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Kunduz & beyond

At 02:00 am on October 3rd, 2015, precise repeated strikes from a US airplane destroyed the Médecins Sans Frontières (MSF) Kunduz Trauma Center in Afghanistan. GPS coordinates were known by all parties. 42 people, including 14 staff, were killed. Patients burned in their beds. Some were shot from the air as they fled the burning building (MSF, 2015a).

That same month, 12 hospitals were bombed in Syria (MSF, 2015b). A staggering 94 attacks against MSF-supported facilities were recorded in 2015 (MSF, 2016b), the worst year on record with the Syrian and Russian forces responsible for 95% of assaults, according to Physician for Human Rights (SHCC, 2016). Meanwhile in Yemen, where the Saudi-led coalition has been active, MSF operations came under attack four times in the three months that followed the Kunduz attack (MSF, 2016 a).

Bombings only represent a splinter of violence against health care, and it remains difficult to speak about trends for lack of reliable historical data (Abu Sa'Da *et al*, 2013). Yet without needing to introduce a hierarchy of crimes or victims, hospitals attacks have been happening at an alarming rate and are horrific in their own right. And while each attack needs to be understood in its own specificities, it would be myopic not to ask what the overall picture reveals about the provision of care in conflicts.

Some of the traits of contemporary attacks stand out. While acknowledging non state actors' part in violence against health care, it is unsettling that four of the five permanent members of the UN Security Council (UNSC) have been associated to varying degrees with coalitions responsible for bombing hospitals (Liu, 2016a). Explanations range from mistakes, to denials, justification or simply silence. Whether the result of deliberate targeting or indiscriminate bombings, the destruction of hospitals and related loss of lives have prompted many to denounce the erosion of respect for existing norms, including International Humanitarian Law (IHL) (CPHHR, 2013). Attacks continued unabated as the UNSC was adopting resolution 2286 reaffirming the protection of civilians and health care in conflict on May 3, 2016.

Different dynamics

In Syria, the destruction of health care speaks to a larger reality that some have dubbed a "war on civilians" (The Lancet, 2014). The director of the destroyed Al Quds Hospital provided an on-point illustration: *"I understand the importance to call for respect for hospitals,"* he said, *"but soon there will be no patients to go for treatment there"*. Schools, markets, places of worships are all fair game, along with medical facilities. Each attack further depletes the ranks of local medical providers. Destruction leads to interruption of routine services and emergency care when people need it most. And with attacks come fear: people would rather forego the reopening of a hospital than risk further bombing (Liu, 2016b). Beyond the direct and indirect health outcomes (yet to be properly evaluated), bombing hospitals is inherently about destroying the last spaces of humanity in war. Eradicating the possibility of life by depriving people of essential survival means.

Another critical dynamic pertains to the notion of the enemy and his entitlements. Abiding by medical ethics and putting into practice the principle of impartiality underpinning the humanitarian act, doctors – including MSF ones – must treat all on the basis of needs, including those labelled as "criminals" or "terrorists". They do not dispense treatment based on the justness or morality of a cause. Yet it is this very approach which is being chipped away at when Assad's government passes laws de facto criminalizing the provision of care in opposition areas; when Afghan representatives insinuate that the presence of terrorists in Kunduz hospital justified the attack; or when the Saudi-led coalition spokesperson cites Houthis military activity to declare a hospital a legitimate target (HRC, 2013; CBS News, 2015).

Impartial care

At a time when aerial means replacing ground troops, when special forces operate outside traditional military hierarchies, and counter-terrorism measures escape public scrutiny, the revolutionary reciprocity of care enshrined in the Geneva conventions no longer seems as crucial as it once might have. Similarly, the basic tenant of medical ethics, the treatment of all on the basis of need, is being queried. A backdrop conducive to negating impartiality is emerging, with the lending hand of revisionist military ethicists (Calain, 2016). Questioning the Just-war Theory, they are refuting the concept of moral equality of combatants, and the once absolute distinction between civilians and combatants (McMahan, 2004). They offer interpretations which suggest "wounded or non-combatants from the *unjust* side have a responsibility that comes in degrees" and "that harming or killing them is a matter of proportionality rather than discrimination" (McMahan, 2004 & 2011). Pushed to their extremes, they imply that those treating all might appear complicit and could themselves become liable to defensive killings from *just* parties (Frowe, 2014).

At this testing moment for medical ethics, humanitarian medicine and the provision of care to all who need it, policy makers ought to take a stance against the complacent de-humanization of the enemy and reinforce the imperative of impartial care in conflicts – for the benefit of all and that of our collective humanity.

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