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Medical care in armed conflict: Perpetrator discourse in historical perspective

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Abstract

Although the Geneva Conventions have been successively revised since 1864, norms regarding the protection of medical care have been frequently disregarded. Despite current claims of international humanitarian law in crisis, comparing historic levels of violations with contemporary incidents is quantitatively challenging. Reviewing past reactions and justifications used by perpetrators of attacks on medical care can, however, be revealing. Based on a series of emblematic cases, qualitative analysis of perpetrator discourse can contribute to a better understanding of why the protection of medical care in armed conflict continues to be problematic to this day, notably through the rationales given for attacks, which have remained remarkably consistent over time.

Keywords: perpetrator discourse, attacks on medical care, international humanitarian law, Geneva Conventions, International Committee of the Red Cross, Médecins Sans Frontières, Franco-Prussian War, World War I Hospital Ships, Second Italo-Ethiopian War, Second Sino-Japanese War, Nigerian Civil War.

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Targeting of medical care: "Inherent to the conduct of hostilities"?

Having witnessed the consequences of Red Cross field hospitals bombed by the Italian Air Force in 1930s Ethiopia, an exasperated delegate of the International Committee of the Red Cross (ICRC) reflected on the challenges of protecting medical care in "a small war … a purely colonial affair".[1] He fretted over the long-term implications of the bombing and machine-gunning of neutral Red Cross ambulances by a "civilized country" and could not imagine the Geneva Convention being respected in the next European war.[2] Writing over thirty years later about blockaded Biafra and faced with a deliberate attack on yet another hospital, a Red Cross official was more resigned. It was suggested that the targeting of hospitals "since the war in Ethiopia to the conflict in Vietnam" had become so frequent that "some consider these practices as inherent to the conduct of hostilities".[3]

In the context of repeated bombardments, the cynicism underlying these comments is understandable. But if the norms surrounding the protection of medical care have been historically and repeatedly disregarded in multiple contexts, it is reasonable to ask how this reconciles with the development of international humanitarian law (IHL), a body of law successively revised and expanded to increase protection for medical staff and victims. By looking specifically at how violations of the Geneva Conventions have been justified by the perpetrators themselves, it should be possible to shed some light on the persistence of such attacks over space and time, and why attacks on medical care in armed conflict have been so difficult to arrest.

Examples of violations of the laws of war protecting medical care can be found in almost all conflicts post-1864 Geneva Convention, seeming to confirm what one observer has described as the "lack of substance behind claims of sanctuary or, at the very least, their contested status in the midst of fast-moving tactical war operations".[4] Put more succinctly, especially as concerns medical neutrality, the red cross emblem has likely been "misused in every war since the founding of the Red Cross", including deliberate violations in order to secure "military gains".[5] Accepting that IHL has been frequently challenged is, however, difficult to square with more recent claims of an accelerated and pervasive deterioration in norms. When analysts today provocatively ask whether the "rules

1 ICRC Archives (ICRCA), B CR 210-15, "Delegate Report No. 6", 9 January 1936 (author's translation).
2 *Ibid.*
3 ICRCA, B AG 202 147-008.08, "Bombardement de l'hôpital d'Owa Omamma au Biafra", 27 December 1968 (author's translation).
4 Bertrand Taithe, "Danger, Risk, Security and Protection: Concepts at the Heart of the History of Humanitarian Aid", in Michaël Neuman and Fabrice Weissman (eds), *Saving Lives and Staying Alive: Humanitarian Security in the Age of Risk Management*, Hurst & Co., London, 2016, p. 43.
5 Rainer Baudendistel, *Between Bombs and Good Intentions: The Red Cross and the Italo-Ethiopian War, 1935–1936*, Berghahn Books, Oxford, 2006, p. 102.

of war" are a thing of the past,[6] or the former director-general of the World Health Organization (WHO) states that "healthcare is under attack now more than ever",[7] it is important to understand the historical baseline for such references.

This is not to dispute the current severity or frequency of attacks on health care. Be it in Syria, Yemen or many other conflict settings, there is a depressing array of data documenting the attacks on medical staff and infrastructure. As an entry point to the subject matter, the research for this paper has leaned heavily on initiatives like Médecins Sans Frontières' (MSF) Medical Care Under Fire and Not a Target campaigns, the ICRC's Health Care in Danger project, WHO's Attacks on Health Care initiative, and the Safeguarding Health in Conflict coalition, to name just a few.[8] But despite the recent attention given to such attacks, historical analysis to support contemporary claims that health care is more under attack today than in the past is lacking. And attempting to answer questions of deterioration of respect for the laws of war over time is fraught with methodological challenges.

The accounting of war casualties is already notoriously difficult, especially as to what constitutes a targeted attack or collateral damage. Even within a limited time frame and focus, "deficiencies in the extent and methods of reporting" proved problematic in attempting to quantify attacks on health care between 1989 and 2008.[9] Integrating variables such as the "increased numbers of aid workers in the field" without any record of actual exposure is likewise difficult, and highlights the danger of pointing to a single "global trend".[10] This is not to disregard quantitative research, but rather to note that results can be easily prejudiced by different factors, from what actually constitutes an incident to the techniques used to collect data. Within a single organization like MSF, "ambiguous definitions without any consistency between sections" has resulted in "significant reporting bias".[11]

Compounding issues of data collection and analysis in attempting to determine whether IHL was better applied or respected in the past is the challenge of comparing epochs. Juxtaposing radically different contexts and typologies of attacks, in terms of incidents and frequency, risks producing distorted or irrelevant generalizations.[12] The same might be said for the

6 Refers to a panel discussion, "Rules in War – A Thing of the Past?", hosted by the Center for Strategic and International Studies, 10 May 2019.

7 "WHA 67 – Healthcare Under Attack", *IFMSA'S Official Blog, International Federation of Medical Students' Associations*, 25 May 2014, available at: https://ifmsa.wordpress.com/2014/05/25/wha-67-healthcare-under-attack/.

8 See, respectively: www.msf.org/medical-care-under-fire; http://notatarget.msf.org/index.html; www.icrc.org/en/publication/4072-health-care-danger-making-case; www.who.int/emergencies/attacks-on-health-care/attacks-on-health-care-28November2018.pdf?ua=1; and www.safeguardinghealth.org/about-coalition. All internet references were accessed in April 2019.

9 Leonard S. Rubenstein and Melanie D. Bittle, "Responsibility for Protection of Medical Workers and Facilities in Armed Conflict", *The Lancet*, Vol. 375, No. 9711, 23 January 2010, p. 329.

10 MSF, *Medical Care Under Fire: An Analysis of MSF's Experience of Violence and Insecurity in the Field*, Internal Report, March 2016.

11 Fabrice Weissman, "Security Incident Narratives Buried in Numbers: The MSF Example", in M. Neuman and F. Weissman (eds), above note 4, p. 68.

12 Philippe Calain, "Attacks on Hospitals: An Alarming Problem for Military Medicine as Well as for Humanitarian Medicine", *International Review of the Armed Forces Medical Services*, Vol. 90, No. 3, September 2017, p. 73.

propensity of perpetrators to respond to accusations when confronted with different forms of public pressure, combined with the increased and rapid availability of information over time. The comparative application of the Geneva Conventions is also problematic given that this has never been static; rather, the Conventions are living documents periodically revised to expand the scope of protections to different categories of victims and forms of conflict. Basically, as there is no consensus on how to calculate the disregard for medical neutrality and corresponding attacks today, the task of comparative historical analysis is made significantly more difficult.

By focusing on perpetrator discourse, the challenges of incongruous data collection and the comparison of different historical periods can be partially addressed. This is not to argue that qualitative analysis of the narratives used to justify violations of IHL can quantitatively answer the question of whether "protections for wartime medical care are more or less respected than in the past".[13] Rather, by exploring the responses of those accused of targeting wartime medical care, the present study will highlight the obvious: that these attacks have long existed, at times on a massive scale. More importantly, through the analysis of the often public rationales for such attacks, a contribution can be made to understanding why ensuring the protection of medical care has proven so difficult, both historically and in contemporary conflicts.

Key to this research has been an internal paper that emerged from the Medical Care Under Fire project, entitled "Attacks on MSF Hospitals: The Discursive Practices of Perpetrators" and dating from November 2016. The objective at the time was to "acquire a better understanding of the discursive practices of perpetrators and their blame-avoidance strategies", very much in reference to MSF's experience in Afghanistan, Syria, Yemen, South Sudan and Ukraine. The classification scheme identified four main positions with multiple nuances. The first two, "remaining silent" or "not taking a position, stalling or avoiding the discussion" are trickier to document historically. However, the third category, "admitting involvement", either through some form of apology or attempted justification for the attack, can be particularly revealing, as can the fourth position, "denial of involvement", when combined with a narrative to reinforce a rejection of responsibility.[14]

This frame of "discursive practices" will thus be applied to a series of historical case studies, all dating from the advent of the 1864 Geneva Convention and presented chronologically. The Franco-Prussian War demonstrates the challenges of ensuring a basic understanding and diffusion of early Convention statutes. An analysis of the attacks on hospital boats in World War I benefits from the well-documented arguments used by the belligerents when attempting to justify their respective transgressions. The ICRC Archives (ICRCA) in Geneva contain a wealth of information on both Ethiopia in the 1930s and Biafra in the 1960s; this

13 ICRC, "Call for Papers: Historical Perspectives on Medical Care in Armed Conflict", 24 October 2018.
14 Maude Montani, "Attacks on MSF Hospitals: The Discursive Practices of Perpetrators", Internal Paper, MSF, Research Unit on Humanitarian Stakes and Practices, 3 November 2016.

information has been well-trodden by other researchers, although to a lesser degree as concerns the discourse surrounding attacks on medical care. The Second Sino-Japanese War, meanwhile, reveals some of the challenges, and eventual ineffectiveness, of attempting to secure protection through the spontaneous co-opting of the Red Cross name and emblem.

This selection of contexts is by no means intended to be comprehensive, and some of the omissions are glaringly obvious – notably, additional examples from World War II and post-colonial States in the Middle East. Indeed, some of the choices can be considered opportunistic and partially based on the resources available. The case studies can however be perceived as emblematic of at least some of the challenges involved when applying the "laws of war" from the late nineteenth century onwards. Following the case studies, two concluding sections will briefly look at other historical examples and further avenues of research, while also attempting to highlight some of the broader trends in perpetrator discourse relevant to contemporary attacks on medical care.

Numerous other caveats to the research should be noted from the start. The focus is almost entirely on hospital attacks, given the highly symbolic nature of hospitals as protected structures. This is done in the full knowledge that "attacks on health services can take many forms, including kidnappings, robberies, threats etc", and that this is only one aspect of the broader violence which takes place against civilians and humanitarian actors.[15] The identification of the perpetrator is a contemporary challenge that can directly influence the nature of the resulting protest, but in the context of this paper, the aggressor is generally obvious.[16] Finally, none of the case studies are intended to cover all aspects of the selected conflict; rather, they look specifically at perpetrator discourse for comparative value.

It should hardly be surprising that no party to a conflict will willingly admit to a premeditated targeted or indiscriminate attack. Yet if it is "difficult to ascribe attacks against health care facilities to a single pattern of aggression and clear lines of responsibility", let alone intentionality, some of the tactics used by those responsible to escape blame do share similarities.[17] The lessons such historical analysis provides can help us to understand why the protection of medical care in armed conflicts remains problematic to this day.

