Primum Non Nocere:
International Humanitarian Medical Relief in Post-Cold War Conflict

by

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B.A. (Columbia University) 1994

A thesis submitted in partial satisfaction of the
requirements for the degree of

Master of Science

in

Health and Medical Sciences

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA, BERKELEY

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Spring 1998

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Medicine is a social science and politics is medicine on a large scale.

VIRCHOW

INTRODUCTION

We like to think that humankind has grown progressively more civil over its history, but as we near the end of the millennium, war and political violence continue to disrupt the lives of over 50 million people, creating waves of refugees and destroying the fabric of societies around the globe. In the wake of such epidemic human tragedy has emerged a renewed commitment by the international community, in the form of an outpouring of humanitarian assistance efforts, to temper this violence with compassion. The sad legacies of Rwanda, Somalia, Bosnia and other internal conflicts have inspired in the international community a revitalized humanitarian movement, conceived in human rights theory and moral outrage, and dedicated to the provision of emergency assistance to populations in need. Humanitarian intervention is defined by Tesón as "proportionate transboundary help, including forcible help, provided by governments to individuals in another state who are being denied basic human rights and who themselves would be rationally willing to revolt against their repressive government."[1] In an update of this definition it becomes essential to include non-governmental agencies (NGOs), currently some of the most visible actors in the field of humanitarian relief work. Almost a century and a half after the founding of the Red Cross, there are now hundreds of organizations dedicated to such service of populations in crisis. Much of the humanitarian industry's rapid growth has occurred within the climate of geopolitical flux and the virtual meltdown of state sovereignty that characterize the post-Cold War era. In this context, governments, private agencies, and individuals have discovered how easily strategies of humanitarian assistance can be used to circumvent the shortcomings of international law in mitigating the devastating effects of complex emergencies on vulnerable communities. They have also discovered how easily such well-intentioned work can be caught up in the net of the political violence it aims to oppose. Despite the increased awareness and visibility of conflict situations, the massive proliferation of humanitarian actors and agencies, and a breakdown of many of the political

barriers to intervention, humanitarian relief has experienced more setbacks than ever before in its history. With the increasing financial resources and political significance of humanitarian actors in complex international situations, we must begin to ask the difficult questions - what are we really trying to accomplish and are we ultimately doing more harm than good?

This paper aims to examine the interplay of humanitarian relief and the medical profession, with particular attention to the way this relationship is manifest in the different models of humanitarianism which characterize the post-Cold War era. Historically, the major ideology-defining events of the modern humanitarian movement since the founding of the Red Cross reveal how much the prevailing models of relief provision have drawn on the professional values and social symbolism of medical practice in building their own ethical framework. Medical treatment, of soldiers and later of civilians, has been a defining feature of wartime relief since its official beginnings in the battlefields of 19th century Europe, and volunteer physicians have been a consistent presence throughout. But beyond just the obvious technical contributions of the medical profession, humanitarian relief has also incorporated basic elements of medical ideology into its operational ethos. One might even draw an analogy between the doctor patient relationship and the donor beneficiary relationship; both are similarly fraught with good intentions, unbalanced power dynamics, and deep often overlooked social and political significance.

Without question, the environment of post-Cold War conflict has made the task of bringing relief a difficult one. Organizations are facing the dilemma of how to respond to the multiple needs of populations devastated by the often compounded effects of famine, political instability, economic scarcity, and war. The challenges of the last half century's conflicts have exposed the limitations of a medical model of relief provision, grounded in a tradition of meeting immediate material health needs within a strictly western moral framework. Many relief organizations have answered this challenge with a comprehensive approach to health needs that incorporates a more socially and politically aggressive

agenda. Rebelling against a medical tradition which defines their roles as professionals but limits their reach as relief providers. These new demands pose a unique dilemma for medical groups, which are finding it increasingly difficult to define their principles and understand their most effective roles in the new humanitarian world order.

HISTORY

HENRI DUNANT AND THE ICRC

Many traditions of humanitarian service long predate the founding of the Red Cross. Early Christianity emphasized the religious virtue of charity, and as early as the 5th century, hospitals developed to fulfill the Christian obligation of caring for the poor and the sick. By the 9th century, this duty was adopted by religious orders such as the Benedictine monks, the Hospitallers, the Order of St. John, and the Teutonic knights, who pursued this mission during the Crusades.[2] The origin of humanitarian missions abroad can be traced to the Protestant medical missionaries of the 17th and 18th centuries. The physicians' work on these missions was inextricably tied to the primary aim of spreading the Christian message, and doctors usually served the auxiliary function of ensuring the health of the preachers and their families and attracting a daily audience of listeners.[3]

The modern humanitarian movement has its roots in the battlefield of Solferino; its history reveals how the unique skills and ideology of medical practitioners helped to inspire a new paradigm of humanitarianism in wartime. Inspired by the horrors he witnessed in Italy, Henri Dunant wrote a compelling memoir which called for the creation of an international society to mitigate the atrocities of war. He insisted that "the deep and pain-filled shock of Solferino must be transmitted in this brief account, which would truthfully record what my own eyes had seen. Others must share it so that the humanitarian idea, which was filling me with enthusiasm, might bear fruit and develop of its own strength."[4] Dunant's original humanitarian idea was motivated by his observation of the unmet medical needs of soldiers wounded in battle. He spread his message in letters which appealed to the consciences of individuals in power, describing the scenes he had witnessed and the lack of medical caretakers in the field. In one letter to the Comtesse of Gasparin Dunant wrote, "We have 40,000 wounded, Austrians and Allies, from this dreadful event. There are not

enough doctors and I have to supplement them, for better or worse, with a few peasant women and prisoners."[5] In another letter to General de Beaufort, he described

> Never shall I be able to forget the eyes of these victims who wished to kiss my hand. It was shocking. The poor French soldier, so brave in danger, so patient in suffering, and so grateful for a glass of water!
>
> The appearance of the battlefield is nothing compared with the despair of the poor wretches who lay in heaps one, two, even three days without care, without help, believing themselves abandoned . . . The doctors have done what they could. But there are not enough of them . . . [6]

By capturing in words the suffering of the soldiers, Dunant tried to convey the necessity of his newfound purpose, the creation of a society of aid providers which would later grow to become the paradigm of wartime relief.

