Historical Antecedents to Understanding Contemporary Attacks on Healthcare[1]

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In an operational capacity for *Médecins Sans Frontières* (MSF), the present author had the opportunity to visit the organization's medical activities in the Nuba Mountains in early 2013. Geographically situated in Sudan's South Kordofan province, armed resistance from the Sudan People's Liberation Movement's northern brethren had continued despite South Sudanese independence in 2011. The reaction from Khartoum included the bombing of combatants and civilians alike.

While aerial bombardment has been portrayed as sanitized warfare, the view from the ground is obviously far different. In the MSF-supported hospital in Farandalla village, basic precautions had been taken. Trenches and foxholes were dug in the immediate vicinity. When the highly recognizable drone of a Soviet-made Antonov was heard, time permitting, patients and staff were evacuated underground. Barrel bombs were the preferred ordnance, essentially highly imprecise "improvised containers" filled with explosive material (Weapons Law Encyclopaedia 2013). Local wisdom contended that once sheltered you would be extremely unlucky to experience a direct hit, burst eardrums being the more common eventuality.

Luck for Farandalla's sole medical facility ran out the following year when two bombs hit the hospital on 16 June 2014, wounding several patients and an MSF staff member (MSF 17 June 2014). A little over seven months later, the same structure was "directly targeted" by the Sudanese Air Force with a cluster of thirteen bombs landing inside and outside the hospital compound, again resulting in injuries but no fatalities. On both occasions the authorities in Khartoum were aware of "MSF presence and activities in the hospital." And while MSF publicly condemned the attacks there were also practical consequences with the second incident leading to the organisation suspending medical activities in South Kordofan, depriving the population of one of the few healthcare providers in the region (MSF 22 January 2015).

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The indiscriminate bombing campaign in the Nuba Mountains, and the notable targeting of Farandalla's hospital, is hardly exceptional as concerns the protection of medical services in armed conflict. From the admittedly limited prism of MSF's experience over the past decade, colleagues, patients, caretakers, and associated staff have been killed in Ethiopia, Afghanistan, South Sudan, Syria, Yemen, Central African Republic, Burkina Faso and, most recently, the Occupied Palestinian Territory. In all cases, attempts are made to "establish the facts on what happened and why, and to establish whether we can put teams back on the ground" (MSF 8 June 2021).

But there is also a bigger picture. That respect for the principle of medical neutrality has had a chequered past would be an understatement, that violations of medical neutrality continue to this day obvious to most observers. But while identifying explanatory factors can be elusive, attempts at understanding the nature of each attack relevant to each context can be revealing. This chapter offers a comparative analysis as to how a historian's toolbox can be employed to better understand contemporary attacks on healthcare. A broad historical overview of medical neutrality will be provided, while remaining cognizant of the challenges of comparing different epochs, before delving into methodological considerations. Concrete illustrations, both historical and recent, will be provided throughout the narrative before highlighting gaps and suggestions for future research.

Lieber's Long Shadow

It might seem common sense that the hospital in Farandalla was operating under a banner of medical neutrality, but this should not be taken for granted. Protected status can be revoked if "used to commit, outside their humanitarian duties, acts harmful to the enemy", a fundamental tension when balancing military and humanitarian prerogatives. But even then, exceptional circumstances aside, such protection can only cease "after due warning has been given", including the provision of a "reasonable time limit." This was not the case in the described example, a clearly designated civilian hospital "organized to give care to the wounded and sick, the infirm and maternity cases" (Convention IV, articles 18 and 19). However, in a confrontation between international humanitarian law (IHL) and the cynical reality of what can be described as military necessity, the latter took precedence irrespective of the existing statutes.

Leos Müller (2019) has described neutrality as a "strange thing", a concept that has frequently been dismissed as "either unrealistic or immoral – or both." It certainly has a long history with origins that predate the modern era. As with other aspects of international law such as diplomatic immunity and formal treaties, its roots can be traced "back to the days of Rome and

Greece, or even earlier times" (Jessup and Déak 1935, 3-4). As a foreign policy option, neutrality has been particularly attractive to smaller states, a guarantor of sorts for their sovereignty and independence. It remains a "key concept of international law" today, playing a central role in the rise of "internationalism, humanitarianism and the peace movement, and so has contributed to the foundations of twentieth-century international organizations such as the League of Nations and the United Nations" (Müller 2019, 3).

While state neutrality essentially means not taking sides in a conflict; avoiding military alliances; and not taking actions that would advantage one side or another, applying this concept to aid organizations requires a different approach. For humanitarian neutrality to function all sides must accept that relief actions are "not hostile acts, nor are they de facto contributions to the war efforts of one of the belligerents." This includes humanitarian personnel who are expected to "abstain from any direct participation in hostilities or committing an act harmful to a party to the conflict" (Bouchet-Saulnier 2015). The application of medical neutrality follows a similar logic: not only non-interference in medical services during armed conflict, but those same medical services must ensure the impartial treatment of the sick and wounded irrespective of their provenance.