A "perfect outbreak" of red crosses: The Franco-Prussian War (1870–71)

The Franco-Prussian War of 1870–71 marked the first conflict where the Geneva Convention was applicable to both sides.[18] From the outset, a pattern of

15 *Ibid.*
16 In contemporary terms, "the perpetrator" can refer to States, coalitions or non-State armed groups.
17 P. Calain, above note 12.
18 The Geneva Convention was applied during the Second Schleswig War of 1864 and the Austro-Prussian War of 1866, but these can be considered "semi-experiments" as only the Kingdom of Prussia had signed the Convention. Bertrand Taithe, *Defeated Flesh: Welfare, Warfare and the Making of Modern France*, Manchester University Press, Manchester, 1999, p. 165.

accusation and counter-accusation by the belligerents over non-respect of the Convention was established, reinforced by propaganda campaigns during and after the conclusion of hostilities. Misuse of the red cross emblem was particularly controversial, and was repeatedly exploited as both a rationale and retrospective justification for attacks on medical care. This reflected a lack of knowledge around the Convention and difficulties in applicability given the rapid territorial advance by the Prussians. Indeed, despite the proliferation of Red Cross flags around French towns and villages, either in the hope of slowing down the Prussian army or providing a measure of protection, the attacks continued, along with their indignant responses.[19]

The challenges faced by a nascent Red Cross during this period have been described as "the teething problems of Dunant's noble invention".[20] Of the original three proposals that emerged from *A Memory of Solferino*, all were in place: volunteer societies, including national incarnations in France and Germany; a recognized and agreed-upon emblem for identification and protection; and, of course, the treaty itself, providing protection to military hospitals and medical personnel.[21] Applying Article 5 of the 1864 Convention, however, would prove especially challenging. This essentially stated that a property could be entitled to neutrality and thus protection through the "presence of any wounded combatant receiving shelter and care".[22] Combined with an exemption from billeting and war levies, in a context of active combat and foreign occupation, there was an obvious temptation for the civilian population to try and secure the advantages of protection afforded by the Convention.[23]

In terms of attacks on medical care, it was during the initial invasion, as opposed to occupation, that most abuses occurred. The International Committee[24] president at the time, Gustave Moynier, later wrote that ambulances close to the action were particularly exposed, but while they were "damaged on numerous occasions", this could be explained as a "hazard of war".[25] It should be noted that in the context of the time, "ambulance" was a fairly ambiguous term and could refer to "field ambulances, mobile ambulances, station ambulances, fixed ambulances or depots for wounded and even ambulances attached to a hospital of one of the Parties to the conflict".[26]

19 R. Baudendistel, above note 5, pp. 102–103.
20 B. Taithe, above note 18, p. 155.
21 J. Henri Dunant, *Un Souvenir de Solferino*, Imprimerie Jule-Guillaume Fick, Geneva, 1862.
22 Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field of 22 August 1864 (1864 Geneva Convention), Art. 5.
23 *Ibid.*
24 It was only in 1876 that the International Committee formally adopted the name International Committee of the Red Cross, hence the use of the former at the time of the Franco-Prussian War.
25 Gustave Moynier, *La Convention de Genève pendant la Guerre Franco-Allemande*, Soullier & Wirth, Geneva, 1873, pp. 30–32 (author's translation).
26 In addition to the French and German versions, medical support came from twelve National Aid Societies for the Nursing of the Sick and Wounded in the Field (as National Red Cross Societies were then known): Austria, Belgium, Great Britain, Holland, Italy, Luxembourg, Norway, Portugal, Russia, Spain, Sweden and Switzerland, as well as the United States, despite not yet having a Society. Victor Segesvary, *The Franco-Prussian War of 1870–1871: The Birth of Red Cross Solidarity*, Editions L'Age D'Homme, Geneva, 1971, pp. 8, 10–11.

However, while there were obvious dangers to having overlapped or uncoordinated medical services operating close to the fighting, a primary cause of infractions was deemed general "ignorance" by Moynier. A central committee in Berlin distributed 80,000 copies of the Geneva Convention in two languages, accompanied by a short explanatory document; nothing similar occurred on the French side, despite "the Convention being unknown, even among doctors and generals who should have been the first to be instructed".[27] The International Committee, operating an International Agency for Aid to Wounded Military Personnel out of Basel for the duration of the conflict, described the French medical establishment as "badly organized" from the start.[28] This was compounded by the rapid defeat of the French armies, which "almost entirely paralysed" France's medical activity, whereas the German ambulances were better equipped and "enjoyed the advantages of an advancing army".[29]

The combination of ignorance around the Convention and a dynamic military situation certainly led to the perpetration of common wartime atrocities. Bertrand Taithe has described a pattern of the French "neutralizing" structures near the front lines but where "medical staff ignored the Genevan rules and did not wear suitably stamped Red Cross armbands".[30] As the designated ambulance was transformed by the French into an isolated stronghold that the Prussians needed to destroy in order to advance, medical staff and soldiers either "died in action or were executed soon afterwards".[31]

Even more problematic was the "perfect outbreak" of Geneva flags, a reference to the red cross emblem.[32] While the French army did not secure the protections afforded to neutral medical services by the Geneva Convention, "civilians appropriated the most immediately applicable 'war insurance' measures it contained".[33] Red Cross flags were systematically placed on homes to "protect them from projectiles" or, "with the approach of enemy troops, as a guarantee against lodging them".[34] As a further measure, "hospitality was given to one or two wounded",[35] and everyone wanted the wounded under their roofs. As a result, "the Germans on arrival saw only houses where the Red Cross flag blocked their entry".[36] Put more succinctly by the British ambulance operating out of the

27 G. Moynier, above note 25, p. 5.
28 V. Segesvary, above note 26, p. 37.
29 *Ibid.*
30 B. Taithe, above note 18, p. 159.
31 *Ibid.*
32 A British ambulance found the flying of neutral country flags more useful because "experience had taught us to have more faith in its rainbow crosses than in all the Geneva flags that were waving in the city, for there was a perfect outbreak of them". Emma Maria Pearson and Louisa Elizabeth Mclaughlin, *Our Adventures during the War of 1870*, Richard Bentley & Son, London, 1871, p. 149.
33 B. Taithe, above note 18, p. 171.
34 Jules-César Buzzati and Constantin Castori, *De l'emploi abusif du signe et du nom de la Croix-Rouge: Deux mémoires*, ICRC, Geneva, 1890, p. 20 (author's translation).
35 *Ibid*, p. 21.
36 G. Moynier, above note 25, pp. 42–43.

castle of Plessis-lèz-Tours, "it was supposed to be a means of securing [the French houses] from occupation by the Germans. In many instances it failed."[37]

To receive the benefits and protection of neutrality, *ad hoc* ambulances must not only receive wounded soldiers, but must also treat them. However, if the nuances of Article 5 were lost on the French public, the Prussians did not hesitate to accuse the French of "abusing the system by claiming right of sanctuary for individual houses", particularly when the "hospitals" contained only one or two injured soldiers.[38] The French, meanwhile, accused the German military of reneging on their commitments to the Geneva Convention by shelling protected structures.[39]

The German National Aid Society had already announced at the outbreak of war that an ambulance required at least twenty beds to be considered legitimate. And while the newly declared Third Republic declared "at least six wounded" to be the minimum in September 1870, "in most parts of French towns in which the Germans entered" each inhabitant continued to believe they had the right to place a Red Cross flag on the door or window.[40]

Unlike the chaos seen with mobile ambulances early in the conflict, or indeed the spontaneous transformation of entire towns into "neutralized" medical establishments, direct attacks on stationary hospitals were "relatively rare" but did result in more formal responses. According to the French, during the bombardment of Beaugency on 8 December 1870, the Ursulines convent containing 150 French and German wounded received fourteen shells. The German artillery general subsequently claimed that as soon as he became aware that the convent was being hit, the targeting was adjusted to avoid the structure. And complaints that hospitals were being shelled during the siege of Paris provoked "formal denials by the Germans" that the destruction was intentional.[41]

Aside from the direct attacks on hospitals and ambulances, other breaches of the Convention included frequent pillaging and attacks on protected individuals as well as other misuse and abuse of the emblem.[42] Both sides compiled extensive lists of violations, the rule-breaker always being the antagonist.[43] A German newspaper captured public disillusionment by describing the Geneva Convention

37 E. M. Pearson and L. E. Mclaughlin, above note 32.
38 B. Taithe, above note 4, p. 43.
39 *Ibid.*
40 G. Moynier, above note 25, pp. 23–24.
41 *Ibid*, pp. 30–32.
42 The list is lengthy, and includes extreme examples such as parts of the 300-strong Irish Ambulance transforming itself from nurses to soldiers on arrival in Le Havre; the use of the emblem to transport munitions and treasuries; the "murder or attempted murder of doctors and nurses, both by the French and the Germans"; and the less offensive distribution of the Red Cross armband to facilitate the evacuation of the wounded. See J.-C. Buzzati and C. Castori, above note 34, p. 15; G. Moynier, above note 25, pp. 11, 16.
43 For example, shortly after the war, a German publication cited twenty-one recorded firings on German medical staff, and a further thirty-one offences deemed intentional. See *Les Violations de la Convention de Genève par les Français en 1870–1871 : Dépêches, Protocoles, Rapports etc*, Editeurs Charles Duncker, Berlin, 1871, pp. 13–15.

as "humanitarian bull", and Prussian Chancellor Otto von Bismarck openly contemplated withdrawing his support for a treaty "so profoundly ignored by Germany's enemies".[44]

Underlying and buttressing the accusations and counter-accusations was a not particularly original jingoism. In one description of the attack on the French ambulance of Saône-et-Loire in January 1871, we are told: "[N]ever have the laws of humanity, never have the grand and generous principles of the Geneva Convention, since the beginning of this barbaric war, been so indignantly and cruelly trampled underfoot."[45] According to another author, now that the Prussians "shoot doctors, no quarter shall be given".[46] Bismarck, meanwhile, railed against the French press "systematically inoculating" the population against abuses by their own army, "nourishing their ideas of superiority and their pretensions of supremacy over other peoples".[47] Even the International Committee recognized that the German wounded were less exposed to bad treatment from the opposing force than by an "ignorant and fanaticized" local population.[48]

From the perspective of those who drafted the Geneva Convention, there was still cause for optimism after the war. While the reality of violations during the conflict was "undeniable", it was opined that the great majority of abuses would not have taken place "if the belligerent governments had taken measures to prevent or punish".[49] And if unjustified protection might have been sought by both belligerents and citizens, this was largely because "the Convention was insufficiently known or totally ignored".[50]

A more cynical observer would note that the neutrality and protection of medical care might have received lofty words, but this was secondary to military necessity. For both the French and the Germans, "barbarism" was the other's domain, and each side "presented the conflict as the struggle of civilisation against the barbarians".[51] In exceptional cases an accusation might lead to the perpetrator's formal denial, but more often a counter-accusation or justification followed. While violations of the Geneva Convention were well documented by both sides, whether intentional or otherwise, for propaganda purposes the surrounding rhetoric became another tool to dehumanize the enemy.