Dunant sought the help of military and medical experts in assembling the logistical details for *Souvenir de Solferino.* Dr. Louis Appia, who would later join Dunant in founding the Red Cross, contributed the practical knowledge and experience of a military surgeon to bolster Dunant's humanitarian vision.[7] A commission of five men was convened with modest goals, as "General Dufour stated at the second meeting: 'We must lay out the bounds, then others will come to make a path.'"[8] The newly formed commission conceived of an international code of conduct in battle which ensured the protection of wounded combatants and their caregivers. Their notion transcended the idea of just bringing aid to the victims of war by calling for the recognition of the neutral status of such humanitarian medical activity and its providers. Thus the modern humanitarian movement was born.

The establishment of the International Committee of the Red Cross brought an unprecedented unifying ideology to humanitarianism which rested on the revolutionary concept that essential humanity superseded the interests and objectives of the sovereign state, even in war. The codification of these ideals in the first Geneva Convention of 1864 accorded international legitimacy to the rights and roles of medical relief personnel in combat zones, but to uphold these principles still depended on the mutual compliance of

both relief providers and warring parties. With the growth of the Red Cross and Red Crescent movements, the establishment of the United Nations, and the generation of a series of multinationally endorsed declarations and compacts leading up to the 1949 Geneva Conventions, this idea of mutual respect for neutral humanitarian space came to define the very essence of humanitarian aid.

The moral positioning of the Red Cross is reminiscent of the ethical framework which circumscribes western medical practice. One historian in documenting the early activity of the Red Cross observed this parallel and suggested

> The attitude of the Red Cross can be compared only with the position of a doctor who is obliged to care for the needs of a patient without inquiring as to his moral worth. He may have ideas about the value or lack of value of any given lief, but his profession enjoins undiscriminating aid. To the physician, as perhaps to other individuals, life in itself, its pure animal force, is sacred in every form, whether it be in a criminal condemned to die or in a genius. His unique enemy is anything which threatens the life with which he is entrusted. When he gives up this elementary principle of his professional existence - as happens very often today - he has given up himself.
>
> Totalitarian states require the physician to subordinate his profession to national needs: he must appraise the patient according to his value to the community. Thus he is compelled to choose between the hubris of a godlike function or the shame of lowering himself to the level of a politician. Between doctor and patient there can never be any court of appeal. Nor can a non-partisan organization, whose purpose is to aid the wounded in battle, conceive its mission in any other way.[9]

The guiding philosophical principles of the Red Cross came to define the essence of the modern humanitarian movement, but they are in fact very strongly linked to their historical context. Dunant's vision of humanitarianism grew from his own observations of the needs of civilians and wounded personnel in battle and responded to the particular atrocities of nineteenth century conflict. That vision made sense in a scenario where intermittent periods of combat and quiescence enabled volunteers to tend the wounded with relative security, where 'prisoners of war' were individual soldiers rather than entire communities of refugees, and where military strategists recognized clearer distinctions

between battlefields and civilian space. Most of all it required wars that were circumscribed by recognized covenants and rules of engagement, and relied on leaders and combatants who adhered to those rules. Despite these limitations, this model of humanitarianism remained a successful means of getting internationally sanctioned assistance to war victims throughout much of the 20th century.

The founding of the International Committee of the Red Cross in the late 1850's was a milestone in the history of humanitarian aid. What began as an outgrowth of a Swiss nationalist effort to assist the victims of the Italian war for succession[10] developed into a broad transnational movement with member societies in countries around the world. The traditional role of the ICRC focused on protection and assistance, and it became "the guardian of the conventions - in peacetime, educating government and the public about these humanitarian rules of warfare and, in wartime, carrying out activities on both sides of a conflict to ensure their observance."[11] Being the guarantor of the Geneva Conventions brought international legitimacy to the work of the ICRC, but this meant maneuvering within the strict limits of international law, which delimited its efficacy as a relief agency. The actions of the ICRC and its strict legalism became the impelling force which in the late sixties spurred a group of young French doctors to establish a new humanitarian organization that challenged the traditional precepts of humanitarian relief.

MSF and the French Doctors' Movement

The new conflicts of the twentieth century tested the limits of Red Cross model humanitarianism, finally provoking some practitioners to break way from the dominant relief paradigm. As far back as World War II, situations arose in which the ideological stakes were so high that it became an affront to the sensibilities of some not to take sides. These changes brought the once absolute precepts of strict impartiality and neutrality into question. The French Doctors' movement of the late 1960's represented the first

institutionalized break from the traditional humanitarian assistance model of the ICRC. In response to the perceived inadequacies of the Red Cross in dealing with the Nigerian civil war, a group of French physicians led by Bernard Kouchner founded Médecins Sans Frontières to come literally to the rescue when international humanitarian law fell short of meeting the medical needs of vulnerable populations.

The French doctors movement represented a protest against the ICRC's excessive respect for government sovereignty and policy of discretion in the face of human rights violations.[12] Joelle Tanguy, executive director of MSF-USA explained that "Doctors Without Borders was created because of the Red Cross, or because of the limitations of the Red Cross" in the Nigerian civil war. While working in Biafra for the ICRC, Kouchner and other French medical volunteers "were so repelled by the atrocities against civilians that they violated their contract with the Red Cross and spoke out publicly. Looking back at the events of Biafra has led some to question the 'truth' of identifying the Nigerian Civil war as a genocide. But at that time, having witnessed the bombing of hospitals and been the target of threats from Nigerian soldiers, the French doctors felt compelled to call world attention to the suffering of the Biafrans and to denounce the brutality of the oppressors.

Also contributing to the new revolutionary spirit of the French doctors in Biafra was a changing state of affairs in France. In 1968, young student radicals challenged traditional political, social, and ethical ideals, and set out to define new more socially conscious objectives. Though the leaders of the movement are quick to deny it,[13] at least part of the impetus to protest the status quo stemmed from the guilt that accompanied French decolonization, an "anti-colonial backlash dating from the French wars in Algeria and Indochina."[14] Another motivation was the still painful memory of unmitigated historical atrocities. Kouchner recalls, "I came to care for the people in Biafra because I hadn't been able to do so in Guernica, at Auschwitz, at Babi Yar, at Oradour-sur-Glane, or at Setif in Algeria. What we came to do in Biafra was to exorcise the nightmare of all those accumulated butcheries perpetuated by the human race, which had not been interfered with

at the time of crying need."[15] This new ideology of social responsibility provided the foundation for the ideals that would become the defining principles of the French doctors movement.