Tracing the origins of medical neutrality in the codified legal sense invariably involves returning to the mountain of literature produced since the First Geneva Convention of 1864. De Baets has argued that prior to this foundational moment, the history of humanitarianism was "often neglected apart from some occasional philosophical musings about the bellicose nature of human beings or the ritual nod to the 1648 Peace of Westphalia." But if IHL is indeed divided into "before and after Henry Dunant", a contemporary of the driving force behind the establishment of the Red Cross merits similar attention albeit for very different reasons (2022, 1588). Francis Lieber explored and then advocated for the application of military necessity when articulating his vision of the rules of war, including the protection of medical services.

In the context of IHL, the concept of military necessity posits that rapidly achieving battlefield objectives should be a priority even when this at times necessitates extreme levels of violence. Commissioned to draft *Instructions for the Government of the Armies of the United States in the Field*, Lieber completed his work the year before the First Geneva Convention was enacted. The parallels and divergences are striking. In his detailed study, Leonard Rubenstein (2021, 23) notes that Lieber's code encouraged the protection of hospitals but only insofar as "the contingencies and the necessities of the fight will permit", the "necessities of the fight" essentially permitting both the denial of care and the destruction of medical facilities. This dichotomy of visions has been summarized as Dunant's "absolutist protective stance" versus

Lieber's view that compassion for the casualties of war must be "tempered by the need to win a just war, and quickly – that is, military necessity" (Rubenstein 2021, 34).

However much rejected in law, Lieber's arguments have maintained an outsized influence in military doctrine, understandably terrifying to the humanitarian sector. The most recent incarnation of the Geneva Conventions remains the only international legal framework that aid organizations can draw on to "justify their own presence in war zones and make demands for access and protections" (Hofman 2021, 204). This precarious legitimacy is placed fundamentally at risk by actions that closely resemble a nineteenth century interpretation of military necessity, a concept that "easily morphs into military convenience" (Rubenstein 2021, 58). It is difficult to understand and interpret at least some of the attacks on healthcare today without integrating the logic of Lieber's long shadow.

Mitigating Historical Pitfalls

Even with a clear understanding of medical neutrality and its applications, infractions are difficult to compare in historical terms. The Geneva Conventions themselves, along with contemporary interpretations under customary law, can be described as living documents, their many incarnations reflecting both the changing means of waging war and attempts to broaden the scope of safeguards available. The eventual incorporation of non-international armed conflicts into the IHL protective framework being an obvious case in point. There are however other pitfalls to comparative analyses when investigating violations of medical neutrality that merit review.

Juxtaposing historical epochs, whether in terms of vastly different contexts or attack typologies, raises questions of comparison over space and time which are extremely difficult to answer, especially in quantitative terms. This includes data collection which can vary within organizations let alone across the humanitarian sector, even today. Such challenges are compounded by the increase in the number of aid agencies which can have a direct impact on levels of exposure and the frequency of incidents. Determining whether an attack was deliberate, dismissive of basic precautions, or unfortunate collateral damage is similarly challenging and often impossible. Finally, different forms of public pressure, notably through the rapid availability of information and disinformation, can skew analyses.

Given the above constraints, clarifying the investigation parameters is paramount. To return to the prism of MSF's experience, in the event of an attack on medical facilities, personnel or patients, some form of denunciation will almost certainly appear, often followed by "calls for an

independent investigation." However, an internal analysis is likewise essential to both resist and, if necessary, challenge the "narrative and facts" put forward by various actors in a conflict in addition to the media and other interested parties. Another important objective is to improve the security measures of existing operations, including the identification of potential blind spots as per MSF's protected status, and to feed further negotiations to secure stronger agreements with the belligerent parties. In all cases, "exhaustiveness" is essential to avoid "subjectivity, presumptions and bias." Elements that can be asserted with a "high level of certainty should be presented as such", adding to the credibility of conclusions that could cause discomfort or embarrassment to those responsible for an attack, intentional or otherwise (MSF Minimum standards 2016).

With those objectives in mind, useful recourse to historical methods becomes self-evident, especially when a broad-brush search for long-term trends is replaced with a more granular and context-driven approach. Whether exposing a long-forgotten attack on a medical structure or a recent violation, basic archival investigative work is similar in attempting to reconstruct events as factually as possible. This includes the use of formal primary sources, diplomatic and legal documentation for example, and recourse to informal exchanges, such as personal letters and memoirs versus twenty-first century communication. Similarly, context and risk analyses need to be based on information available at the time, including the identification of potential patterns of attack, given the risk of retrospective bias, essentially unintentionally passing judgement through the subjectivity of hindsight, irrespective of the time interval.