44 Caroline Moorehead, *Dunant's Dream: War, Switzerland and the History of the Red Cross*, Carroll & Graf Publishers, New York, 1999, pp. 82, 123.
45 F. Christot, *Le Massacre de l'ambulance de Saône-et-Loire, Vingtrinier : Rapport lu au Comité médical de secours aux blessés, le 7 juillet 1871*, Lyon, 1871, pp. 15–16 (author's translation).
46 Charles-Aimé Dauban, *La Guerre comme la font les Prussiens*, Henri Plon, Paris, 1870, p. 69 (author's translation).
47 *Les Violations de la Convention de Genève*, above note 43, p. 11 (author's translation).
48 G. Moynier, above note 25, p. 44.
49 *Ibid*, p. 4.
50 J.-C. Buzzati and C. Castori, above note 34, p. 18.
51 B. Taithe, above note 18, p. 163.

Floating targets: Hospital ships in World War I (1914–18)

The intentional sinking of hospital ships during World War I was a dramatic illustration of the systematic targeting of medical care during a conflict (although the number of hospital ships lost pales in comparison to those of merchant shipping). Comparatively speaking, however, there is a curious dearth of research on the subject, especially as the press of the day used the losses as a "powerful anti-Germanic propaganda weapon".[52] Occurring primarily around the British Isles and Eastern Mediterranean in a context of large-scale maritime blockades, these attacks led to periodic attempts at denial or shifting the blame. But much like in the Franco-Prussian War, brutality was primarily justified by accusations of the enemy refusing to respect the rules of the 1906 Geneva Convention.

Hospital ships are essentially "floating hospitals", often requisitioned commercial vessels. Their protected status under the second Geneva Convention was the result of a long and somewhat torturous process. The importance of extending the land provisions of the original treaty to naval warfare was recognized early on and the relevant articles laid out at a Diplomatic Conference in 1868. But while the provisions were largely recognized, it was not until 1899 that the Hague Convention for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention was formally adopted.[53] Further revisions resulted in a completed document in October 1907, based on the 1906 Geneva Convention, that "laid down the conditions under which hospital ships were entitled to immunity from attack and under which they had to be respected in time of war".[54]

Of the main provisions from the expanded treaty, Article 1 designated as hospital ships "those solely with a view to assisting the wounded, sick and shipwrecked" and whose function was duly "communicated to the belligerent powers" prior to use, before or during hostilities. Article 3 states that they are to be "respected and exempt from capture", while Article 4 notes that the sick and wounded should be accepted "without distinction of nationality" and that governments should "undertake not to use these ships for any military purpose".[55] Article 5 describes the presentation of military hospital ships, "painted white outside with a horizontal band of green about a metre and half in breadth" (illuminated at night), flying their national flag and the Red Cross flag,

52 Although not addressed in this paper, mines also represented a danger to all shipping and caused significant damage. Germany was accused of violating the Hague Convention by laying mines in international waters. Stephen McGreal, *The War on Hospital Ships: 1914–1918*, Pen & Sword Maritime, Barnsley, 2008, pp. 7, 43.

53 Additional Articles relating to the Condition of the Wounded in War, Geneva, 20 October 1868; Convention (III) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention of 22 August 1864, The Hague, 29 July 1899.

54 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 6 July 1906 (1906 Geneva Convention); John H. Plumridge, *Hospital Ships and Ambulance Trains*, Seeley, Service & Co., London, 1975, p. 35.

55 Hague Convention (X) for the Adaptation to Maritime Warfare of the Principles of the Geneva Convention, 18 October 1907, Arts 1, 3, 4, 5.

along with an additional national flag if from a neutral state.[56] Furthermore, while no circumstances are envisioned where a hospital ship can be sunk, belligerents do have the right to "control and search them".[57]

Within months of the war's outbreak, the latter clause became a point of contention. On 18 October 1914 the registered German hospital ship *Ophelia* was boarded and searched, as laid out in the Convention. Despite claims of innocence from Germany and accusations of British piracy, the ship was brought back to a British port. Pointing to suspicious behaviour and evidence of secret codes received, the British eventually declared the *Ophelia* a "lawful prize" as it had been found to be acting as "a scout or a spy for the enemy".[58] This incident became a reference point and was regularly raised by Germany when it was later accused of intentionally targeting Allied hospital ships.[59]

The first recorded attack of the war on a hospital ship took place on 1 February 1915 when a German submarine fired a single torpedo at the British ship *Asturias* while on route to Le Havre, despite it being daylight and with Red Cross markings "clearly visible".[60] Denounced for violating the "absolute respect due to hospital vessels", the incident is significant not so much for being the first of what would become an increasingly frequent occurrence, but rather for the German reaction. Communicating via the German embassy in Washington, the Germans apologized for mistaking the vessel for a transport, noted that the torpedo did not explode, and pointed out that the attack was abandoned as soon as the *Asturias* was recognized as a hospital ship.[61]

Attacks were not limited to British hospital ships. The Turkish government admitted responsibility for sinking the Russian hospital ship *Portugal* on 17 March 1916, claiming that it was mistaken for a transport in the "uncertain morning light".[62] After a second Russian hospital ship, the *Vpered*, was torpedoed and sunk in July of the same year, Russia retaliated by refusing to recognize the Turkish hospital ship *Bulgaria*. Nor were the perpetrators limited to the Central Powers – on 18 March 1916 the Austro-Hungarian hospital ship *Elektra* was torpedoed by an "Entente allied submarine", with the French later admitting that the ship was attacked in error despite the "prescribed visible marks".[63]

The sinking of the British *Britannic* on 21 November 1916 encapsulated many of the claims and counter-claims that were emerging from attacks on hospital ships. Germany initially denied responsibility, blaming a Turkish submarine recently purchased from the German navy and all the while suggesting that the *Britannic* was being used as a troop transport. It was also initially unclear

56 *Ibid.*
57 *Ibid.*
58 "Hold German Hospital Ship: British Authorities Say the Ophelia was Really a Scout", *New York Times*, 22 May 1915.
59 S. McGreal, above note 52, pp. 28–32.
60 J. H. Plumridge, above note 54, pp. 36, 44.
61 S. McGreal, above note 52, pp. 59–60.
62 "Teuton Hospital Ship Sunk in the Adriatic: Berlin says Allied Submarine Torpedoed Her – Sailor Drowned, Two Nurses Hurt", *New York Times*, 20 March 1916.
63 *Ibid.*

if the *Britannic* was torpedoed or hit a mine until the German newspaper *Kieler Zeitung* published a statement on 3 December 1916 claiming that the ship was indeed "transporting fresh troops for our enemies" and that if it had been otherwise "our submarines would never, of course, have torpedoed her".[64] The British response was to publish a list of all passengers, note Britain's observance of the Geneva and Hague Conventions, and repeat that British hospital ships "carry neither personnel nor material other than that authorized by those Conventions".[65]

A new period of intensity arrived with the resumption of unrestricted submarine warfare from 1 February 1917. Although the implications went far beyond the already much-infringed neutrality of hospital ships, the German government made specific mention of medical care at sea. In a memorandum three days earlier, enemy governments, "especially the British Government", were accused of using hospital ships for military purposes and thereby "violating the Hague Convention regarding the application of the Geneva Convention to maritime warfare".[66] Numerous examples were provided, especially regarding the transport of troops and munitions "under the hypocritical cloak of the Red Cross".[67]

Consequently, while it asserted that it was "entitled" to free itself from the treaty obligations, the German government submitted that it would continue to respect the Convention "for reasons of humanity".[68] However, Germany would henceforth ban hospital ships from the main theatre of war (essentially the southern part of the North Sea and the English Channel), and any vessel entering this area would be "considered as belligerent" and "attacked without further consideration".[69]

The British response contained a rebuttal for each accusation, notably around the "excessive use of hospital ships" during the Gallipoli campaign and changes in hospital ship registration "with supposed intention to deceive", a measure more likely to increase the risk of attack than anything else. Regarding troop and munition transport, the British chided the Germans for having been deceived by the "fallacious deductions of their witnesses".[70] The crux of their argument, however, rested on Article 4: that unlike during the *Ophelia* incident, "German submarines and other warships have never once exercised the right of

64 "I. – The First Year: The 'Britannic'", in Unknown Author, *The War on Hospital Ships: With Narratives of Eye-Witnesses and British and German Diplomatic Correspondence*, Harper & Brothers Publishers, New York and London, 1918.

65 S. McGreal, above note 52, p. 118.

66 "III. – Diplomatic Correspondence: Memorandum of the German Government Respecting the Misuse of Enemy Hospital Ships", in Unknown Author, above note 64.

67 *Ibid.*

68 *Ibid.* Continued accusations that the British used hospital ships for the transport of troops and munitions led to the German barred zone being extended to include the Mediterranean Sea on 26 May 1917. The Germans stated that they would "regard all hospital ships in these waters as enemy vessels of war and would attack on sight". S. McGreal, above note 52, p. 158.

69 *Ibid.*

70 "III. – Diplomatic Correspondence: Memorandum of the British Government in Reply to German Allegations of the Improper Use of British Hospital Ships", in Unknown Author, above note 64.

inspecting British hospital ships".[71] Instead of verifying their assumptions, they "proceeded to the extreme step of ruthlessly attacking innocent hospital ships engaged in their humane task of serving the sick and wounded".[72]

The ICRC also weighed in with a note of 29 January 1917 which referred to the new German strategy as being "in contradiction to the humanitarian conventions which [Germany] has pledged itself solemnly to respect".[73] After reviewing the agreed-upon conditions for hospital ship accreditation and "right of search", it was emphasized that irrespective of suspicions, there is "in no case any right to sink a ship and expose to death the hospital staff and the wounded".[74]

Despite such interventions, a further eight hospital ships were torpedoed before the Armistice of 11 November 1918.[75] These included the *Asturias*, which did not survive a second attack on 20 March 1917. Taking the place of the apology two years earlier, there were the now familiar recriminations. A German wireless message noted how remarkable it would have been that the "English in the case of the *Asturias* should have abstained from their customary procedure of using hospital ships for the transport of troops and munitions".[76]

Nor was the Allied reaction comparable to that seen earlier in the war. While mass casualties in France and Belgium might have been acceptable in a "war of attrition", attacks on hospital ships provoked public anger that was duly exploited to justify new levels of violence. This was the context of the British and French aviation bombing of the German town of Freiburg, an action that produced "satisfactory results".[77] And if there was any doubt over the justification, high explosives were accompanied by leaflets stating in German: "As reprisal for the sinking of the hospital ship *Asturias* which took place on the night of 20th/21st March 1917."[78]

More pragmatically, the continued sinking of hospital ships provoked responses other than simple reprisals. When the *Donegal* and *Lanfranc* were sunk on 17 April 1917, the British referred to both as hospital ships, but only one carried Red Cross insignia. This was subsequently explained as a necessity given that the habitual markings "render[ed] them more conspicuous targets for German submarines".[79] In fact, the "entire status of hospital ships" was being reconsidered by the British government, with certain vessels being withdrawn from the list of hospital ships for their own protection.[80] In the propaganda war, this was taken as further proof of "British unscrupulousness".[81]

71 *Ibid.*
72 *Ibid.*
73 "I. – The First Year: The Verdict of the Red Cross", in Unknown Author, above note 64.
74 *Ibid.*
75 J. H. Plumridge, above note 54, p. 42.
76 "I. – The First Year: The 'Donegal' and the 'Lanfranc'", in Unknown Author, above note 64.
77 *Ibid.*; S. McGreal, above note 52, p. 144.
78 S. McGreal, above note 52, p. 141.
79 "I. – The First Year: The 'Donegal' and the 'Lanfranc'", in Unknown Author, above note 64.
80 *Ibid.*
81 S. McGreal, above note 52, p. 150.

