

Law of War and Ethical Considerations for Medical Units During Large Scale Combat Operations

by Patrick Naughton

Introduction

The foundations of Army doctrine are grounded in and guided by Army ethical standards, which are derived from Army Values and the Law of War—both seek to guide Army leaders in the conduct of operations.¹ The new Field Manual (FM) 3-0: *Operations* presents the hypothesis that since 2001, the Army has shifted its focus from training and equipping the force to face peer threats to one concentrated on defeating two insurgencies and confronting global terrorism. It declares that during that time, four nations have developed capabilities that are now able to counter United States (U.S.) advantages across all domains. The four peer threats: Russia, China, Iran, and North Korea, present the most significant readiness challenge to U.S. forces since the Cold War. They require the U.S. Army to reorient itself back to preparing to face a peer competitor on the battlefield.² With this shift, the U.S. military medical community must re-familiarize itself with international and Department of Defense (DoD) Law of War guidance and other ethical considerations when employing medical units and personnel in a peer operational environment during large scale combat operations. Utilizing inadequately marked and improperly placed medical units in the next war will result in a massive disruption to the ability to provide care due to mistargeting. The employment of medical units in a counterinsurgency environment will not be the same when facing a peer competitor; as such, future peer opponents and their adherence or otherwise to international medical protocols must now be considered.

Due to the adversaries faced over the past seventeen years, and their disregard for international law, the U.S. military's adherence to international medical agreements and ethical considerations has declined. Employing medical units and personnel improperly marked per Geneva Convention Articles and DoD Law of War Manual guidance has become the norm. In addition, the placing of medical facilities next to valid military objectives to capitalize on logistical support has become standard practice.

This essay will examine this topic through five areas. First, the employment of medical units in large scale combat operations per recently released Army doctrine will be explored. Second, international and Department of Defense Law of War guidance will be reviewed. Third, American peer threats and their Law of War and Ethical postures will be examined. Fourth, Information and Intelligence Operations and how they can be leveraged by medical units will be discussed. Lastly, U.S. Law of War and Ethical considerations during large scale combat operations when facing a peer competitor will be expounded upon.

Medical Units in Large Scale Combat Operations

FM 3-0: Operations has introduced one key new concept that relates to the arraying of medical units when conducting large scale combat operations. What was once termed the “Rear Area” is now broken into two parts. The first is the Consolidation Area, which is the “portion of the commander’s area of operations that is designated to facilitate the security and stability tasks necessary for freedom of action in the close area and to support the continuous consolidation of gains.”³ The second is the Support Area; this is the “portion of the commander’s area of operations that is designated to facilitate the positioning, employment, and protection of base sustainment assets required to sustain, enable, and control operations.”⁴

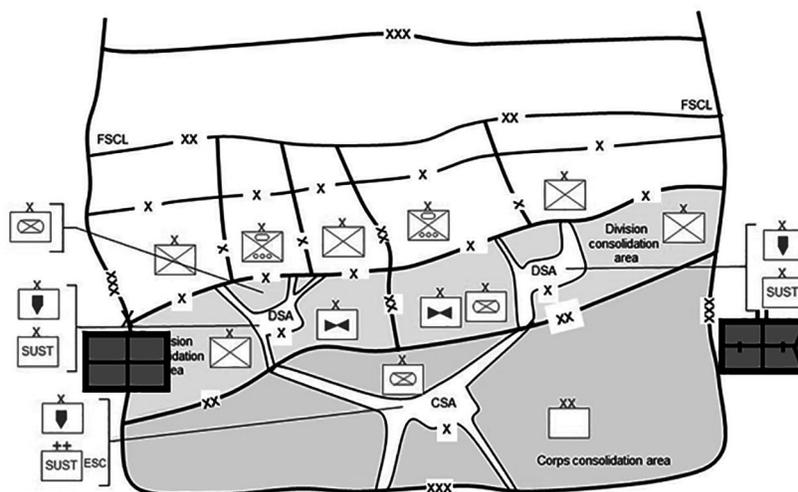


Figure 1. Graphic representation of the Consolidation and Support Areas introduced in FM 3-0, this graphic illustrates where the Medical Brigade and Field Hospital will find themselves.⁵