Resulting from the combined influences of the growing radical tradition in France and the horrors they had witnessed in Biafra, Médecins Sans Frontières (MSF) was created on December 21, 1971. Joelle Tanguy said, "Basically we had the same intentions as the Red Cross, and we just took that charter and it was modified on a cafe table in one evening in Paris. We just struck a few words, changed it for ourselves and said, 'We believe in that charter, but we think they're wrong in interpreting it this way, and we're willing to treat neutrality in a more active way.'" The new charter outlined the role that the founding physicians envisioned for the future of medical relief:

> Médecins Sans Frontières offers assistance to populations in distress, to victims of natural or man-made disasters, to victims of armed conflict, without discrimination, irrespective of race, religion, creed or political affiliation.
>
> MSF observes strict neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance, and demands full and unhindered freedom in the exercise of its functions. MSF members undertake to respect their professional code of ethics and to observe complete independence from all political, economic or religious powers.
>
> As volunteers, members are aware of the risks and dangers of the missions they undertake and have no right to compensation for themselves or their beneficiaries other than that which MSF is able to afford them.[16]

The first priority of the new organization was to be able to mobilize quickly to answer the call of suffering from wherever populations cried out for help. Though criticized at first as "crazy leftist Boy Scouts,"[17] they clung to the founding principles that had inspired them initially, holding fast to the belief that "in the name of indignation and solidarity, there must arise a new right of assistance to people in danger, founded on the morality of extreme need."[18] During these early years MSF doctors achieved a measure of success, adhering

closely to their primary goal of delivering aid to populations in crisis but receiving very little attention from the international community.

By the end of the 1970's MSF had become divided between two factions with diverging ideas on the evolving role of the growing organization. Kouchner and his followers insisted that "MSF should remain a light and mobile body, non-bureaucratic and keep to specific, newsworthy missions."[19] Their minority felt that traditional relief operations fell within the domain of other organizations, such as the Red Cross and UNHCR, who were better able to handle the large-scale operations. Kouchner's opposition, the majority, questioned the effectiveness of his testimony missions and criticized his desire for public attention. The divisive incident was Kouchner's controversial plan to launch a ship, *Ile de Lumière*, to rescue Vietnamese refugees at sea. Kouchner lauded the project as an act of bearing witness, but his critics claimed it was just another example of his egocentricity and denounced it as a publicity stunt.[20] As a result of the conflicting goals within the organization, in 1979-80 two offshoot groups were created, Médecins du Monde (MDM) and Aide Médicale International (AMI).

The French Doctors' "without borders" philosophy took particular exception to the Geneva Convention statute: "The employment of medical personnel of the aid societies not party to a conflict requires the consent of the government of that state and the authorization of the party to the conflict for which the personnel shall be employed."[21] A unique vision which addressed human rights issues as part of a broadened medical agenda distinguished these organizations from traditional humanitarian actors, and their early involvement in the controversial theatre of international politics brought the French Doctors to international attention.

As part of their redefinition of humanitarian philosophy they eschewed strict conventional neutrality in favor of a novel human rights based approach which emphasized impartiality, bearing witness and the duty to intervene. The success and media popularity of MSF and other 'rebel' aid agencies began to chip away at the century old notion that

humanitarianism itself was defined by rigid confines of Red Cross protocol as outlined in the Geneva Conventions.

CONTEXT

The fall of communism, the demise of the Soviet Union, the reunification of Germany and all the other attendant political metamorphoses of the last decade have vastly altered the geopolitical climate. Much has been written by journalists and scholars of international affairs defining this 'Post Cold-War era' of humanitarian assistance, however, there has been little discussion about its impact on international perspectives on humanitarianism; these developments have posed profound logistical and ideological challenges to existing relief paradigms. The defining feature of the Post Cold-War era is the dissolution of the outmoded but comfortable dichotomy of antagonistic superpowers. We can no longer count on the identifiable nation teams of the first World War, the unifying global fascist threat of the second, or the clear 'U.S.' versus 'Them' ideology of the Cold War era. Rony Brauman of MSF-France explained how this dichotomy fueled the humanitarian industry, saying, "MSF was born, was created and unfolded during the East-West confrontation. So human rights, humanitarianism, democracy were on one side. Oppression, totalitarianism, violence on the other side. So there was an obvious linkage between, you know, human rights, humanitarianism, and the - this is the past. This is the past." Another factor which contributes to the complexity of humanitarian assistance is that modern wars are rarely between two powers or between an established authority and insurgents, but competing groups in the absence of any single governmental authority. With no centralized authority, there is no one to be a party to the host country side of the humanitarian covenants. Contemporary conflict lacks the structured, almost 'gentlemanly' conduct of many earlier wars, and therefore doesn't lend itself to the 'playing by the rules' approach which Dunant's idealistic vision of humanitarianism depended upon for its success.

The sociological and political changes in the humanitarian arena have also contributed to a new political significance for wartime relief, placing an even greater strain on the neutral ideology of its mandate. Historically, humanitarian aid has always been

political in the sense that its very existence implies a certain condemnation of the activities of war. Despite meticulous attention to the maintenance of neutrality and impartiality, inevitably even the most sincere acts of good faith may be construed by one group or another as political favoritism. Nevertheless, conventional humanitarianism maintained a certain elemental, albeit 'more in theory than in practice', distance from political affairs. This illusion of perfect neutrality was in many ways made possible by the permissive environment of the Cold War, in which any margin of political ideology could be obscured in the deluge of anti-Communist rhetoric. Even today, an unveiled pro-capitalist bias remains firmly entrenched in USAID donor policy. Without the backdrop of the Cold War to justify their ideological leanings and democratic bias, some humanitarian aid agencies are finding it more difficult to assert their neutrality in the volatile political situations they have faced since the end of the Cold War.

