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INTRODUCTION

"Even War has Rules": On Medical Neutrality and Legitimate Non-violence

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On October 3, 2015 in Kunduz, Afghanistan, a Médecins sans Frontières (MSF) trauma hospital endured an airstrike that killed 42 people and wounded dozens. The airstrike, we would later learn, was carried out by US-led coalition forces, and continued for at least half an hour as MSF personnel contacted military leaders by phone. That the forces responsible for the attack knew the coordinates for the hospital only buttressed claims that the US military knowingly violated the rules of combat. Under international humanitarian law, the clinic is a protected space: the wounded are to be treated regardless of their political affiliations; health workers toiling in the clinic and the clinic itself are supposed to be shielded from the imminent dangers of battle. The incident in Kunduz has since revived international discussion about the norms and rules of war and the place of clinics in armed conflict. As the primary target of the attack, MSF was outspoken in denouncing its architects. In a speech delivered on October 7, 2015 at the Palais de Nations in Geneva, MSF International President, Joanne Liu, remarked:

> The US attack on the MSF hospital in Kunduz was the biggest loss of life for our organisation in an airstrike. Tens of thousands of people in Kunduz can no longer receive medical care now when they need it most. Today we say: enough. Even war has rules….This was not just an attack on our hospital—it was an attack on the Geneva Conventions. This cannot be tolerated. These Conventions govern the rules of war and were established to protect civilians in conflicts—including patients, medical workers and facilities. They bring

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some humanity into what is otherwise an inhumane situation (Médecins Sans Frontières (MSF) 2015).

Liu's message treats the military attack on the hospital as though it were a rare exception, as well as an uniquely inhumane act of warfare.[1] In so doing, she effaces the ways in which the clinic is *routinely* embroiled in and positioned to be co-opted by local and international political struggles. Indeed, while many clinicians and combatants aspire to maintaining the impartiality and safety of hospitals and clinics in the midst of war, these spaces are often politicized and shaped by the very conflicts from which they seek immunity and protection. So too are the clinicians. In other words, while international norms and protocols significantly shape clinical practice in conflict-affected areas, moral outrage at their violation alone does little to shed light on the conditions under which these aspirational norms are commonly undermined.[2]

They also reveal the conundrum that we faced as we edited this special issue: how do we move beyond analysis that props up and naturalizes an imagined divide between legitimate and illegitimate violence? Such a divide parses distinctions between interstate and intrastate state-sponsored violence, revealing the difficulty of who can legitimately claim neutrality, impartiality and the political and social challenges of doing so. In this volume we urge a direction of analysis that moves beyond reiterating the moral norms—impartiality and immunity—governing the delivery of health care during political conflict. We argue for the necessary work of describing and analyzing the conditions under which violations of these norms are possible, and even crucial and constitutive, in the conduct of everyday violence. For us, an essential step toward upholding the norms of humanitarian medical practice in settings of crisis and political instability is to interrogate the everyday political and social relationships that place the clinic itself at the center of the crises—shaping and at times endangering the lives of those who labor and ail within it.

In acknowledging the inherent humanity of protecting health care facilities, Liu also implies that clinical spaces are legitimate spaces of non-violence in otherwise (legitimately) violent conditions—even if this is likely not her intention. As many of the authors in this special issue note, "medical neutrality" as a concept arose from a desire to "humanize" interstate conflict and to make it possible for troops to return to battle, but it has also been, as Peter Redfield writes, "as much a strategic weapon of the weak as a hegemonic assumption of the powerful" (2013:118). These two realities—namely, that neutrality may serve both the powerful and powerless in

[1] In January 2016, five people were killed in a missile strike on an MSF clinic in Yemen. Of course, these are not the only incidents occurring around this period; Turkish president Recip Erdogan denied ambulances to wounded Kurdish civilians trapped in the basement of a residential building after being attacked by the military.

[2] Among notable, but by no means exceptional, examples are: the case of Wouter "Doctor Death" Basson, who under the apartheid regime in South Africa, administered lethal drugs to POWs in southern African independence struggles and engaged in chemical and biological warfare against people hostile to Apartheid regime (Burgess and Purkitt 2001). In the United States, the federal government charged Alan Berkman, noted activist, prisoner advocate and HIV doctor, as an accessory after the fact for murder, for administering medical treatment to injured members of the radical Black Liberation Army and May 19th Communist Organization (Reverby 2014).

addressing violence, and that the clinic may be a site in which violence is propagated—prompt two critical questions about neutrality. First, to whom do we address its violation in situations of intra-state conflict and state-sponsored violence, where international norms are commonly flouted or deemed irrelevant? And second, how has medicine, as a professional practice, and the clinic, as an ideological and physical space in which medical neutrality applies, served as both a site to contest, suppress, uphold or reproduce political violence presumed to occur outside its boundaries? The papers in this volume provide ethnographic accounts which address how rules about the protection of local clinicians and clinical spaces are mobilized, interpreted and reworked in settings of ongoing political conflict, social unrest, and structural violence. Together, they unsettle the idea that medical neutrality operates as an abstraction or universalist ethical aspiration, by demonstrating how it often works as a tool or stance that is thoroughly political, social and cultural.