The radically different narratives that emerged from each sinking of a hospital ship continued to grow further apart as the war neared its end. This was particularly obvious when the *Llandovery Castle*, a Canadian hospital ship sailing from Halifax to Liverpool, was torpedoed on 27 June 1918. Afterwards, lifeboats were shelled and rammed, leaving twenty-four survivors; eighty-eight medical staff and 146 crew were lost.[82] While journals such as the *South African Nursing Record* expressed their horror by suggesting that nothing was to be done with the "beast" but "annihilate him completely", the German government initially denied involvement before alternating between a mine theory or a justified torpedo attack.[83] The Essen newspaper *Rheinisch-Westfälische Zeitung* simply noted that "the vessel probably struck a mine, but even if she was torpedoed it was probably rightly done, as most overseas hospital ships are armed".[84]

Justifications for attacks on hospital ships, and the corresponding condemnation, became so intertwined with wartime propaganda that teasing out the actual facts is a challenge. The sinking of hospital ships early in the war has been described as "casual atrocities" when compared with the Germans' decision to "sink hospital ships systematically in their 'blockaded zone'".[85] By 1918 it was clear that the time for apologies for errors was long past, and attempts at denying involvement were half-hearted at best. It was not so much a question of admitting responsibility but rather a matter of repeating *ad nauseum* the consequences of the enemies' own transgressions.

Yet if reprisals for violations of the Geneva Convention by the enemy were the rationale for the continued targeting of medical care, any reflection on perpetrator discourse cannot be separated from the context. And in terms of tactical effectiveness, however brief, the renewal of unrestricted submarine warfare not only crippled the resupplying of Allied forces but also revived the possibility of a German victory. The broader military prerogative inevitably took precedence over humanitarian considerations, even more so in a war of attrition.

"Wake up Geneva": The Second Italo-Ethiopian War (1935–37)

The Second Italo-Ethiopian War marked the final chapter in the European colonization of the African continent. It is often remembered for the failures of the League of Nations, the club to which Ethiopia had only grudgingly been admitted, and Italy's use of chemical weapons.[86] In the repeated targeting of Red

82 J. H. Plumridge, above note 54, p. 46.
83 S. McGreal, above note 52, pp. 204–205.
84 Such views persisted with the war crimes trial in Leipzig addressing this specific incident. The "continual reports of British abuse of hospital ships" were noted, while the defence denounced the "hunger blockade" and stated that "it was necessary to destroy the men and women in the lifeboats in order to prevent them from reaching their homes and re-joining the war against the Fatherland". *Ibid.*, pp. 205, 222–225.
85 "I. – The First Year: The 'Vperiod'", in Unknown Author, above note 64.
86 "… primarily the blister agent sulphur mustard": see Lina Grip and John Hart, "The Use of Chemical Weapons in the 1935–36 Italo-Ethiopian War", SIPRI Arms Control and Non-proliferation Programme, October 2009.

Cross hospitals, the conflict also provides some of the more blatant examples of attacks on medical care. In attempting to explain and frequently justify those attacks, Italian political and military officials often fell into caricature. Playing on widespread sympathy for European tutelage over the continent, and tolerance for Italy's colonial war, the occasionally fine line between propaganda and the propagation of outright lies was explicitly and repeatedly crossed.

Both Italy and Ethiopia had ratified the 1929 Geneva Convention at the time of the conflict, the latter only months before the Italian invasion on 3 October 1935.[87] Much as the 1906 Convention attempted to address past weaknesses, notably by reducing non-combatant initiatives to help the wounded to "more reasonable proportions" than that seen in conflicts such as the Franco-Prussian War,[88] the 1929 version reflected the recent experience of World War I. Of particular relevance to the Italo-Ethiopian War was the greater precision given to the use of the red cross emblem, notably that it should only be used "to indicate the medical formations and establishments and the personnel and material protected by the Convention".[89]

There are varying estimates on the number of Red Cross hospitals bombed during the conflict. Rainer Baudendistel reviewed lists compiled by the Ethiopian government, the League of Nations and other researchers to settle on seventeen incidents, including "seven direct bombings".[90] He went on to identify three separate phases of the war regarding Italian attitudes and actions towards the Red Cross. An initial period of roughly two months saw "encouraging signs" that the Italian Air Force was "complying with international humanitarian law".[91] A second phase covering December 1935 to March 1936 included much of the fighting and attacks on the Red Cross. A final phase leading up to the occupation of Addis Ababa saw no further attacks, arguably because very few field hospitals remained functional, and those left working did so "under camouflage and escaped detection from the air".[92]

As combat operations increased from late 1935 onwards, it is worth highlighting some of the major incidents that would establish patterns of attack and retrospective rationales. When the Italian Air Force bombed the town of Dessie on 6 December 1935, the ostensible target was Haile Selassie and parts of the Ethiopian leadership, the emperor having arrived the previous week to direct the war effort. In an action that prefigured the strategic bombing of World War II, initial casualty estimates were of fifty dead and 200 wounded. With the first bombs having fallen on the hospital of the American Adventist Mission,

87 Ethiopia ratified the 1929 Geneva Convention on 15 July 1935. This was the third revision of the original 1864 Geneva Convention.
88 1906 Geneva Convention.
89 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Field, 28 July 1929 (1929 Geneva Convention), Art. 24.
90 R. Baudendistel, above note 5, pp. 117. It should also be noted that although the capital was occupied on 5 May 1936, fighting continued up until the last major battle on 19 February 1937 in Gogetti.
91 *Ibid.*, pp. 118–119.
92 *Ibid.*

questions were immediately asked about intentionality.[93] The head of the American mission had little doubt, noting that while the Italians "might not have seen the Red Cross flags over the tents", those on the hospital roof were "certainly easily visible at 6,000 feet up".[94] He went on to note that they might have been targeting the nearby Italian Consulate, occupied by the emperor, but in that case "their aim must have been very bad, as not a bomb fell anywhere near it".[95]

While the ICRC considered the Convention violations in Dessie to be "flagrant", its language was cautious and referred to the hospital bombing as "a horrible error".[96] Diverging views between the ICRC's Geneva headquarters and the two field-based delegates, notably around the degree of Italian intentionality, were not yet entrenched. The Ethiopian emperor was more definitive: noting that the bombings of Red Cross hospitals were "incontestably violations of international law", he asserted that events in Dessie represented yet another transgression by Italy that should be communicated to member States of the League of Nations.[97]

Concerned by bad press over their civilizing mission, the Italians' response was twofold. On the one hand, damage to protected medical structures was questioned. A flight report was duly manipulated to demonstrate that the Red Cross sign "was intact" the day after the bombing.[98] And more cynically still, blame was shifted to the Ethiopians. The Italian Ministry of Foreign Affairs added the retroactive observation that in Dessie, "all was covered with Red-Cross signs including the army camps and even the airfield".[99] This fit with a long-standing Italian campaign on the misuse of the emblem that began as early as October 1935 and had particular resonance with the ICRC.[100] Having already expressed concerns over similar rumours in Harar after being informed that "almost everyone paints a red cross on their roof", it took months for field delegates to demonstrate the contrary.[101]

Justifying subsequent events in Melka Dida would prove more difficult. On 30 December 1935, a Swedish Red Cross field hospital was bombed despite flying the Red Cross flag, the Abyssinian flag and the Swedish flag "in accordance with regulations", along with "easily visible" Red Cross flags spread on the ground.[102] The preliminary count included twenty-eight patients killed in their beds, and a further fifty patients and ambulance staff wounded. In examining the scene of the bombing, the ICRC delegate noted that "of all the parts of the frontline that I

93 ICRCA, B CR 210-15, "Rapport au Comité International de la Croix Rouge du voyage à Dessie du Docteur Junod du 7 décembre au 15 décembre 1935", 17 December 1935.
94 Marcel Junod, *Warrior Without Weapons*, Jonathan Cape, London, 1951, p. 35.
95 *Ibid.*
96 ICRCA, B CR 210-15, "Rapport au Comité International de la Croix Rouge du voyage à Dessie du Docteur Junod du 7 décembre au 15 décembre 1935", 17 December 1935 (author's translation).
97 ICRCA, B CR 210-15, "Texte du télégramme envoyé ce jour par sa majesté l'Empereur (Haile Sellassie I) au Secrétaire General de la Société des Nations à Genève", 6 December 1935 (author's translation).
98 R. Baudendistel, above note 5, p. 124.
99 *Ibid.*, p. 125.
100 *Ibid.*, p. 104.
101 ICRCA, B CR 210-15, "Report No. 2", 30 November 1935 (author's translation).
102 M. Junod, above note 94, p. 47.

have seen with my own eyes, no place was bombed with greater intensity than the Swedish Ambulance".[103]

Already on 22 December there had been overflights during which the Swedish tents had been "machine-gunned".[104] Nobody was injured at the time, and the later survivors assumed it had been in error. Then, in a seemingly unrelated event, an Italian pilot and observer made an emergency landing on 26 December "somewhere behind Abyssinian lines and the natives killed him".[105] Accompanying the bombs four days later were leaflets printed in Amharic, signed by Italian General Rodolfo Graziani, stating: "You have abandoned international law. Our pilot was captured, and you cut off his head and killed him. … For this, you will get what you deserve."[106]

Graziani's demand for revenge was immediately downplayed after the attack, and a new justification of "half-truths and simple lies" was constructed.[107] Key to the new argument was the purported presence of Ethiopian military leaders "who had sought illicit protection of the Red Cross".[108] During exchanges with the Swedish minister in Rome, bad visibility was also added to the list of justifications.[109] Graziani's explanations were repeated in Italian propaganda, especially via the media. The latter tended to present the Swedish bombing as an "indignant" ruse attempting to throw "shadows of suspicion and doubt on the Italian Army".[110]

The ICRC delegate Dr Marcel Junod, after visiting the bombing site, was far more categorical with his analysis, and dismissive of Italian justifications. Compared to the "accidental" bombardment of the American Adventist Mission, he stated, "it seems obvious that the massacre of the Swedish ambulance at Malka Didaka was premeditated".[111] More specifically, the delegate pointed to the preceding overflights, confirming that there were "no armed men in this ambulance and there was no risk of being fired upon".[112] Meanwhile, the "decapitation" of an Italian officer used to justify the bombardment was an "odious lie intended to cover a veritable act of piracy".[113]

There was at least some awareness in the Italian leadership that attacking the Red Cross hospitals could be counter-productive. Mussolini himself noted that while he was "in favour" of a harsh war, in attracting "criticism from all over the world …

103 ICRCA, B CR 210-15, "Rapport du Docteur Marcel Junod au Comité de la Croix Rouge sur le bombardement de la Croix Rouge suédoise par l'aviation italienne, le 30 – 12 – 35, à Melka Didaka", 13 January 1936 (author's translation).
104 M. Junod, above note 94, p. 47.
105 *Ibid.*
106 ICRCA, B CR 210-15, Amharic pamphlet dropped by Italian planes thirty minutes before bombing the Swedish ambulance, undated (author's translation).
107 R. Baudendistel, above note 5, p. 132.
108 *Ibid.*, p. 133.
109 *Ibid.*, p. 137–138.
110 ICRCA, B CR 210-15, internal update to Geneva, 13 January 1936 (author's translation).
111 ICRCA, B CR 210-15, "Delegate Report No. 6", 9 January 1936 (author's translation).
112 *Ibid.*
113 ICRCA, B CR 210-15, internal update to Geneva, 2 January 1936 (author's translation).