The impotence of international peace- and policymakers in dealing with the intractable violence of complex emergencies has also contributed to the increased political significance of humanitarian actors. In regions where international leaders and UN officials have otherwise exercised no definitive foreign policy, the Red Cross or other NGOs may be construed as political representatives rather than neutral, apolitical relief agencies, especially when accompanied by UN or military protection. Many international leaders and NGO representatives alike have seized upon the notion of 'humanitarian diplomacy' - specifically using the relief system as a tool for political intervention. On the one hand, making use of neutral humanitarian space to achieve peacemaking goals allows intervention where it might not otherwise be possible for political reasons, providing a much needed secure forum for conflict resolution. On the other hand, it is the grossest abuse of the privileges of humanitarian neutrality to bring that protected space into the conflict, even as a tool for resolution. Adding a political agenda to a humanitarian assistance mission completely undermines the protective field of neutrality which international humanitarian law was designed to allow. Still, this has become so common a tactic that there is now the

less politically loaded designation of 'humanitarian intervention' which implies a rights based impartial, rather than neutral mandate of relief and is utilized by UN agencies as well as independent NGOs.

Attention is now focused on humanitarian assistance as the object of international legal discourse. Having grown from a political tradition of respect for state sovereignty, the powers of the UN and its member states and the activities of the ICRC are delimited by the constraints of the Geneva Conventions and the Universal Declaration, neither of which provides a sufficient framework for dealing with the internal crises the international community now faces. Recognizing these inadequacies, some are beginning to struggle with the task of bringing international humanitarian law up to date with the massive shifts in global mores and attitudes toward intervention since the end of World War II. Others, fearful of the potential loss of such humane international legislation altogether, are focusing on the renewed relevance and applicability of the Conventions and are calling for increased support from international community in enforcing them.

Outside the policy arena, the surge in media coverage of international events has also brought humanitarian assistance to the forefront of global attention as a media spectacle. Satellite coverage and other technological advances in communications, have thrust the actions of international aid agencies into the limelight, placing their every move under close public scrutiny. Many of the 'new' issues they face in the post-Cold war era are not so much new as they are newly publicized. Covert and strategic slips of neutrality in the name of pragmatism which may have been marginally tolerated are now broadcast around the globe on CNN. The humanitarian community is being called on to define its mandate and defend its choices before an international audience. With so many organizations acting all over the world, the publicity issue raises concerns of competition among agencies for press and funds; public relations have become as essential a part of many organizations' work as assistance projects overseas.

Aside from the already demanding task of providing aid and supplies to vulnerable populations, humanitarian agencies are now being faced with the additional challenge of adapting their guiding principles to suit the changing landscape of international affairs and humanitarian emergencies. This change comes both from within the humanitarian community and from the intensified global attention of both international leaders and the public. In this context, many in the humanitarian community have revisited the guiding principles of humanitarianism. This is an uneasy exercise, both because of the moral and practical dilemmas involved and because of the lack of any established paradigm to take the place the traditional humanitarian ideals at stake.

Understanding the new environment of post-Cold War conflict, we can begin to consider the evolution of humanitarian medical relief in its contemporary context. The following section looks at the themes which emerged in interviews with humanitarian professionals from Médecins Sans Frontières-France (MSF-France), Médecins Sans Frontières/Doctors Without Borders-USA (MSF-USA), Médecins du Monde-France (MDM-France), Doctors of the World-USA (DOW-USA), and the International Committee of the Red Cross in Geneva (ICRC). I conducted the interviews in New York, Paris and Geneva in January of 1998. They point to some of the most pressing concerns in the provision of medical relief today and also illustrate the pervasive influence of medical ideology on contemporary paradigms of humanitarianism.

Access

Secure access to civilian populations within and at the periphery of conflict zones was identified in interviews as one of the biggest obstacles to the delivery of medical relief. According to the Geneva Conventions, the care and treatment of civilians in internal conflict can only be undertaken under the auspices of the government in power. This defines the position of the ICRC. Hernan Reyes, MD of the ICRC explained

> Well, in a way - well, in a way working with the, through the government, in the sense that, you know, we don't barge in, we sort of ask for permission . . . And obviously, you know, some countries may let us in because they just want to use the political - they'll say, "We let the ICRC in." If they want to do that, that's fine, as long as they let us work. We don't mind.

As the guardian of the Geneva Conventions, the ICRC continues to uphold this respect for sovereignty in its negotiations for access to populations, relying on the 'right of initiative' in dealing with government authorities. Dr. Reyes explained the difference between the ICRC position and that of many other NGOs saying, "We ask permission, and if we're told no, it's no . . .they don't ask permission, and they can either be caught getting in in a clandestine way, or they can try to get in without making a big fuss, and it may be tolerated."

Other organizations, like MSF as described earlier, have tried to circumvent state sovereignty and find alternative justifications for their relief activities outside the limits of international humanitarian law. The French doctors relied on principles of medical ethics and human rights theory to support their unauthorized interventions. Their early ideology established the concept of the physician's 'duty to intervene' to validate their relief and advocacy work, as this principle embodied the moral imperative of the physician. Relevant to its meaning in the context of both medicine and humanitarian relief, a moral 'imperative' can be understood either as having the *obligation* or as having the *power or authority* to act in accordance with specific values or principles.[22] The shift from the medical ethics based concept of the 'duty to intervene' to the politically based concept of 'right to intervene' reflected an active interpretation of the physician's imperative. Claudie Durand* of MDM explained the concept of "what we call the *droit d' ingérence* which was the right to interfere in a country, which goes against the principle of sovereignty of states. This is what founded our action. We would say, 'We commit ourselves, and we interfere in, with

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* The opinions expressed by Ms. Durand are her own and do not necessarily reflect the position of Médecins du Monde-France

your sovereignty because . . . we care about the population, the civil population who are suffering from the war.'" In this way, the politically pragmatic concept of the 'right to intervene' still draws its validation from the medical ethic to attend to the needs of suffering wherever it happens because that is the mandate of the physician, as a way to justify access with the ideology.

