RESEARCHING THE IMPACT OF ATTACKS ON HEALTHCARE

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What do we Learn from the History of Attacks on Healthcare?

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Brief Summary

This study 'History Writing and attacks on healthcare' was undertaken jointly by the AHRC-funded research project ('Colonial and Transnational Intimacies: Medical Humanitarianism in the French external Resistance, 1940-1945', AH/T006382/1) and the RIAH consortium. Its aim was to consider how historical accounts and historians' analysis of violence against medical and health structures might inform current debates about attacks on healthcare (AoH), improve data collection, and bolster political support. This study reviewed the historical understandings of the concept of attacks on healthcare and examined how historians have documented past instances of violence to critically consider the evidence and methodological approaches used in their analysis. Doing so suggests both potential and pitfalls of using historical precedents to inform contemporary debates, and highlighted the need for better understanding of the emotional impacts of violence against healthcare workers.

Background

This brief reports on research ('History Writing and attacks on healthcare' and 'Caring across three continents: the Hadfield Spears Ambulance, 1941-1945') that challenges the widespread perception that the current level of attacks against healthcare is unprecedented. It focuses on the centrality of violence in the lived experiences of medical workers and patients throughout the twentieth-century conflicts. Together these two studies ask: How have historians examined past instances of violence against healthcare, often using fragmentary archival sources? How and why has the meaning of attacks on healthcare shifted over time? How did the legal frameworks for the protection of healthcare workers develop? And, finally, how can historical approaches help us think about the impact of violence on the psychological, emotional, and physical health of those attending the wounded and sick?

Our research suggests that the main value of history does not lie in providing 'lessons' for current debates about perpetrators, but instead in the ways in which it can help us think about the changing meanings of attacks on healthcare. It reveals that states and armed groups instrumenalise International Humanitarian Law (IHL) to dehumanise the enemy and legitimise their actions. The research also identifies the various coping mechanisms that healthcare workers have devised to cope with the threat of lethal violence. Crucially, it suggests that history can help improve data collection, by providing methodological insights into how we can evaluate the psychological and emotional impacts of violence on healthcare workers.

While historical methods can yield valuable new insights, they also have some limitations. Using the lens of AoH presents the risk of reading historical events from our current perspective and ethical views, without due consideration of their context and the ways in

which they were understood by contemporaries. For instance, our study of a mobile hospital during the Second World War reveals that medical actors considered instances of violence as part of the 'normal' life of an hospital at the front and therefore not worth recording. These attacks included bombings, explosions, shootings, gunfire, assaults on personnel, theft of medical supplies, illustrating that the nature/type of attacks has not necessarily changed over time. Even so, in both the hospital's official logbook and personal narratives (diaries, published memoirs, and oral interviews), it is difficult to distinguish between attacks deliberately targeting or unintentionally impacting the hospital – another contemporary problem. Furthermore, while archives of medical spaces can provide valuable new insights into how female and male medical workers coped with lethal threats, they can also impoverish our understanding by 'invisibilising' some actors. In the archives of medical spaces of the Second World War, for instance, the perspectives of medical colonial orderlies are not included. Instead, their perspectives are reported and interpreted through the lens/eyes of those whose perspectives were recorded – the French and British medical personnel. (Humbert 'Caring across three continents').

A paradigm shift in the historical perception of attacks on healthcare?

Early proponents of humanitarian laws and practices did not use the terminology of attacks on healthcare, nor did they discuss in much length the broader impacts of instances of violence against healthcare actors. As a result, many instances of violence have not been recorded as such and they have not received sustained attention throughout the twentieth century. In the late 1990s and early 2000s, understandings of violence affecting healthcare changed significantly. Over time, the concept of AoH became more widely associated with human rights violations and understood as assaults on future medical provisions and health outcomes. This shift reflected a renewed emphasis on the quantification of war losses and insistence on the global as a relevant site of policymaking (Crombé, Humbert, Taithe 'History-Writing and Attacks on Healthcare'). In other words, the development of HR frameworks (and later focus on quantification of war losses) has led to more of a focus on incidents (in relation to the provision of healthcare) as opposed to seeing attacks as part of the altered normality of life at war.

Even so, the development of the legal frameworks for the protection of healthcare workers was not a progressive and uncontested endeavour. Historians have debunked foundational myths about the critical role of self-promoting visionaries such as Henri Dunant and Florence Nightingale in the 1860s, demonstrating that international norms regarding the protection of the wounded, sick, healthcare personnel and settings were processes of political compromise that served the political and financial interests of the great powers. There were also renegotiated and limited over time. For instance, the legal and cultural concept of 'medical neutrality', was removed from the Geneva convention in 1906, and has been heavily debated across the twentieth century. Profoundly ambiguous, this concept remains prevalent in the historical literature of wartime violence against health and care. (Segesser, 'Le concept de

neutralité et la Convention de Genève de 1864'; Crombé, *The Future of an Ambiguity: A History of Medical Neutrality*, Hurst forthcoming).