we are only making our task more difficult".[114] Orders were duly given to "respect all Red Cross installations" wherever they may be, but in practice, military expediency continued to take precedence and the attacks continued.[115]

While the public rationales varied, they largely focused on the themes described above, especially around the misuse of the red cross emblem. The Ethiopians were repeatedly accused of using the emblem to "protect military material" and to "camouflage their own positions", in addition to field hospitals being transformed into shelters for their military leaders.[116]

Underlying accusations against the Ethiopians' inability to conform to the requirements of the Geneva Convention was a racial construct sadly not out of place in the 1930s and fitting with the Italians' civilizing claim. In describing the "savage and bloodthirsty" murder of Italian labourers on 13 February 1936, the Italian government noted that this was simply the latest in "a series of systematic and barbarous crimes which not only arouse irrepressible horror, but bear witness to the uncivilized condition of Ethiopia".[117] When the authenticity of "presumed bombardments" could not be denied, when Ethiopian misuse of the red cross emblem was not credible, the uncivilized nature of the adversary was put forward.[118] This was the crux of Mussolini's claim as Addis Ababa was about to fall to Italian forces: "The missionaries of the different Red Crosses have been killed or wounded by the Abyssinians who are too backward to be able to respect emblems."[119]

Meanwhile, the impact on medical operations was nothing short of catastrophic. Following a bombardment in Woldia in January 1936 that destroyed well-marked medical supplies, Major Bourgogne of the Ethiopian medical service cabled the ICRC, demanding: "Wake up Geneva as is evident Italians making special target of any Red Cross."[120] While the ICRC was not entirely convinced this particular attack was intentional, an update to headquarters did note that both locals and Red Cross staff "shared the opinion of Major Burgoyne".[121] A mitigating measure is described where "patients are brought daily outside at around 7 am and placed under trees a reasonable distance from the Red Cross emblems"; the report then states that the Red Cross risks becoming "the laughing stock of the country".[122]

Over the coming months, individual ambulances and field hospitals took the more obvious step of simply removing the emblem as "the Italians are taking the Red Crosses as targets during their operations and bomb them wherever they

114 R. Baudendistel, above note 5, p. 138.
115 *Ibid.*
116 *Ibid.*, p. 160.
117 "Abyssinian Atrocities Committed against Italian Workmen: Protest by the Italian Government to the League of Nations", Communication from the Italian Government, Official No. C.123.M.62, Geneva, 19 March 1936.
118 ICRCA, B CR 210-15, "Extrait du supplément de presse" (Italian source), 25 January 1936 (author's translation).
119 R. Baudendistel, above note 5, p. 116.
120 ICRCA, B CR 210-15, telegram, 15 January 1936.
121 ICRCA, B CR 210-15, "Reports No. 7bis", 20 January 1936 (author's translation).
122 *Ibid.*

find them".[123] As the head delegate noted, it was difficult for the National Red Cross Societies (National Societies) to do any differently as he had "no desire to see members of Red Cross ambulances assassinated for reasons of stubborn doctrine".[124] By the end of April 1936, most National Societies had been bombed or had ceased to function, with the exception of the Norwegians.[125]

Despite concerns at ICRC headquarters of antagonizing fascist Italy, protests were sent to the Italian Red Cross. In one response, the answer was limited to forwarding a newspaper clipping that described the destruction of ambulances in World War I by all sides.[126] The message was clear: how can one be condemned for acts committed by all? The Italian Red Cross delegate in Ethiopia helpfully summarized the attitudes of his compatriots in noting that "nothing was expected from the Red Cross in Geneva", while the National Societies and doctors were "mercenaries, sell-outs and against us".[127]

Unsuccessful attempts by the Red Cross to negotiate a level of protection from Italian bombardments in Ethiopia inevitably led to disillusionment among its staff. Propaganda and manipulation of facts, patently false to those on the ground, could only contribute further to that disillusionment. Questioning of eyewitness accounts of Red Cross field hospitals being intentionally targeted, and the blaming of the "Abyssinian barbarian" for their own violations of the Convention to justify those acts, took place in a much broader struggle.[128] The failure to mitigate the risks to providing medical care, and the Red Cross's own sad irrelevance, was neatly captured by the head ICRC delegate: in such a conflict, he said, there was "no possibility of *caritas inter arma*, it's all-out war, pure and simple, with no distinction between soldiers and civilians"; and as for the Red Cross, "it's hardly surprising that it has been swallowed up along the way".[129]

A footnote to total war: The Second Sino-Japanese War (1937–45)

Given the scale and duration of the conflict, and especially the well-documented attacks on all civilian structures, the Second Sino-Japanese War might seem an odd addition to an analysis of perpetrator discourse specifically focused on medical care. It illustrates the challenge of singling out the protection of hospitals in contexts where entire cities are razed. Nevertheless, a pattern of accusations did emerge shortly after the Japanese invaded on 7 July 1937. And as their forces

123 ICRCA, B CR 210-15, "Report No. 13", 25 March 1936 (author's translation).
124 ICRCA, B CR 210-15, "Reports No. 7bis", 20 January 1936 (author's translation).
125 ICRCA, B CR 210-15, "Report No. 14", 18 April 1936. The delegate also notes that the Ethiopians were beginning to see the ICRC as "pro-Italian" as it had "not sufficiently reacted to the bombing of colleagues" (author's translation).
126 ICRCA, B CR 210-8, "Aeroplani e Crosci Rosse", from *Il Giornale d'Italia*, sent from the Italian Red Cross to ICRC Geneva, 7 April 1936.
127 R. Baudendistel, above note 5, p. 112.
128 C. Moorehead, above note 44, p. 309.
129 ICRCA, B CR 210-15, "Report No. 13", 25 March 1936 (author's translation).

extended inland to Nanking, seat of the Nationalist Government of the Republic of China, mutual recriminations shifted to include Japanese propaganda intended to counter a narrative of atrocities that certainly included structures ostensibly protected by the Geneva Convention.

Japan had a well-organized National Society and had ratified the 1929 Geneva Convention on 18 December 1934.[130] Shortly after the outbreak of hostilities, the Japanese Red Cross actually refused an ICRC offer of support as it had sufficient preparation "for all eventualities".[131] Despite China having also acceded to the 1929 Convention, in addition to being more amenable to external support, the ICRC considered the protection of the Red Cross by both parties to be "extremely difficult".[132] The Shanghai-based delegate concluded early on that the "mentality of Orientals" meant they were incapable of "our way of thinking".[133] Both parties were "mutually accusing each other of abusing the Red Cross", acts that the delegate "would not put [his] hand in the fire to say [were] not the case".[134]

In practice this resulted in the two countries' National Societies sending their respective reproaches via Geneva, which were then duly forwarded to the accused party. The list was long. Initial accusations came from the Japanese, charging the Chinese with "indescribable atrocities" against Japanese civilians in Tongzhou.[135] This was followed in quick succession by claims that three Japanese hospital ships had been bombed or shelled between 29 August and 12 September 1937.[136] The dropping of Chinese incendiary bombs on a Red Cross hospital during the Battle of Shanghai was likewise relayed on 20 October 1937.[137]

The Chinese Red Cross also launched "strong protests" at the attack on medical structures by the Japanese military, such as the Chenju Red Cross hospital on 18 August 1937.[138] Its primary complaints, however, involved the targeting of ambulances "despite flags and insignia", a frequent occurrence resulting in the destruction of seven from a fleet of thirty by the end of August.[139] Many of the exchanges included denials by both belligerents, and despite evidence to the contrary, the analysis of the ICRC resembled that of the

130 Note that Japan had signed but not ratified 1929 Convention relative to the Treatment of Prisoners of War.

131 ICRCA, B CR 217-1, 1-105, telegram, Japanese Red Cross to ICRC Geneva, 17 August 1937.

132 ICRCA, B CR 217-1, 1-105, internal update to Geneva, 21 October 1937.

133 *Ibid.*

134 *Ibid.*

135 ICRCA, B CR 217-1, 1-105, telegrams, Japanese Red Cross to ICRC Geneva, 3 and 5 August 1937.

136 In Wousungohen, Poutoung and Wousoung respectively. ICRCA, B CR 217-1, 1-105, telegram, Japanese Red Cross to ICRC Geneva, 14 September 1937.

137 ICRCA, B CR 217-2, 106-200, telegraph, Japanese Red Cross to ICRC Geneva, 20 October 1937.

138 This includes incidents on 19, 23 and 30 August 1937. ICRCA, B CR 217-1, 1-105, "Telegrammes Retélégraphié par la Ligue des Sociétés de la Croix-Rouge", 29 August 1937.

139 *Ibid.* (author's translation). Protests against Japanese atrocities, including the bombing of hospitals supported or run by the Chinese Red Cross, were likewise relayed in the press during this same period. See "Les Japonais ont bombardé le camp de la Croix-Rouge", Argus International de la Presse, 4 September 1937; "Nous sommes revenus au temps des barbares: Emouvant appel de Madame Chiang-Kai-Shek", Argus International de la Presse, 18 September 1937; "Deux communications chinoises à la S.D.N. sur les bombardements des non-combattants et des villes ouvertes, l'emploi des balles dum-dum et des gaz toxiques par les Japonais", Argus International de la Presse, 18 October 1937.

early stages of the Italo-Ethiopian War: that violations of the Convention were "less the result of bad intentions than negligence".[140]

The occupation of Nanking by the Imperial Japanese Army dispelled any pretence of "negligence" in the targeting of medical structures, even as the destruction went far beyond that of hospitals. Already by November 1937, and with the Nationalist army in retreat, information was relayed from the American Red Cross that trucks and railway cars evacuating the wounded from Shanghai to Nanking were being "consistently attacked by Japanese planes".[141] Due to "bombs and machinegun fire", half of all transports were destroyed, and movement could only proceed at night. Of the 1,500 patients who survived the journey, all were septic "because of [the] impossibility of giving them early attention".[142] With the arrival of Japanese forces imminent, it was observed on 10 December 1937 that the Chinese staff had fled the University of Nanking Hospital and that "bodies were everywhere – clogging the rooms, corridors, and even exits".[143]

By the evening of 13 December 1937, the Japanese army controlled the entirety of Nanking. The remaining foreigners had already formed the Nanking Christian War Relief Committee and established a "safety zone" that initially provided sanctuary to 100,000 displaced. They renamed themselves the International Red Cross Committee for Nanking and took charge of the former military hospitals at the Ministry of Foreign Affairs, the Ministry of Railways and the Ministry of War, in addition to the University of Nanking Hospital.[144] The Japanese military commander was informed of these developments by letter the following day and given assurances from the self-appointed Committee that all men at these sites had been disarmed and that the buildings would only be used "for hospital purposes".[145]

Regardless, on 14 December 1937 the Japanese army broke into the hospital at the Ministry of Foreign Affairs, forbade access to medical staff and eventually removed wounded soldiers, who were "marched out and systematically shot".[146] The process was repeated at the other hospitals until only the University of Nanking Hospital remained functional, although it too was looted and saw patients "either bayoneted or shot".[147]

140 ICRCA, B CR 217-2, 106-200, internal update to Geneva, 21 October 1937.
141 ICRCA, B CR 217-3, 201-400, internal update to Geneva, 11 November 1937.
142 *Ibid.*
143 Iris Chang, *The Rape of Nanking: The Forgotten Holocaust of World War II*, Penguin, London, 1997, p. 115.
144 ICRCA, B CR 217-3, 201-400, Secretary of the International Red Cross Committee for Nanking to ICRC Delegate in Hankow, 22 December 1937.
145 John Rabe, "Letter to Japanese Commander of Nanking", in Hsü Shuhi (ed.), *Documents of the Nanking Safety Zone*, Kelly & Walsh, Shanghai, 1939, pp. 2–3.
146 I. Chang, above note 143, p. 125.
147 Lewis S. C. Smythe, "Cases of Disorder by Japanese Soldiers in the Safety Zone", in H. Shuhi (ed.), above note 145, p. 10; ICRCA, B CR 217-3, 201-400, Secretary of the International Red Cross Committee for Nanking to ICRC Delegate in Hankow, 22 December 1937.