One problem with the concept of the 'right to intervene' is its focus on the rights of agencies over the rights of individuals. Derek Wong, executive director of DOW-USA, said, "a theme that's surfacing is the notion of getting access to victims, you know, rather than providing or safeguarding human rights." The subtle semantic change from the *duty to intervene* to the *right to intervene* reflected a dramatic conceptual shift from the sovereignty of the political state to the sovereignty of the humanitarian agency. In a critique of Operation Lifeline Sudan, Alex de Waal of African Rights suggests that humanitarian access "should assert the right of vulnerable people to have access to international relief, even though this might involve violation of state sovereignty. In practice, it seems to refer to the right of international relief organizations to be operational in a region where there are people they recognize as needy."[23] Even though the organizations who use it do so for the benefit of the populations they serve, this incarnation of the moral imperative reflects a unconscious movement from population to agency in which organizational interests, albeit interests motivated by a desire to help the populations, are seen as proxy for those of the population. Rony Brauman of MSF-France explained the hypocrisy of this position:

> More than anything, I see the kind of self-righteous speeches coming from the NGOs, but nothing else. So, no, there is no set of principles, no guidance in general, except the interests of the NGO, which are confused with the interests of the people who are going to help. And this kind of presentation of the NGOs as a kind of a trade union of the victims or the representative of the victims is a lie, is a dream or a lie. If you're indulgent, it's a dream; if you're more critical, it's a lie.

Another more practical problem is that despite its ethical basis and good intention, the 'right to intervene' has neither a legal basis nor a means of enforcement. As a means of

getting access to populations without bowing to government permission, the French Doctors 'right to intervene' was at first very successful. Pierre Laurent of MDM-France explained, "You have to say nobody is respecting the Geneva Convention, so we have to find another way. And the idea was not to find, to create a new law, but it was to create a new dynamic. And for that it [the right to intervene] was a success. Even if ten years after we have to say, we have to redo the same thing . . . the solution is not there." So despite its initial utility, the 'right to intervene' is not the all-access passport many humanitarians hoped it would become. Claudie Durand of MDM-France discussed the limitations of the right to intervene

> We thought that with this concept we would be able to go anywhere and impose the kind of, if not the right, at least a philosophy to intervene. And what we are acknowledging now is that it just didn't happen, in the sense that you do not get in a country if this country doesn't want you to get in. And we are faced with problems of access to population. . . . So all the lawyers and, of course, the countries in the south said, but this right does not exist conceptually. Legally it does not exist. And it's maybe in some cases an exception to the rule, but it's surely not a right as such. So you cannot argue and use this argument to get in the countries the way you want to access.

Many agencies have discovered that simply declaring your authority does not make it so, especially when international law states otherwise.

In some cases, getting access can be essentially just symbolic, more about the physical presence of outsiders than relief provision. Hernan Reyes of ICRC criticized one NGO for this, saying "ten years ago in Afghanistan, well, OK, they had one little team of three people. So what difference does it make? Nothing. . . . Totally symbolic." Pierre Laurent of MDM admitted that even with their increasing resources, NGO presence remains primarily symbolic

> It's not only a political position. I mean it's not only to say, "OK, we can't stay without world facing humanitarian violations or human rights violations." It's not only that. It's to say, OK, we have to be really realistic. Our action is more or less symbolic. Even if we have million dollars in some areas our action is symbolic. Our capacity to do, to help and to care.

Symbolically then, the impact of the concept of the right to intervene on the field of humanitarian medical relief has less to do with the all-important means of access than it does with Dunant's original emotional appeal to the moral conscience of humankind. Though it may have failed politically as a guarantor of access, ideologically the French doctors expression of the right to intervene did succeed in reawakening the belief that individual people could unite to take action in response to suffering, even on the other side of the globe. Pierre Laurent of MDM-France said, "We have had the conviction that maybe the only one thing that the French doctor, in that the French doctor succeeded was that today, today a humanitarian crisis was not acceptable for the international community." This has been an especially motivating factor among doctors, who embrace it as a surrogate for what they had hoped medicine would supply. Derek Wong of DOW-USA said that when physicians want to volunteer, "What we hear from them when they call us up is that many of them are frustrated with HMO's. . . . And they say, 'I'm no longer a doctor. What I was trained to do in medical school is not what I'm doing now, and so I really want to help in any way that I can, so I want to join your organization.'"

Manipulation

Access to the vulnerable population is essential to any relief operation, but when agencies prioritize access, they can sometimes be so singularly focused on 'getting in' that they overlook the potentially adverse consequences of their actions. Medical relief professionals are aware of this danger; the fear of and frustration at the manipulation of aid by warring parties was a recurrent theme in interviews. International humanitarian law was created to separate neutral humanitarian space from military space and thereby prevent the incorporation of relief into political violence. In many of the internal conflicts of the post cold war period this division has been impossible to make. De Waal detailed how this manipulation of relief occurred in Sudan

> Since the resumption of the war in late 1989, OLS has had few successes, and is generally recognized to have caused som serious problems for the people of Sudan. Rather than being integrated into a dynamic of peace, it has become part of the cycle of war . . . Unknown quantities of relief are diverted to the military on both sides. War strategies have come to revolve around relief. Juba would almost certainly have fallen in the late 1980s or early 1990s without relief flights; more recently relief has provided a major strategic boost to the SPLA. Aid prevents both sides from being forced to be accountable to their constituents. In short, relief is prolonging the war, by constraining the military strategies of each side, and contributing to a stalemate.[24]

When medical relief is abused and manipulated, agencies must face the limitations of their good intentions and the difficult ethical dilemma of whether their work does more good than harm. In many situations described in interviews, the manipulation of relief can be linked to two of the issues raised by post cold war conflict the need to negotiate for access and the political naiveté of humanitarian workers and agencies.

In many cases, it is the process of negotiating access which enables relief to be so easily manipulated by parties to the conflict. The ICRC is bound by the Geneva Conventions to seek the approval of government authority for any relief activities it undertakes, and so it by definition must negotiate for access. But even with the touted 'right to intervene', in reality, the necessity of dealing with government or military authorities in securing access is practically universal in a complex emergency situation. Negotiated access is often what gets agencies into trouble because it can align them with oppressive regimes or force them to make deals they do not fully understand the consequences of, thus setting up the opportunity for relief to be integrated into the violence. Mike Toole of MSF-Australia wrote that "establishing a relief programme in a conflict zone often places the agency in a position of moral compromise; to operate in that area may require payments to local militia for protection . . . In the Rwandan refugee camps in Zaire, efforts to ensure the equitable distribution of relief supplies were thwarted by political and military leaders in the camps, many of whom had been directly involved in the genocide in Rwanda."[25] Manipulation of relief and its being integrated into the fabric of political

violence is one of the biggest ethical concerns of medical relief professionals. Much of the manipulation of humanitarian aid occurs unbeknownst to the agencies which are its objects, or they find out only when it is too late. But in some cases, agencies knowingly tolerate the manipulation and abuse of relief as the only means of getting some fraction of aid to endangered groups. Mike Toole described how "relief workers seeking to maintain their services may have to turn a blind eye to blatant corruption, theft of relief supplies, and flagrant human rights abuses."[26] Hernan Reyes of the ICRC criticized the work of another NGO saying

> They were at the mercy of the local Muhajadin commanders, who milked them through the nose to get, you know, because, "You want to work here, fine. But you bring us medicine, bring us this, bring us that," even though medically it wasn't necessary. But, you know, they wanted so much to be there that they were working in the town . . . one of the doctors told, you know, we were - what we were doing (a) wasn't very useful, and wasn't really very ethical, but it was a way of staying there.