The instrumentalization and politicization of IHL

Our research also suggests that we need to be cautious about the laws about the protection of healthcare personnel and nuanced about their benevolent self-image. Throughout the twentieth century, some medical workers and patients were granted legal protection (and thus in theory protected) but not others. There were also tensions between legal norms and medical staff's self-understanding of the law and their roles in conflicts. For instance, during the war in South Africa from 1899 and 1902, Boer fighters held differing conceptions to their British counterparts of what constituted medical 'neutrality' and the meaning of the 1864 Geneva Convention. Pre-existing medical cultures and portrayals of the Boers as 'uncivilised' shaped the meaning of neutrality and the provision of medical care in the conflict. Although the application of the terms of the Geneva Convention was recognised by all participants in the conflict which broke out in October 1899, the British and Boer sides had different understandings of what neutrality entailed. In the Boer states, wartime citizenship dissolved the neat distinction between fighter and doctor. As a result, Boer medical personnel were frequently detained and deported by British soldiers on the grounds that they had violated their neutrality by participating in the conflict (Brazil, 'Swapping the Red Cross badge for their bandolier and gun'). Further, throughout the century, states and armed groups employed IHL to dehumanize their enemies and legitimise their actions. For instance, during the Second World War, enemy attacks on British medical personnel on board navy ships fuelled the state production of 'reassurance' propaganda which positioned Britain as more compliant with the laws of war than Axis nations (Houghton, 'Under the 'Best Possible Protection?').

Our research suggests that the realities of war (whether regular or irregular) often complicated definitions of who should be considered as medical staff or as patient protected under the terms of international humanitarian law. In some instances, the distinction collapsed as the realities of guerrilla warfare contradicted medical staff's non-combatant status. This was the case during the Second World War, when the Nazis considered resistance caregivers and patients as terrorists. In April 1944, German authorities declared that anyone in occupied France who took care of a person injured by firearms or explosives was compelled to report their patient, thereby breaking doctor-patient confidentiality, a legal obligation since 1810 (Simonin, 'Le Comité Medical de la Résistance'). Medical doctors massively refused to follow the rules and joined the resistance (Balu, 'Wounded and caregivers of the Resistance in occupied France'). More recently our study of the Nepalese civil war showed how government and Maoist insurgents valued health care as a political tool, simultaneously resourcing and threatening healthcare professionals. (Taithe et al, 'Like Yam Between Two Stones').

The psychological and emotional impacts of violence

Using the lenses of intersectionality, emotions and intimacy, our research points to the need to take into consideration the gender dynamics of medical experiences and narratives of violence. For instance, 'Caring across three continents: the Hadfield Spears Ambulance, 1941-1945' analyses how military attacks and instances of violence impacted on the psychological, emotional, and physical health of those attending the wounded within an international mobile unit that moved across three continents. The study draws on a diverse set of sources, which includes archival records, private diaries and correspondence, published memoirs and oral interviews conducted between 1987 and 1993 by the Imperial War Museum. These sources, however, do not give transparent access to the sentiments and emotions of those who wrote them. Oral interviews and life-writings were shaped by the prevailing cultural norms. In other words, the stories related by doctors, nurses, ambulance drivers (etc.) tell us something of their experiences of violence, whilst the act of narration tells us who they were at the time of telling (in the immediate post-war or later). This research thus unearths a shared moral expectation emphasising self-control, abnegation and psychological detachment when looking after the wounded and sick in the face of events that could trigger fear, isolation and physical and mental trauma. It reveals that this shared ethos (an 'ethos of stoicism') was central to forming a successful (though not inclusive) transnational community, to individual's coping mechanisms and to the ways in which they later remembered and narrated their wartime experiences.

Conclusion

As attacks against healthcare in armed conflicts remain an intractable political and humanitarian issue, this study demonstrates that academics, legal and civil society experts and activists should be cautious when using historical precedents to draw lessons for the present. In particular, a historical lens points to changing concepts of attacks and their meaning, to a long tradition of politicicising/instrumentalising IHL, and to the need to examine the emotional and psychological impacts of violence. As such, historical approaches are useful to on-going debates about collecting data and understanding of the impacts of AoH. But 'using' history should not mean simply invoking an attack in the past and isolating it from its context to draw lessons for the present. Instead, historical approaches calls for attention to what was distinctive about each attack and conflict and how contemporaries talked about, forgot or remembered it.

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About RIAH

Researching the Impact of Attacks on Healthcare (RIAH) is a multi-institution and disciplinary programme to improve our understanding of the immediate, long-term, and wider impacts on healthcare on populations in contexts that have experienced armed conflict. Funded by the FCDO of the UK government.

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