The Consolidation Area is where “activities to make enduring any temporary operational success and set the conditions for a stable environment allowing for a transition of control to legitimate authorities” will occur.⁶ Though this sounds like a new concept, it is not; *FM 3-0* just gives it a name and codifies it. (See Figure 1 above.) Historical precedence exists for it—consider American activities in World War II (WWII) Germany. Note, the Consolidation Area may not be labeled as such in Operations Orders and Graphic Overlays; however, it will be recognizable as it will be the designated area behind maneuver elements in the Forward Edge of the Battle Area (FEBA). Security for the Consolidation Area will be the responsibility of a Brigade Combat Team (BCT) that can defeat all Levels of Threat.

Located within the Consolidation Areas will be Support Areas. These will consist of Base Camps or Base Camp Clusters that contain sustainment assets to include medical units. The Maneuver Enhancement Brigade (MEB), or Sustainment Brigade (SUS BDE) if an MEB is not available, will manage the array of these Base Camps/Clusters and the overall placements of Support Areas. The MEB (or SUS BDE) is expected to be able to defeat up to a Level II Threat in these areas. Any Level III threats will be defeated by a Tactical Combat Force (TCF) provided by the BCT in the Consolidation Area.

Medical planners must understand and grasp this new doctrinal concept when considering where to employ their units. In addition, MEBs and SUS BDEs need to understand the necessity to clearly mark medical units and keep them away from military objectives when located in these areas. All components of the military medical community will need to start training with MEBs and SUS BDEs if they are to be prepared to exercise this relationship in the Consolidation/Support Areas during large scale combat operations in a deployed environment against a peer threat.

International and Department of Defense Law of War Guidance

Per the International Committee of the Red Cross and Red Crescent: “The Geneva Conventions and their Additional Protocols form the core of international humanitarian law, which regulates the conduct of armed conflict and seeks to limit its effects.”⁷ The Geneva Convention contains numerous Articles directly related to medical forces on the battlefield. However, Articles 19, 24, 39, and 42 are critical because they speak to the proper employment and markings of medical units in the Consolidation and Support areas. Signatories to the Geneva Convention and its Protocols have agreed to the following:

1st Convention, Article 19: 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...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.⁸

1st Convention, Article 24: Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, staff exclusively engaged in the administration of medical units and establishments, as well as chaplains attached to the armed forces, shall be respected and protected in all circumstances.⁹

1st Convention, Article 42: The distinctive flag [*red cross or other recognized emblem*] of the Convention shall be hoisted only over such medical units and establishments as are entitled to be respected under the Convention...Parties to the conflict shall take the necessary steps, in so far as military considerations permit, to make the distinctive emblems indicating medical units and establishments clearly visible to the enemy land, air or naval forces, in order to obviate the possibility of any hostile action.¹⁰

1st Convention, Article 39: Under the direction of the competent military authority, the emblem shall be displayed on the flags, armlets and on all equipment employed in the Medical Service.¹¹

The *DoD Law of War Manual*, last updated in December of 2016, supports the Geneva Convention Articles and codifies the guidance to all DoD branches, which can then be found in service specific Law of War FMs and doctrine. Though the manual does support the Conventions, it does contain one crucial caveat:

The display of the distinctive emblem is under the direction of the competent military authority. Thus, the military command may authorize the removal or obscuring of the distinctive emblem for tactical purposes, such as camouflage. Similarly, it would be appropriate for the distinctive emblem to be removed if it is assessed that enemy forces will fail to respect the emblem and seek to attack medical personnel; display of the emblem in such circumstances would not be considered “feasible” because in that instance it would not result in a humanitarian benefit. In the practice of the United States, removal or obscuration of the distinctive emblem has generally been controlled by the responsible major tactical commander, such as a brigade commander or higher.¹²