Relief agencies are also manipulated by national governments who want to portray a better image to the international community. NGOs are often the unwilling participants in this charade because of their political naiveté, and as Claudie Durand of MDM-France explained, because the problem of securing access can be tied to this kind of political agenda:

> More and more we access to population if we serve a strategic or geopolitical interest of a country. Zaire--United States last year, we just didn't get access, have access to the population. And when we were able to get in, it was because they had cleaned up everything, and that we were able to get in because we wouldn't have been able to see and bear witness of massacres and things like this.

This reflects not only the way in which negotiated access can lead to abuse of humanitarian assistance, but also how politically naive many NGOs can be in the complicated dealings of complex emergencies. In explaining how easily such good intentions can be abused, Rony

Brauman of MSF-France recast the entire history of the French Doctors movement in light of this realization:

> It was a cheat, it was a lie what happened in - you know, the idea of the, let's say, the founding fathers of MSF was that the Red Cross had kept silent in the concentration camps during World War II and that, once again, relief workers were finding themselves in a genocidal situation, and that this time they wouldn't renew the mistakes of the old Red Cross in the Nazi camps, and they would speak out and denounce. The problem is that that was propaganda. There was no genocide in Biafra. There was absolutely nothing like a genocide in Biafra. And there was a war, which is dirty, which is cruel, which is bloody, but which was not a genocide. That's what a war is. Anyway, anyway, there was no genocide. This genocide was a theme of propaganda launched the Biafra leadership explicitly . . . And the French doctors who were working with the Red Cross in Biafra bought this, without any kind of criticism. They bought the whole thing. So, you know, when you base your philosophy of action on a propaganda lie, you find yourself in a real problem.

In the very worst of cases of manipulation, the humanitarian groups and their operations are themselves the unknowing pawns of military strategy, even being used as bait in a perversion of the very essence of relief which in which it becomes actively integrated into the political violence. Joelle Tanguy of MSF-USA related this horrifying example

> the local authority in eastern Zaire, the Rebel Alliance, said to us that they would not let us go through check points unless we had a, what they called a facilitator with us. That was only to insure that we were always in good security and if we encountered any kind of trouble, that there would be somebody there to protect us, and to negotiate for us and so on. We said, 'Well I guess we have to.' And then we ended up falling into a pattern whereby we would go with a facilitator to what was a supposed area where there were refugees in trouble. We would identify that there were refugees in the region, do the whole exploratory mission in one day, say we were coming back the next day, load all the trucks, get to the check point the next day, and find out we can't go through. And a week later we would go back through, they would allow us to go back, and we would find out that there had been a massacre the day after we had gone there. Basically, we were used by the military as the - in fact, the facilitator was a military servant - we were used to find the refugees, to spot them, so then afterwards they

> would massacre them. The fact that it was an Médecins Sans Frontières car that was going around the region talking about, 'Yes, we're coming tomorrow,' pulled all the refugees out of the forest, created a rumor that said we can get help tomorrow, and then they call came to the road, and they all got massacred. Now we are encountering gravesites in that region. How can you actually ever, ever, ever accept that . . ?

The manipulation of relief and the perversion of such good intentions has forced the international humanitarian community to reexamine its actions in complicated political situations, and pay new heed to the potential political implications of their efforts to help populations in need. From this realization has grown a political consciousness among relief providers, which had led to new considerations regarding the most appropriate role for medical relief agencies, particularly the French doctors groups, to take in order to address their mandates in the most efficient and morally sound way.

ROLE

The increased political significance of humanitarian relief operations in international conflicts has opened up many new avenues of intervention for medical relief organizations to address the health needs of the populations they serve. With this new freedom, however, the ethical dilemma of potentially doing more harm than good has led agencies to question what is the most appropriate role for these organizations to take in the complex political arena of post-Cold War conflict. In his paper *Humanitarianism Unbound* Alex de Waal described several potential roles of humanitarian agencies

> In political emergencies of the 1990s . . . the "enlarged mandate" of operational NGOs includes:
>
> - Primary or even exclusive responsibility for the delivery of services such as relief or health care
> - Human rights
> - Conflict resolution
> - Publicity, lobby and advocacy on all of the above, and on international response to emergencies.[27]

The traditional role of medical relief centers on addressing acute health needs, as seen in both the history of relief in war and in international legal guidelines for its provision as delimited by medical neutrality. This is a traditional medical viewpoint which focuses on immediate bodily concerns over other potential effectors of health status. One medical sociologist explained this with an historical reference to the professional influence of the germ theory of disease causation, saying that "the medical model is not concerned primarily with questions of prevention since it approaches the problem of disease through the experience of germ theory which involves a highly interventionist and specific form of medical practice."[28] Some physician groups, however, have taken their mandate far beyond the limits of what is traditionally construed as medical responsibility.

The French Doctors movement brought the concept of 'bearing witness' to the field of medical relief, as part of a novel human rights agenda which viewed the physician's

obligation to relieve suffering in a broader social context. The importance of "bearing witness" was one of the guiding principles of the French doctors movement. It began with Biafra when Kouchner and the other ICRC volunteers "decided to break the oath of confidentiality they had signed with the Red Cross and to report what they saw. As healers, they argued, they had the duty to alert the world to the agony they witnessed, and to condemn the oppression causing it."[29] Joelle Tanguy of MSF-USA explained

> they were under an oath of nondisclosure and therefore not allowed to basically use the last instrument, and a much more powerful one than their stethoscope and their medical capacity, which was international public opinion. And it was perceived at the time that arriving late and not being able to stir up public opinion worldwide to force the belligerents to act differently was basically giving themselves no chance to help those populations. And you could not feel satisfied with simply having practiced medicine. That would not be acceptable.