This special issue is the result of a two-day symposium held at Brown University, which was co-sponsored by the Watson Institute, the Humanities Initiative and the Department of Anthropology at Brown University and the Science, Religion and Culture Program at Harvard Divinity School in May 2014. It broadly addresses the challenges that political conflicts pose to the practice of medical neutrality and impartiality by mostly *local* clinicians under conditions of state-sponsored and intrastate violence. The speakers at the symposium worked in places as diverse as the US, Sierra Leone, Mozambique, Pakistan, Egypt, Somalia, Israel/Palestine and Turkey. Although they represent a small sample of what was presented during the symposium, the papers in this issue contain ethnographic case studies that address the everyday negotiations of medical neutrality in times of crisis and kin concepts: global health diplomacy and humanitarian medicine. Together these papers highlight the conflicts, tensions and solidarities that politicize clinical spaces and clinical practice.

In this introduction, we will outline three themes that emerge in this set of papers, rather than providing a case-by-case summary of their contents. Together, the papers demonstrate that, as integral members of the communities in which they live and practice, doctors and other health workers are always positioned socially and politically. Medical ethics and international norms hold that medicine should be practiced *impartially* in situations of conflict, and that health care workers and patients be *immune* from attack. Medical neutrality—in these two senses of the term—is understood to be a universal moral norm, upheld in international law. Yet insights from medical anthropologists working in conflict-affected settings suggest that addressing social, political and institutional conditions shaping the possibilities of neutrality are a necessary first step, without which appeals to moral or even legal norms are not only insufficient, but may also be counterproductive.

Civilizing War: When Neutrality and Immunity are Mobilized in Cases of Intrastate Conflict

Popular narratives of health workers in conflict characterize them as operating ethically, by virtue of their profession (Wagner 2015). In taking the Hippocratic Oath to "do no harm," doctors are committed to upholding the ethical principles of

nonmaleficence and beneficence and to deliver just and nondiscriminatory health care. Examples of physicians' direct participation in political torture, abuse of their medical positions for financial benefit, or participation in harmful experimentation on human subjects are often seen as anomalous violations of medical ethical norms (Washington 2006; Collins 2014; Berkman 1995). Yet we know from a large body of social science research that human behavior is deeply situation-dependent, and that social dynamics shaped by notions of accountability, autonomy and social responsibility strongly influence moral decision-making related to health (Dilger et al. 2015). Similarly, clinics set up to tend to the wounded on various sides of conflict may be subject to attacks that meet strategic political objectives (Zeilig 2016).

Rather than considering violations in medical ethics and attacks on health care workers and clinical spaces to be exceptional, we seek to understand them as common occurrences that must be understood within their broader social and political contexts. Put another way, these papers show how medical neutrality, when invoked, is cultivated and negotiated during political conflict. Medical neutrality developed as an agreement between warring parties that each side would treat the other's wounded soldiers. During inter-state conflicts in World Wars I and II, artifacts such as field hospitals and ideologies, such as that of medical neutrality, were developed in the interests of state power. Thus, we must ask: how are these artifacts and ideologies of inter-state war mobilized in places of intra-state conflict where local civilian health workers are involved, as in the popular uprisings in Egypt and Turkey, or the popular Palestinian resistance to Israeli military occupation? What kind of political realities do these mobilizations reveal? What conditions do they produce?

Bayoumi and Hamdy, writing about 2011 protests in Cairo's Tahrir Square, explain that during the early days of protests, many eyewitnesses reported that ambulances were taking injured protesters to police stations rather than to hospitals, that doctors refused to treat protesters for fear of reprisal, and that doctors colluded with police officers by explicitly denying violence in their documentation of protesters' injuries. Some physicians also risked their lives to erect field hospitals in the square, by helping to carry injured protesters to hospitals when ambulances were unreliable and by documenting state violence. The latter group of doctors, who insisted that they were "apolitical" before the uprisings, noted that their intimate encounters with state violence against unarmed protesters had motivated them to condemn the government's reaction to the protests. Yet the authors argue that this narrative of the physicians should not be taken at face value to explain *why* they sought to uphold medical neutrality while others in their profession flagrantly violated it. In stressing their reaction as "natural" for someone of their profession, the doctors justified their relief work as within the purview of medicine, at a time when their work was described as "treacherous" and "politically dissident" by the supporters of the regime. Many physicians who also witnessed violence chose to look the other way, vociferously denied that violence had occurred, or assisted the police in further punishing the protesters.