The massacres carried out in Nanking, including those specifically targeting medical care, initially provoked steps by the Japanese to limit international exposure. The ICRC delegate in China was repeatedly refused access. It was only in mid-1938 and from the comparative safety of Hong Kong that he was able to escape censors and forward the "Nanking Report" to Geneva. This document provides a daily journal of the "complete anarchy" of Japanese occupation in December 1937, describing a "city laid waste, ravaged, completely looted, much of it burned".[148] However, news had already filtered out well before the report made it to Geneva, notably via three American journalists who had remained in Nanking during the early stages of the occupation. In addition to publishing detailed accounts, newsreel was also smuggled out, leading the Japanese military to "seal off the city to prevent other reporters from coming in" and "impede the return of foreign diplomats".[149]

The emergence of reporting from Nanking in the world press was followed by international condemnation. It was no longer enough to limit foreign witnesses, and initial celebrations in Japan over the conquest of the Chinese capital shifted to an intensified propaganda campaign intended to demonstrate a more humane reality. The authors of the "Nanking Report" noted that already by the end of December, Japanese newspapers were claiming that "stores were rapidly opening up and business was returning to normal".[150] Meanwhile, the city had been emptied of Chinese looters and "peace and order now reigned".[151] These two angles would be repeated in the months to come. The picture presented was essentially that of a benevolent victor being welcomed by spontaneous crowds ever grateful for their liberation, while the supposed "outrages" were the result of uncooperative Chinese often acting at the behest of foreigners.[152]

The interchange of reporting and propaganda stemming in part from the carnage in Nanking largely overshadowed the noted attacks on hospitals. Initial plans for an ICRC delegate to "make known the location of Red Cross units and warn against their bombardment" had come to naught.[153] With the ICRC underfunded and understaffed, a single delegate had eventually been sent "principally as … an observer", and the posting was abandoned after 1939.[154] Nevertheless, basic patterns did emerge as several tactics were used to avoid responsibility for breaches of the Geneva Convention. Neither side admitted involvement, and each accusation was followed by a counter-accusation. During the Japanese occupation of Nanking, when documentary evidence of violations could no longer be denied, a counter-narrative was propagated that shifted blame to the victims.

148 ICRCA, B CR 217-4, 401-600, "Nanking Report" accompanying internal update to Geneva, 2 May 1938. The Report was drafted by members of the local International Red Cross Committee for Nanking and was considered "authentic" despite being unsigned due to the risk to the authors.
149 I. Chang, above note 143, pp. 144–147.
150 ICRCA, B CR 217-4, 401-600, "Nanking Report" accompanying internal update to Geneva, 2 May 1938.
151 *Ibid.*
152 I. Chang, above note 143, pp. 149–153.
153 ICRCA, B CR 217, "Activities of the International Committee of the Red Cross in China during the Sino-Japanese Conflict, 1937–1939", undated.
154 *Ibid.*

More broadly, the fate of protected medical structures in the Far East was lost in the sheer scale of civilian suffering, culminating in the use of atomic weapons in Hiroshima and Nagasaki in 1945. In an unusual step, there was an early attempt by the ICRC in Geneva to remind the belligerents of their obligations to the 1907 Hague Convention regarding the targeting of civilians and related infrastructure.[155] This was perhaps the most likely indicator of the shape of future conflicts, and the ICRC delegate in China stated as much before his departure. In his view, the potential for mass destruction of entire populations should become a central issue for the ICRC "as modern armies are becoming more and more murderous, and as bombing raids are taking a more sinister and horrible form".[156]

More honoured in the breach: The Nigerian Civil War (1967–70)

When the Republic of Biafra declared independence from Nigeria on 30 May 1967, the international legal context had evolved considerably. Earlier incarnations of the Geneva Convention made no mention of "civilians", and rather referred to "unarmed inhabitants, non-combatants and the enemy or occupied population".[157] Following the atrocities of World War II, such as those described in occupied China, the fate of civilian populations became a specific subject of IHL through Geneva Convention IV of 1949. As relevant for the Nigerian Civil War was Article 3 common to the four Geneva Conventions, which extended coverage to "conflicts not of an international character".

These innovations would prove controversial in Biafra despite Nigeria having ratified the 1949 Conventions and Biafran leader Odumegwu Ojukwu agreeing to abide by its principles. Over the course of the conflict, which would last until the capitulation of Biafra in January 1970, both sides would be accused of instrumentalizing humanitarian aid and conducting massacres.[158] Relations between the Nigerian military government and the ICRC were particularly tense, with access to the blockaded territory a point of friction requiring constant negotiation.[159] Receiving less attention was what can be described as the systematic targeting of hospitals by the Nigerian Air Force. In this regard a familiar pattern emerges, beginning with a chaotic mix of apology and denial by those responsible, eventually shifting to accusations of misinformation and attempts to justify the incidents.

ICRC delegates identified at least sixteen occasions where medical structures were attacked in Biafra as the Nigerian State attempted to suppress the secessionist

155 ICRCA, B CR 217-4, 401-600, letters to Ministry of Foreign Affairs for the Imperial Government of Japan and Ministry of Foreign Affairs for the Republic of China, 5 March 1938.
156 C. Moorehead, above note 44, p. 368.
157 Hugo Slim, *Killing Civilians: Method, Madness and Morality in War*, Hurst & Co., London, 2007, p. 19.
158 C. Moorehead, above note 44, p. 617.
159 Marie-Luce Desgrandchamps, "'Organising the Unpredictable': The Nigeria-Biafra War and its Impact on the ICRC", *International Review of the Red Cross*, Vol. 94, No. 888, 2012, pp. 1413–1414.

movement.[160] Although the circumstances in each case differ, a closer inspection of the correspondence surrounding some of the incidents is revealing both for the Nigerian government's position and the subsequent reaction. Mary Slessor Hospital in Itu was a particularly flagrant example. Located on a hill and isolated from other dwellings, consisting of four main buildings "each distinctly marked on the roof with a Red Cross", the long-established hospital was bombed on 23 January 1968, resulting in severe structural damage and six deaths.[161] In a letter of protest to the Nigerian government, an ICRC delegate noted the unlikelihood of error given that the attack occurred in plain daylight and was carried out "by highly skilled experts" against a "distinctly recognizable hospital".[162] A subsequent memorandum suggested that only a well-founded suspicion that the hospital was being used for military purposes could provide a reasonable explanation.[163]

The response from the Federal Military Government was relatively apologetic even as other possible scenarios were broached. According to the Nigerians, poor weather pointed to a simple "mistake", or unscrupulous rebels were "taking advantage" of the Red Cross to secure protection.[164] Regardless, a degree of responsibility was accepted; the "Commander-in-Chief was very distressed" about the attack and was well aware that such acts were "contrary to the spirit of the Geneva Convention".[165] Looking to the future, an internal investigation was launched to avoid a "recurrence of the serial raids on hospital establishments".[166]

Complaints over the attack in Itu were not limited to the ICRC. But while anger from organizations like the Biafran National Red Cross might not be especially surprising, another more disturbing rationale was raised. Despite a commitment to keep "military installations away from hospital locations", along with the "necessity" of using the red cross emblem for medical structures, the Biafran authorities suggested that marking hospitals actually made them a target.[167] Such fears were reiterated by the Overseas Council of the Church of Scotland, a sponsor of the Mary Slessor Hospital. Given the circumstances of the attack, not

160 ICRCA, B AG 202 147-008.01, "Reference: Bombing, Strifing [*sic*] of Hospitals and Civilians", internal update to Geneva, 26 February 1968. By February 1968 the ICRC Delegate and Special Representative to Biafra had identified eleven medical structures that had been attacked. Subsequent reports and analyses reveal five further incidents (the ICRC Community Hospital in Awo-Omamma being targeted twice).

161 ICRCA, B AG 202 147-008.05, "Letter of Protest" to Y.A. Gobir, Permanent Secretary to the Federal Military Government, 5 February 1968.

162 *Ibid.*

163 ICRCA, B AG 202 147-008.05, "Memorandum Concerning the Protection of Both Civilian and Military Hospitals in Time of War and Armed Conflict", sent to the Federal Military Government of Nigeria from the ICRC, 7 February 1968.

164 ICRCA, B AG 202 147-008.05, letter from Permanent Secretary to Federal Military Government, 7 February 1968.

165 *Ibid.*

166 *Ibid.*

167 ICRCA, B AG 202 147-008.05, "Letter of Protest", Moses M.K. Iloh, National Secretary, Biafran National Red Cross, to ICRC, 10 February 1968. The same letter noted the "distressing fact that the country [the United Kingdom] which sponsored Nigeria's admission into the International Red Cross is today sponsoring her acts of genocide", including in its recent confirmation "that she was still supplying arms to Nigeria".

only could there be no doubt that it was "deliberately aimed against the hospital", but it was being "questioned very gravely whether it was wise to use the well-known emblem recognized by States throughout the world".[168] In a precursor to today's claims of IHL in crisis, the Scots suggested that few States, in the event of war, would "honour a Convention which is now somewhat out of date".[169]

Within the ICRC, especially field delegates, there seems to have been little doubt that the hospital raids were "absolutely deliberate".[170] Indeed, determining that the sites targeted were scenes of active combat would seem to depend on "whether one considers the whole of Biafra as a battle zone".[171] Objections to the Federal Military Government consequently became less ambivalent. In another letter of protest from May 1968, the ICRC delegate-general for Africa noted that attacks on hospitals had continued despite the federal authorities having on several occasions "publicly declared that the pilots had been ordered to stop attacking and bombing civilian targets".[172] Corroborated accounts of the "apparently deliberate bombing of civilian population and the air-attack against hospitals and first-aid stations in disregard of the Red Cross emblem" were duly relayed.[173] And as with previous protests, the relevant violations of the Geneva Conventions were underlined in legal terms.[174]

As accusations against the Nigerian Air Force increased in frequency and severity, the response from the Nigerian government became equally intransigent and defensive. Responding to yet another protest over an air raid, this time "deliberately aimed at the ICRC Aboh Hospital" on 19 October 1968, the Ministry of External Affairs was dismissive.[175] In addition to not understanding the reasoning behind the protest, given that there was "no damage to ICRC

168 ICRCA, B AG 202 147-008.05, letters from Overseas Council, Church of Scotland, to ICRC, 22 February and 26 March 1968.

169 *Ibid.* This reference was specifically towards the Hague Convention of 1907, although the protection of "neutralized" medical structures is the general understanding.

170 ICRCA, B AG 202 147-008.01, "Reference: Bombing, Strifing [*sic*] of Hospitals and Civilians", internal update to Geneva, 26 February 1968.