The avenues for speaking out vary, but the ultimate goal of bearing witness is to draw the attention of the international community to gross violations of human rights, and in doing do assert a moral pressure on the perpetrators.[30]

The debate surrounding the French doctors' commitment to bearing witness arises from the question of whether or not international social and political issues, such as human rights, fall within the legitimate domain of medical concern. Though some of the ethical traditions can be extrapolated to apply loosely to the broader international scope of political activism, they lack an authoritative commentary on a physician's obligations or lack thereof to actively address these issues on a global scale, and make no reference of any kind to bearing witness. The earliest reference to the doctor's responsibility for upholding human rights comes from the fundamental medical ethic to "do no harm." This credo prohibits a physician from committing acts contrary to the interest of the patient. Extending this idea to apply in the area of human rights, the ethic condemns physician participation in any activity that violates the rights of the individual. Outside of his duty to abstain from committing human rights violations, "do no harm" makes no demands on physicians to actively speak

out against the misconduct of others. Similarly, the "Principles of Medical Ethics relevant to the role of health personnel, particularly physicians" adopted by the UN General Assembly in 1982 state

> It is a gross contravention of medical ethics, as well as an offense under applicable international instruments, for health personnel, in particular physicians, to engage actively or passively in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.[31]

The important phrase in this article is the one which condemns physician participation in abuses either "actively or passively." That a doctor must not perform acts of torture has been well established by the medical community, even if this ideal is as yet unrealized. What it means to passively participate is unclear. The most conservative interpretation suggests a situation similar to a case which took place in South Africa during apartheid, that of Dr. Benjamin Tucker in his assessment of the injured activist Stephen Biko. Dr. Tucker's failure to give an honest assessment of Biko's medical condition and prevent his being transported to another facility, leading to his subsequent death, can be viewed as indirect participation in the abuse of the activist. Passive participation may also be construed more broadly as protecting the perpetrator of a human rights violation by keeping such abuses secret. This understanding of silence as "passive participation" underlies the principle of bearing witness.

The French doctors groups historical commitment to human rights relies on the assumption that bringing abuses to the attention of the international community will shame perpetrating governments into desisting. Some suggest that appealing to public opinion gives a false sense of accomplishment to relief agencies who forgo non-disclosure. Hernan Reyes of ICRC took this point of view saying, "If they don't want to stop torture, they won't. . . . Even if we publish it, even if we say it out loud, it won't help. The only thing that you have to prove to them, depending on the circumstance, depending on the place,

that torture is not the done thing." In many situations, the simple act of revealing the political wrong causing the problem is not enough.

When speaking out about human rights abuses and social problems fell of the deaf ears of the international community, medical relief took on an even more active political role, with peacekeeping strategies and the lobbying of governments and multilateral agencies such as the UN. This social and political advocacy role has emerged within the new humanitarian environment described earlier that characterizes the post cold war period, in which humanitarian has taken on a much greater political significance than ever before. The demands and benefits of this increased political significance was another theme which emerged in interviews with medical relief providers. Pierre Laurent of MDM-France explained the evolution of this new political role

> There's a conflict change with us from international conflict to internal conflict and now to private conflict, like in Chechnya or in Somalia, for example. And in the same time of this evolution, the humanitarian organization became finally, because of our action and power and representation on the field, became part of the international community. And we are a strong element of all the political strategy in the field. So that means in some case we can be killed, in some case we can be protected because of interest, in some others we can be expelled.

One of the reasons for the increased importance of the humanitarian community in international politics is the growth of the industry and its concomitant increase in visibility and resources. Joelle Tanguy of MSF-USA explained, "Now there are many non-governmental organizations, and that's a great thing. They're much more powerful. They're much more funded. And that's a great thing because the breadth, the scope of humanitarian relief has expanded beyond the very few organizations that used to be. And very many more organizations will be in refugee camps, even in war zones." The impact of this increase in the number of agencies was also mentioned by François Jean of MSF-France, who explained, "If you compare ten years ago and now, ten years ago there was only ICRC and really a handful of NGOs. Now you have hundreds of international organizations, NGOs, not to say about advocacy organizations, rights organizations, who

are present in the very center of conflict situations." The rapid growth of relief agencies and operations has meant an increased representation of the humanitarian ideal in conflict zones, but it has also had some negative consequences, as explained by Rony Brauman of MSF-France

> What has changed is that the international community is getting more and more involved, and the other change is the importance, quantitative importance, of the relief movement. Yes, how it's grown through the '80s. And now you have a real competition for resources and positions. So this has distorted, I think, the philosophy of humanitarian aid.

The increased quantitative presence of relief agencies has paralleled the decrease in international political representation in difficult conflict situations, and the humanitarian community has taken on the responsibility of acting in proxy for disinterested governments and the UN.[32] Joelle Tanguy of MSF-USA explained how the NGOs have been forced to assume much of the diplomatic responsibility of governments, mostly by default

> In the last six years there's been a trend. Government funding increased for humanitarian organizations, and government direct political intervention retreated. It was very clear at the beginning of the Bosnia crisis. It was, of course, very clear when Somalia became visibly a political problem, no longer just a couple of drought problem, in the perception of government. It was clear in many places that you no longer had governments walking into a situation as political actors or security actors. But, instead, they were walking in as humanitarian actors. And, of course, the best example is the Great Lakes region in Africa. And, because of that, that means there are no more political actors. The humanitarian actors are seen as the only representation of the outside.

This increased political significance can be empowering to medical agencies that view their obligations widely, but as yet there is very little understanding of the actual impact of humanitarian groups, often inexperienced with the political realm, having such power. Claudie Durand from MDM -France stressed the need to establish terms for this increased political presence which reflect NGOs increased responsibility in such situations

> this is my opinion as a lawyer. For me it would be the recognition by the political people of the role the NGOs and the civil society plays in the international, on the international scene, which means giving the NGOs a status, which means

> giving them rights and obligations, but having it being part of the decision, and also part of the responsibility, because this is the counterpart you cannot just have more power and not being and sharing the responsibility.