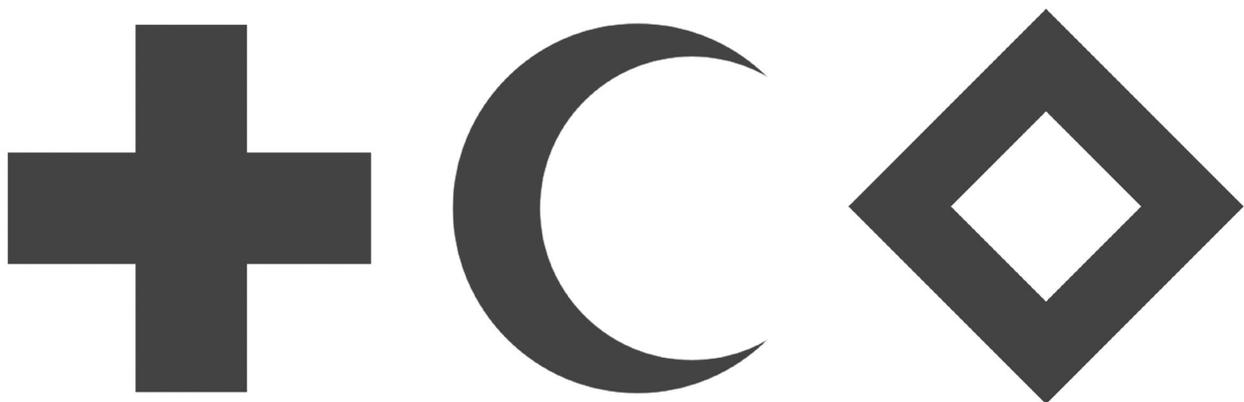


Figure 2. Internationally recognized medical emblem markings: Red Cross, Red Crescent, and Red Crystal.¹³

This stipulation has dominated the past seventeen years of employment of medical units and personnel due to the nature of the adversaries faced, who do not respect any international standards. Unfortunately, this thought process continues to direct military medical and non-medical planners on how to employ medical units in Consolidation and Support Areas when preparing to face a peer competitor. Though the DoD Law of War Manual allows for this proviso, it does caution that: “The absence of the distinctive emblem may increase the risk that enemy forces will not recognize the protected status of military medical...and attack them in error.”¹⁴

Medical Law of War and Ethical Posture of Near Peer Threats

The first Geneva Convention occurred in 1949 after WWII; however, many of the rules later codified were largely adhered to by the combatants. The Convention was also observed in the Korean conflict, though both conflicts did experience violations on the tactical level, evidenced by actions in Hong Kong, Singapore, and the Chaplain-Medic Massacre.¹⁵ Neither conflicts saw an intentional direct deep strike conducted against a properly marked medical unit, though the enemy had the capability to do so.

Examining the posture being demonstrated and observed regarding the medical Law of War and ethical considerations of peer threats in Russia, China, Iran, and North Korea is important when considering the emplacement of medical units. All these countries are signatories to the 1st Convention of 1949, which includes Articles 19, 24, 39 and 42.¹⁶ However, the act of signing does not guarantee they will abide by the guidance. Examining past events and current actions is the only way to determine if they will respect international law regarding the protection of medical units and personnel.

