NATO approved ammunition of 5.56mm rounds (or smaller) and can be maintained and operated by a single person (not crew-served).

State. A term commonly used in international relations to refer to a nation or country.

Unconventional Warfare. A broad spectrum of military and paramilitary operations, normally of long duration, predominantly conducted through, with, or by indigenous or surrogate forces who are organized, trained, equipped, supported, and directed in varying degrees by an external source. It includes, but is not limited to, guerrilla warfare, subversion, sabotage, intelligence activities, and unconventional assisted recovery. Also called UW.

APPENDIX A

THE AMEDD FORCE PROTECTION SURVEY

The purpose of this survey was to gain more perspective from relevant leaders across the AMEDD on how prevalent the problem of securing medical assets in the COE actually is and also to solicit ideas from AMEDD leaders on how to mitigate this risk. Authorization for conducting this survey was given by the Army Research Institute, via the Command and General Staff College's Quality Assurance Office. The control number for the survey is: QAO 08-044. The following section explains the survey questions and explains how the responses were interpreted. The final part of this appendix contains a copy of the actual survey as it was presented to the participants.

In questions on the survey, the respondents are asked about their experiences with the protection of medical assets in the COE. The contemporary operational environment (COE) refers to the complex global environment the United States faces today. The COE is a global system of systems, comprised of numerous variables that interact to create intertwined national, political, economic, social, spiritual, cultural, and military interests, challenges, and threats. It is the environment that resulted from rapid advances in technology, the shift in power created by the collapse of the Soviet Union, traditional cultural, religious, and ethnic rivalries, economic interdependence, and the complex dynamics of a single global super-power (Ott 2002, 30). In short, the environments that Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) are being conducted in are good examples of the COE.

In all, 239 invitations to participate in the survey were sent out to select AMEDD leaders, of which 75 successfully completed it, resulting in a completion percentage of 31

percent. The survey consisted of only five questions and two of those were optional, depending on the participant's answers to certain questions.

Survey Question #1

As an AMEDD element, have you, your medical assets or your patients ever been deliberately attacked (by regular or irregular forces) while conducting military operations in the Contemporary Operating Environment (COE)?

For the purposes of clarity, some explanation on what constitutes a “deliberate” attack must be addressed. One of the areas trying to be determined on the survey was the amount of unlawful attacks on medical units who maintain a protected under the Geneva Conventions. This would mean that the enemy force had full knowledge of the medical unit's protected status and conducted the attack with disregard for this status. One area of uncertainty with regards “deliberate” attacks is indirect fire, which for the purposes of this thesis consists primarily of mortars. Because indirect fire is relatively inaccurate, when compared to direct fire, it was sometimes difficult to determine whether the attack on the medical asset with indirect fire was done intentionally or accidentally. Because of this, the results from the survey regarding indirect fire have been broken down into two categories. One category being incidences in which it was confirmed through reliable sources that the intent of the indirect attack was to engage the medical asset, which we will name “confirmed,” and the other category being incidences where medical units were attacked via indirect fire in which it could not be determined what the enemy's desired target actually was, which we will call “unconfirmed.” With this understanding in mind regarding deliberate attacks, the results from the survey can now be explored.

Survey Question #2

You indicated your AMEDD element had been deliberately attacked; briefly describe the nature of the attack(s).

From the answers, five distinct categories for the method of attacks were identified. The first three categories were “small arms,” “rocket propelled grenade” (RPG), “improvised explosive device” (IED), and the final two dealt with indirect fire and were termed “indirect (confirmed)” and “indirect (unconfirmed).” The last two categories refer to the previous discussion in this section regarding the difficulties in determining whether or not an attack on a medical element via indirect fire was deliberate or not. With regards to the statistics of the survey, if it was determined that the attack described in question two fell into the “indirect (unconfirmed)” category, that answer would then effect the previous answer given in question one, and would change the “Yes” response to a “No.” Also note that the total number of incidences described in the respondents’ answers to question two will not equal the number of “Yes” responses in question one because some of the respondents had multiple experiences with deliberate attacks, and described separately. For example, one respondent explained that on one medical evacuation mission his properly marked ambulance was attacked by small arms fire and in a separate incidence, his medical convoy received RPG fire.

Survey Question #3

As an AMEDD leader, have you ever had difficulties with providing adequate force protection to your unit and/or your patients during a military operation?

Question 3 was a “Yes/No” question and requires no further explanation.

Survey Question #4

You indicated that as an AMEDD leader, you had difficulties with providing adequate force protection to your unit and/or your patients during a military operation. Please describe the difficulty you had with providing force protection for the medical element(s).

Although there were many differing answers to question four, the responses could be categorized into similar schools of thought. In an effort to quantify the responses and identify any major themes, the answers were organized into the following categories:

1. Security assets unavailable. This category includes the responses that indicated that they had difficulties in coordinating and obtaining adequate security assets needed to accomplish their medical mission. For the purposes of this category, “minimum security requirements” refers to the constraints put on the military force by its higher headquarters. In the COE, U.S. Army organizations are housed in cantonment areas, typically called Forward Operating Bases (FOBs), and the tactical commanders emplace strict provisions on all elements leaving the FOBs. These restrictions almost always include a minimum security requirement. For example, in OIF, it is commonplace for commanders to establish as policy that all elements must have at least four vehicles in order to conduct a mission outside of the FOB. The responses that fell into this category include issues such as a lack of MP availability for escorting ground evacuation missions, no available non-medical personnel to assist with security requirements and security forces detailed for securing medical assets being taken away due to other mission requirements.

