Perspective Piece

Direct Killing of Patients in Humanitarian Situations and Armed Conflicts: The Profession of Medicine Is Losing Its Meaning

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Abstract. During armed conflicts over the past several years, attacks on humanitarian workers and patients have increased, including the most recent overt killing of patients in their hospital beds in South Sudan and Central African Republic, and bombardments of hospitals in Iraq, Syria, and other countries. Direct attacks on patients inside hospitals, as well as social structural dynamics that undermine patient safety and security, are met with apparent indifference by international and medical communities. How can the medical profession remain silent and stand by while these factors render its core mission futile? In this article, I aim to shed light on this issue, and its implications for the future of the neutral and impartial provision of medical care; provide an analysis of underlying and contributing factors; discuss current international strategies; reflect on the responsibility of health providers; explore ways to strengthen our roles as physician advocates; and call for the medical profession to do more to protect medicine's core values.

INTRODUCTION

On February 26, 2014, Doctors without Borders/Medecins Sans Frontieres (MSF) reported that multiple armed groups attacked hospitals in Malakal and Leer in South Sudan. Tens of patients lying in their beds or in operating rooms were shot dead; others suffered gunshot wounds but survived. Patient wards were burned, medications and medical equipment were destroyed, and an entire hospital building in Leer was burned to the ground.¹ Since December 2013, MSF has reported a disturbing pattern of direct threats against medical staff and patients in South Sudan and in the Central African Republic. Most recently, hospitals in Iraq, Syria, and other countries in the Middle East have been attacked and bombarded. These patterns undermine the basic trust essential for patients to seek medical care and have grave implications for the provision of medical care in humanitarian crises. In any form of armed conflict, it is in grave violation of the Geneva Convention and International Humanitarian Law (IHL) whenever violence toward and deliberate killing of civilians and those not participating in combat (including the wounded, sick, and prisoners of war) is perpetrated, along with any destruction or appropriation of property not justified by military necessity.²

THE INTERNATIONAL COMMUNITY: WHERE IS THE OUTRAGE?

The IHL guarantees the protection of hospitals (IHL's articles 14, 18, and 19), the wounded and sick (article 16), and hospital staff and aid workers (article 20); the secure and safe provision of hygiene and public health (article 56); and the protection and provision of food and medical supplies for the affected population (article 55) with penal sanctions for breaches of this law (articles 146 and 147).² All parties and states have an obligation to uphold IHL and use their influence to prevent and end such violations. Among international non-governmental organizations (INGOs), MSF and the Interna-

tional Committee of the Red Cross overtly condemned the killing of patients in South Sudan in continuation of their ongoing advocacy initiative "healthcare in danger."³ The World Health Organization's Humanitarian Health Action only reported the outbreak of diseases in South Sudan. The U.S. and European medical and public health associations, and the World Medical Association overlooked these incidents and their potential consequences. Although the United Nations Special Representative for South Sudan described the "shocking scenes" in Malakal Hospital,⁴ the United Nations International Law Section commemorated the 60th anniversary of its International Law Commission without referring to the recent killings in South Sudan.

In 2012, the United Nations Inter-Agency Standing Committee for coordination of humanitarian affairs identified numerous systematic weaknesses in the current humanitarian practice to actively engage with relevant stakeholders to ensure the protection of international human rights, humanitarian and refugee laws. It subsequently declared the protection of these rights a priority statement for 2013–2015. The United Nations "Rights Up Front" plan of action and its Inter-Agency Standing Committee statement in 2013 led to emphasis by the Global Protection Cluster on the prevention of and response to rights violations as key strategic considerations that must systematically inform humanitarian analyses and policy making in humanitarian response efforts.⁵ The plan marks a transition away from a traditional condemnation and reactive response to a more proactive approach against violations of IHL.

CHALLENGES OF THE "NEO-HUMANITARIAN" ERA

Today's conflicts are often subject to overwhelming international influence, whether due to interest in local resources, arms trade, foreign policy, or globalization, and therefore are complicated and political in origin. As a result, humanitarian operations, which use more than 19 million workers worldwide, have undergone considerable transformations, prompting the concept of "neo-humanitarianism," and the appropriation of humanitarian principles for political and military operations.^{6,7} The post-9/11 wars in Afghanistan, Iraq, Libya, and most recently the sham vaccination campaign in Pakistan have