Russia, as evidenced in its recent conflict in Georgia, is willing and capable of using direct air support (DAS) in conjunction with ground forces. Its combined arms approach targeting key nodes with DAS is capable and will be able to reach U.S. Consolidation Areas.¹⁷ Many experts feel that Russia will respect properly marked medical units during the deep fight due to its belief in itself as a pillar of western civilization and culture. However, if its enemy does not abide by Geneva standards, then Russia can be counted on to reply negatively in kind.¹⁸ Nonetheless, Russia does send mixed messages, as evidenced by its past actions in Syria and accusations of purposefully targeting medical facilities as a war strategy.¹⁹

China has not been involved in large scale combat operations since Korea. Its recent military experience has primarily focused on humanitarian assistance and disaster relief operations. Experts have not discovered anything in Chinese doctrine that specifically permits purposefully targeting medical facilities, though they will direct fire against logistics and command and control nodes during the deep fight. Examining covert messaging may be critical to determining China’s intent toward military medical operations. All training events conducted by the Peoples Liberation Army (PLA) have properly marked medical evacuation platforms and facilities present. This indicates that they will respect appropriately marked medical units located in the Consolidation Area.²⁰ (See Figure 3 on page 123.)

Iran is an emerging peer competitor that is attempting to leverage what strengths it has in the event it engages in conflict against the U.S. It has observed the conflicts in Iraq, Afghanistan, and Israel to glean lessons that can be incorporated into its own armed forces. It believes America is vulnerable due to its over reliance on technology, regional basing, and adverse nature toward risk and heavy casualties. Iran plans to counter American might through religiously motivated soldiers, strategic depth, and a willingness to accept high casualties. The concept of a mosaic defense has recently been implemented in Iran’s defensive strategy. The plan centers on its ability to draw the enemy into its border to create strategic depth. Then, through independently led forces, it can conduct an insurgency on U.S. extended lines of communication located in the Support and Consolidation Areas. This battle of attrition is meant to win a victory by eroding America’s commitment through high casualties.²¹ The Iranian strategy will place its forces on a collision path with



Figure 3. Aboard Chinese hospital ship Peace Ark during a multilateral exercise in 2013. Note properly marked medical aircraft and medical brassards worn by its personnel. Could be a covert message on Chinese intent to respect international medical rules.²²

medical units. Based on Iran’s human rights record, how it will treat properly marked medical units during large scale combat operations is a concern.²³

Of the top four peer threats, North Korea is the big unknown. According to the United States Army Training and Doctrine Command 2015 *Threat Tactics Report*, North Korea understands that the American Consolidation and Support Areas are an exposed Center of Gravity that they can exploit. It will focus conventional fires, para-military, and Special Forces in these areas to attack key command, supply, and logistical centers.²⁴ Due to its many weaknesses in protecting its own rear, it may seek to avoid targeting enemy medical units to protect what it can in its own support areas. However, despite being a signatory to the 1st Geneva Convention, actions demonstrated during the Korean War and the USS Pueblo incident suggest that it is highly unlikely that they will abide by any Laws of War. Experts believe that most North Korean soldiers and officers have most likely never received any training on international protocols.²⁵ The employment and proper marking of American medical units will need to be carefully considered in a conflict against North Korea.

Leveraging Information and Intelligence Operations for Medical Units

When facing peer competitors, the U.S. will need to heavily leverage Information Operations (IO) and the Intelligence Process when employing medical units and personnel in the Consolidation and Support Areas. IO is the “integrated employment, during military operations, of information-related capabilities in concert with other lines of operation to influence, disrupt, corrupt, or usurp the decision-making of adversaries and potential adversaries while protecting our own.”²⁶ While the Law of War may not seem as ready fodder for an IO campaign, it is in fact one of the easiest areas with which to exploit and influence U.S. actions. The recently published *DoD Law of War Manual* is evidence of this. First released in 2015, it included the term “unprivileged belligerents” when referring to journalists on the battlefield. Russia Today, an international television network funded by the Russian government, seized upon this wording and waged a highly effective IO campaign criticizing the manual and the U.S.²⁷ It was so effective that in December 2016, the U.S. released an updated version that removed the controversial wording and added clarification on the protection afforded to journalists.²⁸ This illustrates how enemies can use Law of War guidance in an IO campaign to influence actions—simply interchange the word medical for journalist for context.