To ask why doctors played such different roles in the uprisings, Bayoumi and Hamdy argue, is the same as asking why ordinary people espouse different positions

along a political spectrum. Medical training and active clinical practice does not predict how physicians will act if political violence breaks out in their communities; historical and ethnographic research demonstrates that, time and again, social and political divisions permeate societies of which doctors are a part.

Guy Shalev focuses on the accounts of a Palestinian doctor providing health services in Israel during the longstanding Israel-Palestine conflict. Specifically, he analyzes Israeli reception of the memoir of Palestinian physician Izzeldin Abuelaish, to ask how it achieved "an extremely rare degree of visibility and sympathy" from an Israeli public that often dismisses accounts of Palestinian suffering as unreliable. Shalev describes how these doctors draw on "their medical profession to gain credibility and visibility, and challenge the limitations on the legitimacy of Palestinian grievances." Paradoxically, then, physicians claim the implicit political neutrality of their profession to lend legitimacy to their own political positions. Hate, Shalev notes, becomes a diagnosable condition, in which biomedicine both functions outside the social, political and subjective interests of the Israeli settler colonial state, a context in which Palestinian accounts of suffering are legitimized and made "reliable" when recounted through medicine.

Clinical Space as an Extension of Violence

Emma Varley, writing of the semi-autonomous Gilgit-Baltistan region of northern Pakistan, shows how the clinic, far from being a space of neutrality, can be a site in which neglect and harm are directed along lines of sectarian affiliation. These sectarian divisions "produce[d] vulnerability, spectacular violence and death for both healthcare providers and patients." In particular, Varley describes an acute sectarian crisis in January 2005, during which Sunni civilians, patients, and health care providers were killed in the hospital. In this context, medical spaces "operate as mediums of sectarian discord and violence." The clinic as site of violence was understood by the health care practitioners as neither exceptionally safe nor violent, but rather as an extension of the violent and unpredictable rhythm of life in Gilgit.

Salih Can Aciksoz's paper on protests in Istanbul's Gezi Park, also troubles the assumption that sites of health care are sites of medical neutrality. He describes and analyzes the experiences of protesters and medics during the May 2013 protests, where security forces released tear gas into crowds for the purpose of "riot control." Building on Sloterdijk's ideas about the weaponization of atmosphere, in which "environmental conditions of life, rather than the enemy's bodies, constitute the main target," Aciksoz defines the use of tear gas terms of atmospheric violence.

Where does the site of violence begin and end when poisonous fumes and gases diffuse into public space, burning the eyes, mucosal membranes and lungs of all who have gathered? If intra-state conflicts challenge neutrality norms and our ability to recognize the dangers of healthcare delivery in times of state-sponsored violence, then boundary-transgressing gases similarly raise questions about how to prioritize the safety of health care sites and of the "public." It also compels us to ask if privileging health care sites is even a laudable goal, when the space of the clinic can operate as an extension of the violence enacted in a wider frame. When police and

state violence are aerosolized or "atmospheric," where do we locate conflict? Where is the place of attack? Where do we locate the spaces of healing?

Ideas about space and place, as well as meanings attached to the modes of healing themselves, are implicit but under-examined in our current understanding of the potential for neutrality, and for the protection of populations in times of conflict and violence. Aciksoz argues that atmospheric violence is not identified as such because of the state's presumed monopoly on legitimate violence and the "ideological work of concepts like 'non-lethal' and 'riot-control'… trivialize the adverse health risks of riot control agents." In the context of medical neutrality, then, attacking the environment in which protestors have gathered—and the political ends sought through these techniques of attack—leave little possibility of space for the care for the injured.

Lauren Carruth, drawing on her research in the remote northeastern corner of the Somali region of Ethiopia, demonstrates how the space of the clinic itself can fail to embody neutrality, even in times of peace. Carruth presents the case of a relatively new health center located in Aysha, a site of repeated ethnic-based violence against Somalis. Local Somali residents avoid the health center, which is staffed by Habasha Ethiopian health workers, whom they regard as representatives of an abusive Ethiopian government. The clinic and the health care providers working in it remain starkly segregated from local social life and fail to garner trust or confidence among the local Somali population. Meanwhile, the Habasha Ethiopian health workers, with no training in the Somali language or understanding of the history of political violence, fail to provide care or to foster "therapeutic relationships that might produce optimal health outcomes or social re-integration during violent or otherwise chaotic times." Because locals felt vulnerable to state violence and were particularly vulnerable in times of ill health, they were unable to view state-sponsored health workers as capable of providing them with quality care; conversely, because the clinic did not demonstrate an explicit commitment to impartiality, locals did not feel the health clinic was a safe space for treatment. Perhaps ironically, the mobile clinics staffed by Somalis and Ethiopians and funded by UNICEF—generally perceived by professional bodies like the International Organization of Migration (IOM) as inadequate on account of their providing discontinuous and ephemeral care—did not carry the stain of state-sponsored violence or neglect, and were, therefore, welcomed and more widely used by Somalis. Carruth's call for a brand of global health diplomacy that is attentive to local struggles and conflict, therefore, becomes more salient as international and local groups seek to intervene in the everyday delivery of healthcare amongst conflict-affected populations.