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contributed to “blurring” of lines between military operations and humanitarian aid, severely limiting access to populations and creating precarious situations for aid workers and intended beneficiaries alike.^{6,8} In addition, international laws do not have a reputation of being enforced or exercised equally. Often, they are seen as western values couched in legal jargon, unfamiliar and alienating to societies that once functioned under local community orders and laws.⁹ Violations of IHL and medical ethics at Abu Ghraib and Guantanamo Bay,^{10–14} and conditioning aid to giving up information on the whereabouts of enemies in Afghanistan, committed by the representatives of entities that aim to enforce international laws, happened without ramifications. This may have contributed to further delegitimizing these laws among an already distrusting international community. All these factors likely contributed to a perception of double standard, reinforcing international laws, norms, and medical ethics, without true neutrality and impartiality of humanitarian assistance and medicine that took decades for INGOs to build. This sends the message that any atrocity is justifiable and part of normal warfare. The grave consequences of this unwanted precedence are increasingly evident as the humanitarian space shrinks further to make room for the killing of humanitarian workers and wounded and sick civilians in hospitals. These are not simply isolated tragedies in the midst of war. These issues demand a critical reexamination of strict humanitarian neutrality and highlight the importance of reflection, re-strategizing, new approaches, and broad reform within the humanitarian aid community and the United Nations structure.^{15,16} Although negotiating at the local level to ensure safety and access to patients has been paramount and highlighted by aid agencies such as MSF,¹⁷ more proactive and broader grassroot approaches are equally important and desperately needed to pressure the overarching powerful political forces to adopt a need-based approach in humanitarian aid. INGOs will continue to bear witness with advocacy campaigns at the international level,¹⁸ but the medical community can play a complementary and active role.

MEDICAL PROVIDERS AND A HOLISTIC CONCERN FOR SUFFERING

Rudolph Virchow, the father of social medicine said, “medicine is a social science . . . and as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution . . . physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction.” What would be the point of the profession of medicine and delivery of care when patients are not safe where medicine is practiced? As a community, we need to fully appreciate and address the underlying socio-political causes of our patients’ suffering and mortality, and not accept them as something beyond our control. Mechanisms beyond advocacy at international community levels are needed; we need to use the enormous and largely underused social capital and advocacy resources that the professions of medicine, public health, and academia possess to help identify, influence, and mitigate political forces beyond the immediate areas of conflicts. To this, we can mobilize the historical trust invested in medicine to assure neutrality and impartiality, separating it from neo-humanitarian actions. We must influence stakeholders by our collective voice at the neighborhood level to make it a household story when we talk to our patients,

friends, local and national legislators, as well as on national and international platforms. This is an important time, and this topic should appear on the agenda of every medical or public health conference, of professional societies, and on websites. With the collaboration of the World Health Organization, there needs to be a universal focus on advocating for secure and safe access to medical care and creation of action plans that continuously and effectively address these issues. There needs to be significant efforts to reconcile the principles of medical ethics and IHL. The neutrality and impartiality of medicine should be prioritized, and all efforts made so that foreign policy makers and international actors understand, respect, and facilitate this premise. There are always transnational approaches and solutions that the international community could use to block the perpetrators’ financial, logistical, and arms supplies and their safe passages. Our patients and constituents, and their voices are enormous resources to influence politicians. We must use our collective will to make sure those approaches are taken by those politicians, our representatives.

Broader advocacy initiatives such as MSF’s Access Campaign and the Drug for Neglected Diseases Initiative, which for the last decade or so have worked to protect the interests of the poor in accessing medications in developing regions, have demonstrated positive track records and may need to be replicated to provide a road map and address the overall humanitarian access and neutrality of medicine.^{19,20} Condemnation and advocacy alone is not enough. Atrocities can only be further prevented through exercising unequivocal justice with equal standards, along with improving reporting systems, enhancing preventive measures, and promoting accountability.¹⁶ Measures such as no fly zones or international forces to guard hospitals are not practical. The International community’s responsibilities include, but are not limited to, broader training of military forces, armies and chains of command, and implementing strategies to promote ethical approaches, reinforce penalties, and implement robust, swift, and unequivocally judicial practices to impose consequences on perpetrators, whether local warlords or organized armies of international actors, no matter when and where. Further discussion of potential strategies falls outside the scope of this article; nonetheless, it remains an important factor to ensure a viable and meaningful humanitarian industry.

THE MEDICAL PROFESSION: WHERE IS THE OUTRAGE?

Patients’ safety and security is fundamental to our interventions as medical providers, and their absence undermines our presence and violates ethics. We need to protect patients against harm in hospital beds and all places where medicine is practiced. As a test for the integrity and ethics of medicine as a profession that strives to provide healing and assure the well-being of patients, our legitimacy depends on our solidarity and collective work on behalf of suffering patients, the helpless and the hopeless. There is no guarantee that these atrocities or their broader consequences will stop before reaching our borders. This is a call for ideas, for an open forum for the debate of solutions and for dialogue on the ways we can contribute as a profession. In this way, perhaps we can move beyond condemnation and passive expression of disappointment. How can the medical profession remain silent and stand by while these factors undermine its very essence and

render its core activities futile? Where is the outrage in our profession? We need to express it loudly and clearly, and not allow the killing of patients and shelling of hospitals to become yet another norm in the humanitarian settings.

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