The Intelligence Process is the method by “which information is converted into intelligence and made available to users, consisting of the six interrelated intelligence operations.”²⁹ As already noted, the four peer threats demonstrate their national intent in regards to respecting medical Law of War and Ethical considerations in large scale combat operations by being signatories to international agreements, overt and covert messaging, and through past actions. It will fall on the U.S. intelligence apparatus at all levels to determine the intent of a peer threat regarding the employment of medical units and personnel *before* the next fight. Will the belligerent employ its own medical units in accordance with international standards? Will it respect the proper employment of U.S. medical units? These will be the questions that U.S. intelligence operations will need to answer *prior* to entering major combat operations.

Continuing the current trend of employing medical units and personnel not in accordance with Law of War guidance and ethical considerations will result in the massive destruction of medical forces due to mistargeting. If the U.S. intentionally targets clearly marked enemy medical facilities it will provide adversaries with ammunition for an IO campaign that will have devastating effects on U.S. international prestige and credibility and will weaken alliances and coalitions. Moreover, if the U.S., due to erroneous intelligence and the belief that enemies will not respect international medical guidelines, employ medical forces in a way that they are mistaken for valid military objectives, it will result in their rapid destruction. This will quickly remove the ability of U.S. forces to clear the battlefield of its sick and wounded, thereby eliminating any offensive capabilities. Lastly, the IO campaign works both ways; belligerents that fail to follow international Law of War Guidance can be attacked and condemned in a method that will remove global support for their efforts.

Medical Law of War and Ethical Considerations in Large Scale Combat Operations

Military planners are tasked with the complicated duty of balancing Operational Art and science. The art of operations is the “cognitive approach by commanders and staff” to organize and employ military forces, utilizing their intellectual skill developed through experience and training.³⁰ Operational science “revolves around the physical, quantifiable, and technical aspects of waging war”.³¹ Many planners, when attempting to balance both, examine the practical side of logistics to prevent the bane of maneuver forces spelled out in two elements of Operational Art: culmination and operational reach—both of which often occur due to inadequate planning in the science of resupply. Planners also identify specific sustainment functions that could cause these elements to occur, that being the risk of ammunition or fuel depots being destroyed in deep-strikes.

However, when thinking abstractly using Operational Art, planners often overlook another critical sustainment function: Health Service Support. If these units are destroyed, it would halt any attempt at operational reach and cause all maneuver elements to immediately culminate. The inability to clear the theater of casualties would quickly overwhelm maneuver units and remove their ability to continue the fight. In addition, the morale sapping factor it would have on the force cannot be understated. This fact must be considered when conducting planning during large scale combat operations.

When overlooked by military planners, medical units will be placed in a unique position when operating from the Base Camps in the Consolidation and Support Areas. The BCT and MEB (or SUS BDE) managing these areas will understandably desire all units to be highly camouflaged to avoid deep-strikes. In addition, sustainers will desire that units form around shared logistics nodes or collocate along main avenues of approach to ease resupply efforts for shared commodities such as fuel and water. While the effectiveness of this collocation has been demonstrated in Iraq and Afghanistan, by Law of War standards they are considered legitimate military objectives. A peer competitor who has the capability to strike these targets remotely across vast distances will seek these areas out. Medical units must be employed away from these objectives and within the guidelines of Geneva Article 19 and the DoD Law of War Manual to avoid being

destroyed, a result which would remove the ability to clear the battlefield of casualties and provide any Health Service Support.

International protection standards must be fully leveraged because medical units have no offensive role in any capacity. Medical markings seek to fill defensive gaps that combat units conduct internally through offensive postures. Collocating large medical units within a military objective or placing it under camouflage or “in the wood-line”, removes the defensive protections it has and opens it up for attack from a peer competitor who has deep-strike capabilities. Hence, a medical unit’s greatest form of protection is to openly acknowledge its task and mission through highly visible medical markings. International standards of protection rigorously applied to medical units is not a constraint; rather, it serves as a combat multiplier, allowing units to better support the warfighter by enhancing their survivability under international Law of War guidelines. These protection standards, carefully applied against medical units, seek to protect robust medical treatment facilities, capabilities, and evacuation platforms arrayed in the Consolidation and Support Areas.