There are a few obvious differences that can be emphasized. When comparing historical and recent attacks on healthcare, an inverse form of confidentiality is at play as concerns obtaining sensitive material. Access to the archives of the International Committee of the Red Cross (ICRC) provides an apt demonstration, highly accessible pre-1975, far more restricted afterwards. And while there is no possibility to interview long-deceased actors from historic attacks, there is a forensic reality in contemporary cases that can necessitate extreme measures to protect the identity of those involved, particularly victims and their families. Finally, there are limits to what can be gleaned from the historical record. Drawing lessons from a recent attack can have a level of pragmatic urgency, both to avoid a repetition and to adjust security policies accordingly.

Past Cases and Perpetual Dilemmas

It is this last point that becomes particularly relevant, and tricky to determine, in both historical and contemporary analyses of medical neutrality in practice. Essentially the process and degree

to which codified ideals and aspirations perform in actual conflict zones. In this regard, Larry Minear (1999, 68) has suggested that the "real meaning of neutrality is tested where international humanitarian law and principle encounter the real-world dilemmas in the field." The historical record contains mixed results.

To illustrate these mixed results, the narrative now turns to earlier research by the author on the history of attacks on medical care. Recognizing the difficulties of comparing historic challenges of protection with contemporary incidents, similarities and differences were sought in the public explanations and rationales employed by those responsible for attacks on health facilities and staff. The objective being to see if elements of value relevant to continued attacks today would emerge. Framed as "Medical Care in Armed Conflict: Perpetrator Discourse in Historical Perspective", specific incidents over a wide range of contexts were reconstructed, primarily from first-hand sources, much as previously described.

The analytical framework of perpetrator discourse was based on more recent MSF experiences of attacks on healthcare, some of which will be detailed further on. Broadly these can be summarized as remaining silent; not taking a position, stalling, or avoiding the discussion; admitting involvement, generally with an apology or justification; or denial of involvement, often with some form of rejection narrative. This framework was applied to attacks on medical facilities and ambulances during the Franco-Prussian War from 1870-71; the sinking of hospital ships during World War I from 1914-18; the targeting of Red Cross field hospitals during the Second Italo-Ethiopian War from 1935-37; the occupation and destruction of medical facilities during the Second Sino-Japanese War from 1937-45; and finally multiple instances of public and Red Cross medical structures destroyed during the Nigerian Civil War from 1967-70 (McLean 2019).

In all five case studies a pattern of sorts emerged. In the early phases of a conflict, admissions of responsibility were common, often accompanied by claims of accidental or unintentional targeting of medical care. This was particularly obvious in the torpedoing of hospital ships in the First World War. The Germans relayed an apology for the near-miss of a British hospital ship via their Washington embassy in early 1915 (McGreal 2008, 28-32). Two years later the German narrative had shifted significantly, with regular claims that the British were "violating the Hague Convention regarding the application of the Geneva Convention to maritime warfare" (Diplomatic Correspondence 1918). The accusation of transporting munitions and troops was a convenient justification for the continued targeting of hospital ships in a period of unrestricted submarine warfare.

Allegations that the enemy was abusing the protections granted under the Geneva Conventions and thus jeopardizing the medical neutrality of their health facilities were likewise common to all the case studies. Whether factual or contrived, supposed infractions were used to justify further attacks on hospitals. This then became part of broader wartime propaganda by all sides, reinforcing a dehumanizing rhetoric familiar to most conflicts. In the case of Ethiopia, the Italians integrated broader colonial attitudes into their propaganda. Not only was the Ethiopian resistance abusing the protections granted by medical neutrality, but they were also "too backward to be able to respect emblems" of the Red Cross (Baudendistel 2006, 116). The ICRC was not immune in this regard, suggesting that abuses in the Sino-Japanese War were to be expected on both sides as the "mentality of Orientals" meant they were "incapable of our way of thinking" (ICRC 1937).

The most persistent challenge for medical neutrality, and the most striking element to emerge from the archival material, was countering the logic of military necessity. Irrespective of the rationale presented, humanitarian principles were ultimately expendable when military objectives loomed larger. During the Biafran War, exasperated officials went so far as to question the relevance of "a Convention which is now somewhat out of date", the 1949 incarnation not even twenty years old at the time (Letters from Overseas Council 1968). And in every example studied from the Franco-Prussian War to Nigeria in the 1960s, there were instances of the Red Cross emblem being removed as a risk reduction strategy.