Medical Neutrality as a Political Stance Against Status Quo

The health worker's claim to impartiality may itself be a stance against the state's insistence that it is the sole arbiter of who can live and who can die. The local health worker's claim to an international norm, in other words, may be understood as a direct challenge to the state's claim to sovereignty. In cases where health workers

were attacked, medical immunity was intentionally violated and that health workers may be directly targeted *as health workers*. Such incidents and their analyses raise two questions: can "medical neutrality" accurately describe a situation where there is no neutral ground upon which to stand? Can deploying "neutrality" or "impartiality" protect physicians who are perceived to have taken a position simply by invoking neutrality or impartiality? And what of the social roles that physicians embody? No health worker is *only* a health worker, and not all health workers enter the field hospital with an expectation of 'immunity'—knowing full well that the very act of treating dissidents is defined as an act of betrayal.

Aciksoz found that doctors participating in the Gezi Park protests perceived themselves to be revolutionary in their opposition to the government's crackdown on dissidents, with some of them protesting in plain clothes, unmarked as doctors. But, as doctors, like those in Egypt, they found themselves appealing to "neutrality on the side of victims" (Redfield 2013:103). In addition to having a history of responding to the earthquake in 1999 in the absence of state response, of documenting human rights abuses after the 1980 coup and casualties during protests, and of actively protesting the use of tear gas during the Gezi protests, health workers have done precisely what medical ethics dictates. They insisted on their neutrality as their government accused them of 'terrorism,' of explicitly undermining the state's monopoly on legitimate violence. Moreover, when doctors invoked neutrality while also aiding wounded protesters, they thereby moved to hinder the consolidation of state authority. The treatment of an injured police officer by doctors volunteering at the Gezi infirmaries became the symbol of their professional responsiveness to humanistic demands, and their willingness to treat everyone, whatever their role in the protests.

Bayoumi and Hamdy demonstrate that Egyptian physicians' appeals to medical neutrality served as a potent political stance that shamed the government for its failure to treat wounded dissident protesters. After Egyptian President Hosni Mubarak's removal from power, there were several clashes involving the interim military regime and civilians. During the clashes that took place in November 2011, which became known locally as "the events of Muhammad Mahmoud Street," riot police intentionally targeted field hospitals and first-relief stations erected in the side streets. They beat—and in some cases, detained—the volunteer doctors in military detention centers. During a press conference organized by the Egyptian Medical Syndicate in December 2011, one physician testified that he defied the police officer's orders to "stop treating thugs." The physician responded to the policeman: "It is my duty as a physician to treat the wounded, whoever the wounded is. And if you were sick, I would treat you, too." The policeman replied, "It is *my* decision who you treat, you son of a dog!"

Conclusions

In understanding violations to medical neutrality, together, the papers argue for a critical perspective that distinguishes what *ought to be* from what actually *is*. Assuming that medical neutrality *should* govern medical practice and health care delivery does not in and of itself enable us to understand what social, political, and

institutional conditions need to be in place for medical neutrality to be realized. This is especially true in cases for where social or political unrest is largely "intra-state" and local health workers are drawn into "humanitarian" medicine.

Understanding "what is" requires that we acknowledge how local health workers are often members of communities that experience fractures and political violence; they are therefore subject to the same prescriptions, prohibitions and ethical deliberations related to the conflict, as are other social actors. This focus troubles the assumption that the clinic is necessarily a politically neutral or sanitized space; it may also provoke questions about whether neutrality or immunity can be a universal aim or claim for health workers. Second, these papers suggested that it can be problematic to assume that health workers are primary actors for whom protection is a priority, and that neutrality is a norm to which to adhere, rather than something actively negotiated, subverted and sometimes, upheld. Rather than understanding attacks on health care workers to be exceptional, we advocate an understanding of health care delivery in situations of conflict and social upheaval that places health workers and the attacks on them within their broader political, social and cultural context. Such an analytical move may force us to understand medical neutrality as its own potent political stance, and to more directly reckon with the various forces that oppose it.

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