Ethical considerations can sometimes become confusing when persons are both medical professionals and soldiers. The International Committee of the Red Cross in partnership with numerous other medical organizations has also recognized the growing trend of ignoring properly marked medical personnel and facilities in conflict areas. They state: “Existing norms are no longer sufficient and the general consensus that the medical mission has to be respected in all circumstances has slipped into the background while abuses have increased from sporadic to systematic.”³² Due to this, working across a broad spectrum of civil and military medical groups, they have created and issued a set of principles aimed at assisting military health care workers understand ethical considerations. The document, entitled: *Ethical Principles of*



Figure 4. 95th Evacuation Hospital in Italy, 1944. There is no mistaking that this is a clearly marked medical treatment facility located away from valid military objectives.³³

Health Care in Times of Armed Conflict and Other Emergencies, contains fourteen guiding principles that military medical professionals can follow that nest with current DoD guidance. To include the principle “In fulfilling their duties...health-care personnel are identified by internationally recognized symbols such as the Red Cross, Red Crescent or Red Crystal as a visible manifestation of their protection under applicable international law.”³⁴

Though U.S. military medical personnel have strong core ethical principles engrained through their civilian and military training,³⁵ another area that sends a mixed message internally and externally is the DoD’s departure from wearing medical arm brassards. Once a common accoutrement to all U.S. military medical personnel, it has been removed from usage, though not due to any official guidance. In fact, the medical brassard is still authorized for wear per official Army uniform guidance.³⁶ It has become another victim of the past seventeen years of counterinsurgency operations where, rightfully so, many believe that the wearer presents a target, as seen in Iraq and Afghanistan. Despite this, the DoD has begun to reexamine the proper marking of medical personnel. To adhere with the international Geneva guidance that all medical personnel shall “carry a special identity card bearing the distinctive emblem” and that the “card shall be water-resistant and of such size that it can be carried in the pocket”, the DoD now includes the red cross on identification cards.³⁷ Beginning July of 2014, the DoD began to permanently “issue the Geneva Conventions Common Access Card with a red cross emblem to military personnel and DoD civilian employees in certain medical, medical auxiliary or religious occupational specialties.”³⁸ This is a step in the right direction and something not done until now; previously this card was issued before deployment as a slip of paper, if at all.