Utility and Limits

The point of the very brief summary of selected historical instances of hospital attacks is not to promulgate cynicism over the effectiveness or relevance of IHL today. Protection norms have always been contested and ensuring respect for medical neutrality is far more difficult in practice than in words. Rather, it is to present some of the research angles and related methodologies employed in making sense of past cases, and to broach their applicability to better understanding attacks that continue to this day. Returning to MSF's experience, as we have seen, internal reviews are conducted after major incidents to "gather together the available information, to establish our own version of the facts and to form an opinion" (Mendiharat 2017). A number of examples point to both the utility and limits of such exercises.

On 3 October 2015 a United States gunship fired 211 shells at an MSF-run trauma centre in Kunduz, north-eastern Afghanistan. Including staff, patients and caretakers, at least forty-two people were killed, and a further thirty-seven people were injured. Doubting the veracity of the US and Afghan-conducted inquiries, MSF called for an independent and impartial investigation

by the International Humanitarian Fact-Finding Commission. The states involved must acquiesce for such initiative to be launched and in the case of Kunduz this was refused. MSF's own internal investigation, retracing the exact circumstances of the attack, was thus essential as there was a public narrative that shifted in the days and weeks afterwards, moving from collateral damage and self-defence to an accident. Beyond the specifics of Kunduz, invaluable lessons on deconfliction were likewise developed (MSF 2015).

In 2015 and 2016 a number of MSF-supported structures in northern Yemen were hit by the Saudi-led coalition. The attack on Shiara hospital on 10 January 2016 resulted in 6 deaths and 8 injured; 8 months later Abs rural hospital was hit, killing 19 people including an MSF staff member, and injuring a further twenty-four. As with other serious incidents an internal review took place, including interviews of key staff and eyewitnesses combined with the analysis of internal and external documentation along with photographic material.

Even with the burden of proof lying with the party launching an attack, determining the circumstances and protection status remain key. In the case of Shiara hospital, MSF could state that there was no evidence to "suggest that the hospital was being used for any military purposes that would warrant the loss of its protected status under international law" (MSF 15 March 2016). As for Abs hospital, it could again be asserted that the "neutrality of the hospital had not been compromised, the hospital had not been hosting any political or military activities and a strict no weapon policy was being applied" (MSF 26 September 2016).

A final example concerns the 12 May 2020 massacre at Dasht-e-Barchi hospital, a maternity primarily catering to the minority Hazara community in Kabul. 24 people, mostly expectant mothers along with an MSF midwife, were "deliberately and methodically" killed. The internal investigation again drew on witness statements and analysis of key documentation to develop a detailed description and chronology of the attack. Important information was gleaned from the efficacy of existing security protocols (90 staff were able to take refuge in saferooms) but, despite speculation in the media, there was no confirmation of the culprit. With no claim of responsibility and no public narrative to potentially counter, there were clear limits on what could be learned, including how the medical facility's neutral and protected status was compromised to such an extreme irrespective of the rationale employed (MSF 10 May 2021).

If the methods of analysis for past and present attacks are similar, it is worthwhile returning briefly to an important and already noted difference, the level of urgency. Establishing the "facts and identifying those responsible" for an attack has a direct impact on the continuation of care, demands for justice, and eventually compensation. Identification of the perpetrator is key in this

regard, a task further complicated when perpetrators "deny, refuse or downplay their responsibility" (Mendiharat 2017). The historical record might indicate patterns of behaviour and the perennial shadow of military necessity but leaves little room for optimism in terms of accountability.

Research Gaps

There was certainly no accountability in the bombings of the Farandalla hospital. Suspicion fell on the Sudanese Air Force, quite simply because it was the only armed actor in that particular theatre of operations with that particular capacity. But if holding perpetrators to account can seem hopeless, it does point to an area of research that is relatively unexplored.

The Leipzig war crime trials of 1921 were an exception in this regard, a rare attempt to hold those responsible for an attack on medical care accountable. A German submarine commander was charged with ordering the sinking of the HMHS *Dover Castle*, a hospital ship, and the subsequent machinegunning of survivors. The defence pointed to military necessity, killing the "men and women in the lifeboats in order to prevent them from reaching their homes and re-joining the war against the Fatherland" (McGreal 2008, 225-26). Reviewing past and present cases while integrating perspectives of military necessity and the impact on medical neutrality could still have value.

Other areas to consider could include normative and especially pragmatic attempts to preserve neutral medical space, negotiation strategies employed, and possible mitigation measures. The direct and indirect impact of attacks on medical structures, including broader questions over subsequent access to health and corresponding links to mortality and morbidity, likewise merits attention. And finally, reflections that focus exclusively on violations of IHL, as with this paper, have an inherent bias by focusing exclusively on tragic events that invariably draw the eye. Research highlighting effective strategies at maintaining a protected space for medical care in times of conflict could be equally revealing. Sadly, there is no shortage of historical and contemporary events to explore.

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