2. Inadequate weapon types. This category includes all the responses that indicated that the difficulty they had with providing adequate protection for medical

elements was due to inadequate weapons type. A good example of this is type of requirement would if a commander dictates that all elements leaving the FOB must have at least two crew-served weapons in their formation. The responses that fell into this category encompass incidences where the medical leader could not meet the tactical commander's minimum weapon type requirement because the medical personnel were only authorized to carry the M-4 rifle, or equivalent, and below weapon types.

3. Inadequate vehicular armor. This category includes all the responses that indicated that the difficulty they had with providing adequate protection for medical elements was due to inadequate vehicle armament. Because the risk from IEDs, RPGs and other high explosive devices is high in the COE, tactical commanders often limit operations outside of the cantonment areas to only vehicles that are up-armored, such as tanks, armored personnel carriers and up-armored HMMWVs (high mobility multi-wheeled vehicles). While many units do have the lightly armored M113 tracked ambulance, the preponderance of standard medical evacuation vehicles in the Army consists of un-armored wheeled vehicles, such as the M997 ground ambulance, which is basically a HMMWV with a patient compartment mounted on the back. The responses that fell into this category indicated that they had difficulty in providing adequate protection to their medical elements because of issues with the vehicle armament.

4. Inadequate cantonment facilities. In the COE, the large majority of medical units are conducting their medical mission in mostly fixed facilities located on cantonment areas, such as FOBs. Because of this, the risk to medical units from indirect fire in the form of mortars, and direct fire, from missiles and RPGs, is high. The responses that fell into this category indicated that they had difficulty in providing

adequate protection of their medical elements because of issues with such things as the availability of hardened facilities and protective shelters.

With the four categories established and explained, there is one other facet that must be explained about the responses before they can be analyzed. Similar to question two of the survey, some of the respondents indicated difficulties in more than one area. For example, one respondent indicated that he experienced delays in conducting medical evacuation missions due to the unavailability of a security package and on another occasion, his medical facility was attacked with indirect fire and there were insufficient bunkers for his staff and patients. In order to be as accurate as possible, each separate instance that was explained in the answer will be counted as a separate incident. Because of this, there will appear to be more numbered incidences in the data from question four than the total number of respondents that answered “Yes” to question three.

Survey Question #5

What recommendation(s) do you have for providing adequate protection for medical elements in the Contemporary Operating Environment (COE)?

This answer section was simply a blank text box, in which the respondent could type in any way they wished. Similar to what was done in question four, the answers were grouped into categories in order to quantify the number of like responses.

For question five, the responses were grouped into six distinct categories:

1. Increase weapon capability. The answers that fall into this category consist of respondents that indicated that they believe AMEDD personnel should be authorized to maintain and operate weapon types above the M4/M16 series, to include the M249 and crew-served weapons.

2. Increase vehicle armor. This category consists of responses that suggest that the AMEDD should upgrade the vehicle armor of the medical evacuation vehicles, specifically the wheeled assets, such as the M997s and M996s.

3. Increase training. The answers that were grouped into this category suggest that the AMEDD personnel should be required to do more force protection training, both individual and collective. This training would be in line with what most of the Army units are already regularly conducting, such as convoy live fire, react to enemy contact drills and more weapons training and qualification.

4. Assign permanent security. This category contains all the responses that suggest that permanent, non-medical security forces should be permanently assigned to medical units for the sole purpose of providing force protection. These personnel would be organic to the unit, but would not have protected status under the Geneva Conventions.

5. No change to policies but improved leader education required. Answers in this category suggest that there is no need to change the Army and/or the AMEDD's policies on protecting medical assets within the provisions of the Geneva Conventions. They also suggested that it is up to the AMEDD leader on the ground to ensure that the tactical commander is educated on the medical elements' requirements and limitations under the Geneva Conventions.

6. Remove distinctive markings. This category contains all the responses that suggest that the distinctive Geneva Conventions markings of the Red Cross and Red Crescent be removed from the Army's standard medical vehicles.

Example of the AMEDD Force Protection Survey

- 1) As an AMEDD element, have you, your medical assets or your patients ever been deliberately attacked (by regular or irregular forces) while conducting military operations in the Contemporary Operating Environment (COE)?

() Yes *(if the respondent answered 'Yes' they had to answer question 2)*

() No *(if the respondent answered 'No' they skipped question 2 and answered question 3)*

- 2) You indicated your AMEDD element had been deliberately attacked; briefly describe the nature of the attack(s). (Please be specific) (1200 character limit, about 20 lines.)

- 3) As an AMEDD leader, have you ever had difficulties with providing adequate force protection to your unit and/or your patients during a military operation?

() Yes *(if the respondent answered 'Yes' they had to answer question 4)*

() No *(if the respondent answered 'No' they skipped question 4 and answered question 5)*

- 4) You indicated that as an AMEDD leader, you had difficulties with providing adequate force protection to your unit and/or your patients during a military operation. Please describe the difficulty you had with providing force protection for the medical element(s). (Please be specific) (1200 character limit, about 20 lines.)

- 5) What recommendation(s) do you have for providing adequate protection for medical elements in the Contemporary Operating Environment (COE)? (Please be specific) (1200 character limit, about 20 lines.)

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USACGSC
100 Stimson Avenue
Fort Leavenworth, KS 66027

LTC(R) Russell Thaden
DJIMO
USACGSC
100 Stimson Avenue
Fort Leavenworth, KS 66027

LTC Luis Rodriguez
Legal
USACGSC
100 Stimson Avenue
Fort Leavenworth, KS 66027