171 *Ibid.*

172 ICRCA, B AG 202 147-008.02, "Letter of Protest" to Major General Yakubu Gowon, Head of the Federal Military Government and Commander-in-Chief of the Nigerian Armed Forces, 21 May 1968.

173 *Ibid.*

174 From the attack on Mary Slessor Hospital in Itu: "[M]ilitary hospitals and mobile units for the medical services have been declared protected by Article I of the Geneva Convention of 1864, Article 6 of the Geneva Convention of 1906, Article 6 of the Geneva Convention of 1929 concerning wounded and sick in armed forces in the field and Articles 19 and 23 of the 1st Geneva Convention of 1949" (and "civilian hospitals are protected by the Hague Regulations concerning the Laws and Customs of War on Land, Article 27 and by the IVth Geneva Convention of 1949, Article 18"). ICRCA, B AG 202 147-008.05, "Memorandum Concerning the Protection of Both Civilian and Military Hospitals in Time of War and Armed Conflict", sent to the Federal Military Government of Nigeria from the ICRC, 7 February 1968. From the continued attacks into May 1968: "This protest is based on the Articles 19, 21, 22 and the entire Chapter VII of the first Geneva Convention of August 12, 1949, and on Article 18 of the fourth Geneva Convention relative to the Protection of Civilian Persons in time of war". ICRCA, B AG 202 147-008.02, "Letter of Protest" to Major General Yakubu Gowon, Head of the Federal Military Government and Commander-in-Chief of the Nigerian Armed Forces, 21 May 1968.

175 ICRCA, B AG 202 147-008.07, "Letter of Protest" to the Ministry of External Affairs of the Federal Republic of Nigeria, 31 October 1968.

property or loss of life", the Ministry noted that delegates were not qualified to say if there were "military targets in the area".[176] Then turning on the offensive, the Ministry issued a vague warning. Noting that the ICRC's earlier "partisan actions and pronouncements" had provoked severe strain on relations with the government, the Ministry stated that the former should "refrain from any actions" which could lead to a further deterioration.[177]

The following incidents led to actions that were unlikely to assuage the Nigerian government. Field delegates had already been arguing to "bring these acts to the notice of the public".[178] When the ICRC Community Hospital in Awao-Omamma was bombed on 9 December 1968 and again on 5 January 1969, killing seven people and "badly injuring" at least ten Red Cross staff, there was a move to public denunciation. The usual letters of protest noted the "characterized violation of the principles of the Geneva conventions", and in both cases these were followed by press releases.[179] A 7 January communication noted that it was the second time in a month that "this hospital had been deliberately attacked by the Nigerian Air Force".[180]

Decrypting the Nigerian response to repeated accusations of having targeted hospitals is not easy. While a pro-government local radio station boasted that "hospitals have been attacked or will be attacked",[181] concurrent broadcasts from Lagos "kept denying that Nigerian Air Force planes were attacking civilians and hospitals".[182] The mixed messages continued with public claims from General Yakubu Gowon denying "such raids" while his own administration discreetly acknowledged "mistakes" such as Mary Slessor Hospital in early 1968.[183]

Easier to trace is the positioning of the Nigerian government as both the hospital attacks and the war itself dragged on. An "Operational Code of Conduct for Nigerian Armed Forces" had existed since 1967 and was explicit: "hospitals, hospital staff and patients should not be tampered with or molested".[184] Although more honoured in the breach, reference to the Code of Conduct and the strict instructions "not to bomb any non-military targets" became a ready-

176 ICRCA, B AG 202 147-008.07, letter from Ministry of External Affairs of the Federal Republic of Nigeria to the Commissioner-General, 12 November 1968.
177 *Ibid.*
178 ICRCA, B AG 202 147-008.01, "Reference: Bombing, Strifing [*sic*] of Hospitals and Civilians", internal update to Geneva, 26 February 1968.
179 ICRCA, B AG 202 147-008.08, "Letters of Protest" to the Ministry of External Affairs of the Federal Republic of Nigeria, 10 December 1968 and 6 January 1969.
180 ICRCA, B AG 202 147-008.08, "Attaque d'un hôpital du CICR au Biafra", ICRC Press Release (Communiqué No 925), 12 December 1968; and "Bombardement d'un hôpital CICR au Biafra", ICRC Press Release (Communiqué No 940), 7 January 1969 (author's translation).
181 ICRCA, B AG 202 147-008.01, "Reference: Bombing, Strifing [*sic*] of Hospitals and Civilians", internal update to Geneva, 26 February 1968.
182 *Ibid.*
183 ICRCA, B AG 202 147-008.05, letter from Permanent Secretary to Federal Military Government, 7 February, 1968.
184 ICRCA, B AG 202 147-008.12, "Operational Code of Conduct for Nigerian Armed Forces", undated but shared with ICRC on 28 December 1967.

made answer whenever the government was confronted with a new accusation of transgression.[185]

Two other angles emerged that bear a striking resemblance to the earlier case studies. Already in mid-1968, General Gowon had alluded to "secessionists using hospitals and other protected sites to store arms, munitions and troops".[186] Nearly a year later, and while still "categorically rejecting any charges of indiscriminate bombings", the Nigerian officials openly referred to the "deliberate policy of the rebels" of hiding in population centres.[187] And perhaps more ominously for the ICRC, the Federal Military Government also claimed to be "a victim of scurrilous propaganda".[188] If indeed civilians were hit, the bombings "could only have been accidental" and the resulting casualties "grossly exaggerated".[189]

Essentially the full range of perpetrator discourses was now almost covered in a single conflict, fluctuating from admission to denial, interspersed with retrospective justifications enveloped in nefarious plots ostensibly aimed at discrediting the Nigerian State. The presence of inconvenient international observers highlighting these incongruences was hardly welcome. Put another way, while the Biafrans had "quickly perceived that the surest road to victory was to draw in international support", Nigerians were "anxious to keep the world out".[190] As one of the most visible international humanitarian actors, this pointedly included the ICRC.

In a context where humanitarian aid was arguably used to maintain a rebellion, at least from the Nigerian government's perspective, commitments to the Geneva Conventions were at best a periodic distraction. At worst, the red cross emblem arguably increased vulnerability to attack, and certainly did not supersede military prerogatives.

No shortage of precedents… and precursors

It has been argued that, aside from justifying military action as a response to terrorism, contemporary attacks on hospitals in Yemen, Syria and Afghanistan have "more differences than similarities".[191] Given the disparity of examples and epochs presented in this paper, searching for commonalities would seem an even

185 ICRCA, B AG 202 147-008.02, letter from Permanent Mission of Nigeria to the United Nations to ICRC (No. GI/11/S247), 11 March 1969.
186 ICRCA, B AG 202 147-008.02, internal update to Geneva (Note confidentielle No. P-5), 28 May 1968 (author's translation).
187 ICRCA, B AG 202 147-008.02, letter from Permanent Mission of Nigeria to the United Nations to ICRC (No. GI/11/S247), 11 March 1969.
188 *Ibid.*
189 *Ibid.*
190 C. Moorehead, above note 44, p. 618.
191 Françoise Bouchet-Saulnier and Jonathan Whittall, "An Environment Conducive to Mistakes? Lessons learnt from the Attack on the Médecins Sans Frontières Hospital in Kunduz, Afghanistan", *International Review of the Red Cross*, Vol. 100, No. 907–909, 2019, p. 339.

more futile exercise. Nevertheless, there are rationales that repeat themselves, in the case studies and elsewhere, pointing to broader trends in both historical and contemporary conflicts.

As this brief survey of perpetrator discourse has demonstrated, the categories of justifications used by perpetrators may have varied in time and place, but they are still recognizable. These include genuine or contrived ignorance of the Geneva Conventions, admissions of responsibility in the form of "mistakes", denial of facts, colonial or dehumanizing representations of the enemy, misinformation, blame-shifting, and accusations of partiality. Keeping these points in mind, there is no shortage of historical examples in which to delve more deeply. Or, as an ICRC official noted following the bombing of another hospital in Biafra, there are "many precedents … beyond the incidents of recent months".[192]

Ignorance around the basic tenets of the 1864 Convention was hardly limited to the Franco-Prussian War. The original statutes were deemed largely irrelevant in the 1877–78 Russo-Turkish War, which saw hospitals "systematically shelled".[193] Volunteer doctors at the time argued that there was "no doubting" the Russian intentions as "shell after shell fell in our vicinity".[194] Similar conclusions were drawn regarding the 1899–1902 Boer War, in which proper attention "had not always – or even very often – been paid to the Geneva Convention".[195] In addition to hospitals receiving fire from both sides, the British commander Lord Kitchener demonstrated his understanding of nascent humanitarian law by attempting to attach "his personal military carriage on to the back of a Red Cross train".[196]

Hospital ships also have an under-explored history prior to World War I. In the context of the soon-to-be-finalized protections granted in naval warfare, the first "real test" came in the 1904–05 Russo-Japanese War. While both parties "mainly adhered to their agreements", the Japanese were accused of firing on Russian hospital ships, acts they denied. And in a similar episode to the German *Ophelia* ten years later, the Russian hospital ship *Orel* was captured, accused of "providing other non-medical services to the Russian fleet in ways that amounted to use for military purposes".[197]

Beyond the limited example of the Second Sino-Japanese War presented in this study, there is unsurprisingly a wealth of material documenting violations of IHL during World War II that merit a separate study altogether. Recognizing that civilian structures were not afforded protection by the Geneva Convention at the time, the advantages of singling out hospital attacks in the midst of broader

192 ICRCA, B AG 202 147-008.08, "Bombardement de l'hôpital d'Owa Omamma au Biafra", 27 December 1968 (author's translation).
193 B. Taithe, above note 4, p. 42.
194 Stafford House Committee for the Relief of Sick and Wounded Turkish Soldiers, *Report and Record of the Operations of the Stafford House Committee, Russo-Turkish War, 1877–78*, Spottiswoode & Co., London, 1879, p. 50.
195 C. Moorehead, above note 44, p. 147.
196 *Ibid.*
197 S. McGreal, above note 52, pp. 13–14.

violence against a civilian population are questionable, especially given the difficulties of isolating specific narratives on protected medical structures.