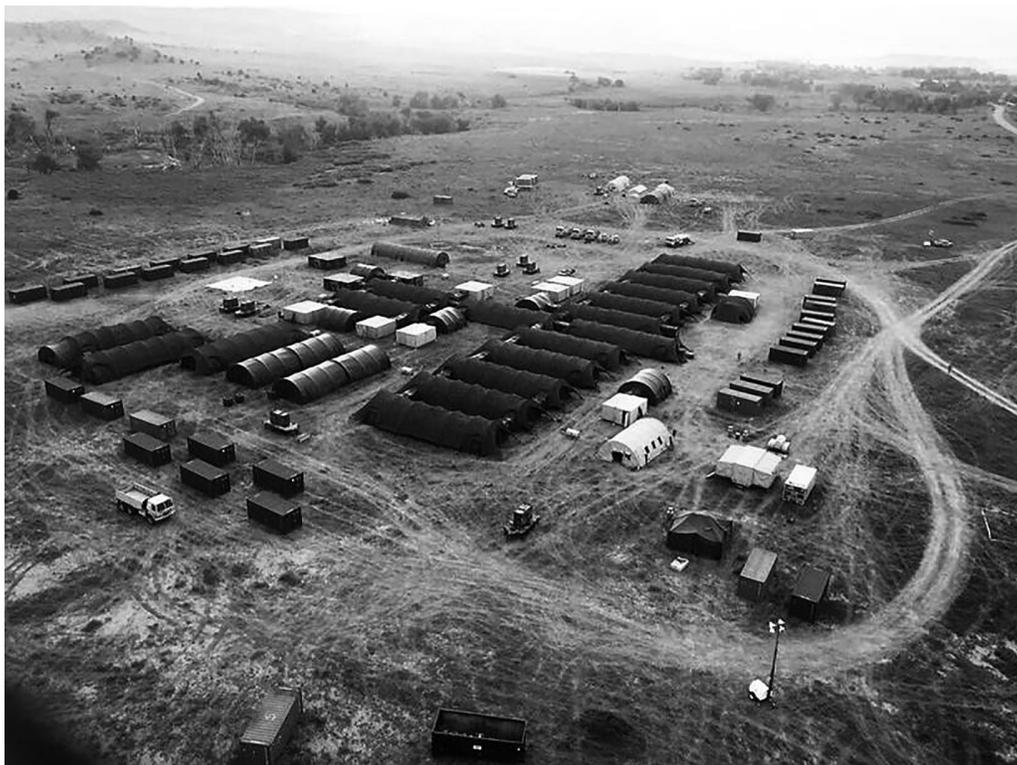


Figure 5. Contemporary U.S. Army Field Hospital established in a field environment. When compared to the hospital from WWII it is easy to see how with the absence of proper medical markings this could be mistaken for a valid military objective by an enemy with deep-strike capability.³⁹

As established, IO and intelligence efforts will be critical in determining what guidance to follow and how to employ medical units and personnel. Military planners, working with national and strategic leaders, will need to determine what message the U.S. wants to send to the world regarding adherence to Law of War guidance and Ethical considerations during large scale combat operations. Planners will need to balance intelligence on the enemies' deep-strike restrictions against U.S. logistics support desires and the survivability, through clearly marked units set away from military objectives, of its Health Service Support structure.

Conclusion

With the U.S. Army reorienting itself back to preparing to face a peer competitor on the battlefield, the military medical community must re-familiarize itself with international and DoD Law of War guidance and other ethical considerations when employing medical units and personnel in a peer operational environment during large scale combat operations. This essay has examined the topic through five areas thereby enabling medical personnel and the warfighter to understand this reorientation: the recently released FM 3-0 that has redefined the area behind the FEBA, international and DoD Law of War guidance, peer threats and their medical Law of War and Ethical postures, leveraging Information and Intelligence, and U.S. Law of War and ethical considerations during large scale combat operations.

Respecting medical international agreements during conflict, adhering to Law of War guidance, and exercising ethical considerations, directly assist in the cessation of conflict through demonstrating mutual respect and providing a common ground for resolution after the war. When facing a peer competitor, intentionally targeting medical units will exacerbate tensions and lead to a bitter conflict, as evidenced during the German-Russian front in WWII, which still defines Russian narratives and its siege mentality today. Furthermore, a direct result of the disregard toward international law is seen in the current conflict in Syria that will have repercussions for generations. Due to this, military training events and doctrine must heavily stress the importance of understanding the protections offered to medical units under internationally established guidelines. America's global terrorism adversaries have not respected international agreements; however, future peer opponents and their adherence or otherwise to international medical protocols must now be considered.

As the United States shifts from stability and counterinsurgency operations and begins to consider the threats these peer competitors offer, it must examine the proper employment and markings of medical units and personnel per Geneva Convention Articles and *DoD Law of War Manual* guidance. This analysis must be done *before* entering large scale combat operations. Each peer threat sends clear or covert messages on how it will treat properly marked medical units in the deep fight, which should be analyzed *prior* to committing to one course of action when employing medical forces. It appears that Russia and China will respect international protocols. Entering a conflict against either with inadequately marked or improperly placed medical units will result in massive disruption to the ability to provide care due to mistargeting. Iran and North Korea may not respect these same rules; employing properly marked medical units in this operational environment will have the opposite effect. Regardless of who the U.S. faces, to avoid learning costly lessons in the opening phases of hostilities with a peer competitor, the American military must have this conversation now.

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