The promulgation of the 1949 Geneva Conventions theoretically resolved this dilemma, although at the time of the 1950–53 Korean War, neither belligerent had proceeded to ratification. While the war is remembered in ICRC lore more for the extreme challenges linked to prisoners of war and their repatriation, misinformation around attacks on medical care was rampant.[198] Despite labelling the ICRC a "capitalist spy organization", the Chinese leadership did not hesitate to accuse the Americans of "bombing well-marked Red Cross hospitals in the North" when convenient.[199] There were also unsubstantiated accusations of bacterial warfare and demands for the ICRC to investigate, presaging a similar move during the 1962–70 North Yemen Civil War.[200] In addition to attacks on the red cross emblems by the Egyptian Air Force, the use of chemical weapons resulted in a disinformation campaign with strong parallels to those used to discredit hospital attacks.[201] In this case it was spectacularly, and falsely, claimed through the Egyptian media that the ICRC had corroborated mass and simultaneous death "from tuberculosis on the Saudi-Yemen border rather than toxic gas".[202]

Events during the Vietnam War, particularly the late 1960s and early 1970s, likewise merit further examination. The confiscation or destruction of National Liberation Front/Viet Cong medical supplies by American and South Vietnamese forces when coming across camouflaged or underground hospitals has been well documented.[203] In terms of perpetrator discourse, the bombing of Bach Mai Hospital in December 1972 could be instructive. After initially denying that American bombs had hit the 950-bed hospital, a Pentagon spokesman subsequently acknowledged "some limited accidental damage".[204] But while Hanoi reported "massive destruction" in its own propaganda, the American government added an element of doubt while continuing to express regret.[205] Essentially, the Americans claimed that no definitive version of events was

198 Max Hastings, *The Korean War*, Pan Books, London, 1987, pp. 475–476.
199 C. Moorehead, above note 44, pp. 570, 573, 575–579.
200 ICRCA, B AG 202 056-026, "Réflexions et commentaires sur le conflit de Corée", ICRC internal review, undated.
201 André Rochat, *L'Homme à la Croix*, Editions de l'Aire, Lausanne, 2005, pp. 231–241; Victoria Clark, *Yemen: Dancing on the Heads of Snakes*, Yale University Press, New Haven, CT, 2010, pp. 96–97.
202 ICRCA B AG 202 225, "C'est la tuberculose et non pas un gaz toxique qui aurait tué les Saoudiens", Al-Akbahr, 22 January 1967 (author's translation). In this case the use of "chlorine gas" was determined in a subsequent scientific analysis. "Concerne: Evénements survenus à Ketaf (Yémen) le 5 janvier 1967", Universität Bern: Gerechtlich-Medizenisches Institut, 1 February 1967.
203 Michel Barde, *La Croix-Rouge et la révolution indochinoise: Histoire du Comité International de la Croix-Rouge dans la guerre du Vietnam*, Centre de Documentation de Recherche sur l'Asie, Institut Universitaire de Hautes Etudes Internationales, Geneva, undated; "Chapter XVI: The Seizure and Destruction of Medical Resources", in Seymour Melman, *In the Name of America*, Turnpike Press, Annandale, VA, 1968, pp. 411–420.
204 Anthony Ripley, "Report of Damage to Hanoi Hospital Confirmed by US", *New York Times*, 3 January 1973.
205 *Ibid.*

possible as damage could have been caused "by bombs, by downed American or North Vietnamese aircraft or by falling antiaircraft missiles".[206]

The latter comments sound remarkably like assertions of the "fog of war" by the United States following its internal investigation of the bombing of MSF's trauma hospital in Kunduz, Afghanistan, on 3 October 2015. Analysis of public statements immediately after this attack also echoes many of the tactics outlined in this research. Contradictory explanations shifted from "collateral damage" and "self-defence" justifications to a "mistake" and "deep regrets". Insinuations from Afghan officials that the hospital represented a legitimate target resemble even more closely the retrospective justifications repeatedly used in the historical case studies above. In this instance, the Afghan officials argued that the attack on a medical structure was justified by the presence of wounded Taliban fighters, invalidating a basic premise of the Geneva Conventions since 1864.[207]

To continue with the original frame of analysis outlined at the beginning of this paper, a brief observation of other contemporary attacks on medical care reveals historical precedents. Saudi Arabia has responded to accusations of having targeted hospitals in Yemen with a discourse that includes both denials and admissions of error, even as it accuses opposition Houthis of storing munitions on protected sites.[208] In Syria, outright denials over the targeting of medical care by Russian and Syrian officials has been accompanied by attempts to discredit the accusers through misinformation campaigns.[209] Unlike the majority of the conflicts presented in the case studies above, the non-international character of current wars combined with the presence of coalitions arguably makes it easier for perpetrators of attacks to shift blame and dilute responsibility.

In reality, all the case studies presented allude to attempts at excluding groups and hospitals from the protections outlined in the Geneva Conventions, even as the circumstances and rationales differed widely. This is the broader trend evident in conflicts today that most clearly has historical precedent, especially apparent in the discourse of those accused of attacks on medical care. If the current counterterrorism narrative attempts to define who is not covered by IHL, its antecedents include similar purported exclusions, be they barbarians, uncivilized natives or those responsible for seditious rebellion.

206 *Ibid.*

207 M. Montani, above note 14.

208 Mariano Castillo, "U. N. Rep Accuses Saudi-Led Coalition of Violating International Law, *CNN*, 12 May 2015, available at: https://edition.cnn.com/2015/05/09/asia/saudi-airstrikes-yemen; Samuel Oakford, "Exclusive: Saudi Arabia Admits Bombing MSF Hospital in Yemen – But Faults MSF", *Vice*, 27 October 2015, available at: https://news.vice.com/en_us/article/kz9zxy/exclusive-saudi-arabia-admits-bombing-msf-hospital-in-yemen-but-faults-msf.

209 Kareem Shaheen and Ian Black, "Airstrike on MSF-Backed Aleppo Hospital Kills Patients and Doctors", *The Guardian*, 28 April 2016, available at: www.theguardian.com/world/2016/apr/28/deadly-airstrike-on-hospital-aleppo-syria-reports-say.

Countering narratives of inevitability

Returning to the case studies, and moving beyond tactical parallels, there are some additional points that bear repeating, none more obvious than the unforgiving reality of "military necessity". A harsh view of the evolution of the Geneva Conventions would have this consistently positioned as the "dominant value of the laws of war".[210] In all the cases reviewed, and irrespective of the rationale or cover employed, humanitarian principles were ultimately jettisoned when they potentially hindered the attainment of a military objective.

In terms of discourse itself, the use of propaganda to dehumanize an enemy is hardly a revelation. An intriguing aspect of the presented case studies, however, is that violations of the Geneva Conventions, whether factual or contrived, were used to justify further violations, namely attacks on hospitals. IHL became a periodically useful addition to the information wars that accompany conflicts. A curious transition could also be seen in the reactions and justifications given by belligerents after hospital attacks. When admissions of responsibility did occur, it was usually in the early stages of hostilities, before positions eventually hardened. At that point, accusations were either dismissed, or attempts were made to justify an attack by pointing to the enemy's own transgressions.

A similar semantic shift was apparent in the narratives that emerged from Red Cross representatives. "Mistaken" or "accidental" bombings became less ambiguous, and the more provocative terms of "deliberate" or "targeted" attacks were used. However, this aspect must also be nuanced with the different attitudes historically displayed by the ICRC depending on whether a conflict was fought between European nations or not. Perpetrator discourse cannot be entirely separated from the political and cultural context. The relative complacency demonstrated by the ICRC towards Italian justifications of attacks in Ethiopia, or scepticism over Japanese and Chinese faculties to integrate the principles of the Geneva Conventions, were very much grounded in Western colonial attitudes of the day.

Finally, a coping mechanism emerged in several cases. When the red cross emblem itself was considered a risk or was actually used to facilitate the targeting of a medical structure, it was simply removed.[211] This could be seen with ambulance crews preferring their national flags in the Franco-Prussian War, the British removing Red Cross markings from hospital ships in World War I, or the pragmatic local initiatives in Ethiopia. Even in Biafra there were suggestions of dispensing with the red cross on hospitals given the number of repeated attacks. Ironically, the removal of an emblem was also used on occasion by perpetrators of attacks to reinforce arguments that the enemy was no longer abiding by the Convention, therefore once again justifying their own actions.

210 Amanda Alexander, "A Short History of International Humanitarian Law", *European Journal of International Law*, Vol. 25, No. 1, 2015, pp. 112–113.

211 As described in the case of Nanking, appropriation of the Red Cross name and emblem had no impact. Arguably a contemporary parallel can be found in the recourse to underground hospitals in parts of opposition-held Syria.

If there is a lesson to be learned from this brief survey of perpetrator discourse, it is certainly not that the Geneva Conventions are a dysfunctional relic of the past or have been systematically ignored. An article that focuses on the reaction of those responsible for attacks on medical care has an inevitable bias, highlighting abuses rather than the innumerable times IHL has been respected and lives have been saved. And irrespective of past and ongoing violations, the Geneva Conventions were and remain a very practical tool as operational space is negotiated. For a humanitarian organization like MSF, this includes a normative approach that refers directly to the "principle of the sanctity of medical space", but also a far more pragmatic approach which accepts the "transgression of standards and laws during conflicts as inevitable".[212] Perpetual negotiation and renegotiation in each specific context, including knowledge of domestic law, are the essential counterparts to IHL.[213]

Recognizing that transgressions of the laws of war are inevitable should by no means be interpreted as meek compliance. The cynicism periodically seen in the case studies from those who experienced attacks on medical care often reinforced attempts at improving protection measures, even when the nature of the attacks was directly disputed in the discourse of the perpetrators. This points to additional avenues of research not fully explored in this article, notably the normative and especially pragmatic attempts made to ensure that hospitals could continue to function in conflict zones, or the impact on corresponding negotiation strategies on the part of humanitarian organizations. Frustrations over the impunity of the perpetrators were likewise only touched upon; this issue has long been identified as a fundamental weakness of IHL, and merits closer attention given its resonance today.[214]

The lack of historical perspective when condemning contemporary attacks on medical care is also striking. MSF's recent assertion that "attacks have gone from random and opportunistic to considered and strategic" lacks nuance, and such a statement could be applied to any of the case studies presented in this paper.[215] The same can be said of the suggestion that medical care impartially provided to the enemy "becomes a justification for violence against health personnel".[216] Rather than an erosion of IHL, protection norms have always been contested. Meanwhile, in terms of perpetrator discourse, the tactics used are remarkably consistent. The sharing of GPS coordinates might have partially replaced the red

212 François Delfosse, "Médecins Sans Frontières on Attacks on Hospitals and the Protection of Health Care in Time of Conflict", *Politorbis*, No. 65, January 2018, p. 30.

213 *Ibid.*

214 As noted in the case study of the Franco-Prussian War, the then president of the International Committee was convinced that the belligerent governments must "punish" transgressors of the Geneva Convention. G. Moynier, above note 25, p. 44. The Leipzig war crimes trial after World War I and the Nigerian government's internal investigations in Biafra were also mentioned but were not analysed in detail.

215 MSF, above note 10.

216 Caroline Abu Sa'Da, Françoise Duroch and Bertrand Taithe, "Attacks on Medical Missions: Overview of a Polymorphous Reality: The Case of Médecins Sans Frontières", *International Review of the Red Cross*, Vol. 95, No. 890, 2013, p. 319.

cross emblem as a protective measure, but the concrete risks undertaken are unaltered, as is the rhetoric used after an attack. Denials, mistakes, partial admissions, justifications based on misuse of a structure, or counter-accusations all have historical foundations.

Reflecting in 1984 on the bombardment of four MSF hospitals in Afghanistan by Soviet aircraft between November 1981 and January 1982, the then MSF president suggested that the reason was a combination of the "material support" provided to the population and the fact that "we are inconvenient witnesses".[217] He then went on to assert that attacks on medical care are "a burning issue today".[218] With nearly four decades of hindsight, this "burning issue" clearly predates Soviet Afghanistan, and remains equally relevant for those attempting to respond to conflicts through the provision of impartial and neutral medical assistance today. The targeting of medical structures might still be considered by some to be inherent to hostilities, but this is nonetheless a narrative to be countered, including through a better understanding of the justifications and rationales buried in perpetrator discourse. At the very least, cutting through perpetrator rhetoric can serve as a timely reminder of existing commitments and protections under IHL. The fragile and often infringed neutrality of medical care was and continues to be at stake.

217 Rony Brauman, President, MSF, "Rapport Moral 1983", General Assembly, May 1984 (author's translation).
218 *Ibid.*