The politicization of medical relief owes much to the cultural shift in medical practice from a physical body only based idea of health to a more comprehensive view which also seeks to identify social and political determinants of health. The field of public health in particular has played a profound role in changing the way the medical community conceptualizes population aspects of health status and disease causation. But even though it takes broader causes into account, relief still maintains a fundamentally 'scientific' bias in that it often uses health statistics, such as birth and mortality rates and other such measures, as the basis even for their social and political activities. Medical sociologist Turner charges that "medicine as a form of social control involves the standardization of illness into phenomena which can be managed by bureaucratic agencies."[33] This appears too true of humanitarian actors as well. Even though their aim is to address the more complex issues which come to bear on the health and well-being of a population, medical NGOs are misguided in believing that such quantitative indices can reflect any of the complexity of social and political factors such as human rights and social justice.

Do physicians bear an added responsibility for addressing the social and political contributors to the health of their patients? Physicians' self-imposed code of medical ethics elicits from society a higher moral standard for medical responsibility. This increased responsibility, the product of both intra-professional and societal expectations, is supported by the idea that because of the unique nature of medical service, "it is intrinsic to the very purposes of medicine that physicians exhibit the greatest sensitivity to any social injustice directly related to their mandate in society."[34] One support for physician involvement in human rights issues comes from the fact that, despite criticisms of medical hubris and paternalism, the medical profession has consistently maintained greater expectations of its members responsibilities to serve. Broadening this ideal of service to an international level

is essential if the medical profession wishes to retain this reputation in a growing global community. Joelle Tanguy of MSF-USA explained the unique position of medical relief in addressing these concerns, "Just like in any agency, for us it's really not just human rights, but it's the larger picture notion of medicine and caring. So it's basically looking at the entire security needs of the person, as opposed to immediate survival, health survival needs." In a world where medical conditions are so strongly intertwined with social issues, doctors must be capable of recognizing the "conditions behind the condition" in order to give their patients the best possible care; similarly, medical relief agencies feel compelled to address the broader social and political elements which underlie the health issues they treat.

Though their professional ethics may impart a certain added social responsibility, medical doctors do not exist in a professional vacuum; physicians too must respond to political situations as individual citizens, according to individual social conscience which layers national, personal, and religious values with professional ones. Pierre Laurent of MDM-France emphasized how the political action of the organization drew from its volunteers as citizens as well as physicians

> We say we are a political organization. For us it is clear. Even if we are a medical organization, that means it's our capacity of doing our specialty. And we are doctors, and we can do things. But, first of all, and that isn't even part of my answer. We are an organization of citizens. And for that, when we are doing something, we are doing a political act. And it was - it's something very clear. I know that it's difficult, for example, for an American organization or even with UK and NGOs to understand, and be so clear with that. But for us it's to say if we are clear with this principle of political action, it's a guarantee not to be manipulated, and we prefer to enter in the complexity of political position.

Many in the humanitarian community are wary of the increased political responsibility of medical relief providers and humanitarian actors in general. Joelle Tanguy of MSF-USA said, "Never a stethoscope has stopped a genocide. It's never food that stopped the famine, if the famine was engineered for political reasons by the active starvation of people. It was never, ever those kind of humanitarian instruments that can prevent a situation. And instead humanitarianism becomes hostage to the whole bargaining

thing and the whole political thing." Alex de Waal, in a critique of Operation Lifeline Sudan, insisted that "humanitarianism cannot solve political problems, it can merely influence the manner in which a political solution is sought."[35] Some humanitarian professions are suspicious of extending this added responsibility too far in such a way that it impedes their primary responsibilities, as Claudie Durand of MDM-France explained how some organizations may say

> "We want the French government, or an international force, to intervene in this country to solve the crisis, and then we will get in." We have - we - we never say something like this. I believe it's not our role to say this. Our role is to ask that international law is applied, is to have access every day if we have, because of the needs of the population and not because - if you want to be extreme, we don't really care if there's a solution, political solution to the crisis. What we care about is the population and how we can access and bring relief to this population.

Another potential consequence of specifically medical relief professionals taking on social and political problems is that relying on a strictly medical agenda independent of political and social processes draws on the growing tendency for parties in power to medicalize social ills. Consider the observation of medical anthropologist Nancy Scheper-Hughes that medical illness is a convenient scapegoat, because "a sick body implicates no one. Such is the special privilege of sickness as a neutral social role...In sickness there is (ideally) no blame, no guilt, no responsibility...Not only the sick person but society and its 'sickening' social relations are gotten of the hook."[36] This is entirely antithetical to the purposes of medicine and it becomes the responsibility of the profession to try to reverse such a blatant corruption of its central role. Confined to narrow definitions of what constitutes medical care, doctors are powerless to deal with such situations appropriately.

The dichotomy between providing direct medical relief and acting via political channels was an often repeated theme in interviews with humanitarian professionals. Pierre Laurent of MDM-France explained, "Today, in what we said, what we explain as the media-cratic world, we have two type of program to help people. The power to do, and the power to speak. And so that means the power to do, we can do, and the power to speak is

to say in some areas we have to use the political - the only way is a political decision." Claudie Durand, also of MDM-France, added

> When we see violations of international law or violations of human rights, our duty is to report this. But this, of course, means how to report it, because if you report it, you might be expelled from the country, and this is probably what's going to happen to you, which means you don't have access. . . so we have this dilemma of should we stay and take care of the population, and is this - in this way, are we more efficient than if we testify and bear witness of what we see and have everybody know and put this kind of pressure as an international community?. . .

Often a discussion of medical relief, especially one which examines the dichotomy of acting quietly or speaking out, degenerates into the simplistic opposition of ICRC model and MSF model relief. It is true that in some countries they have come into conflict with one another and had to jockey for position. But although they have certain key philosophical differences they also have much in common; Joelle Tanguy of MSF described how they are merging closer

> So I think that notion has evolved, and we used to be very confrontational with the Red Cross, which was so secretive and so hush hush that we were seen as the activists versus the neutrality of the Red Cross. I think it is not really true at all anymore. We find ourselves partners of the Red Cross. And even if the Red Cross still sticks to their principle, they have integrated the notion of advocacy. They do it in more diplomatic circles, and we do it in more public circles. We don't have their diplomatic weight, and they cannot afford to be as public. But they - indeed, the lines are merging.

Looking at the increased political significance of humanitarian action and the difficulty for medical relief professionals to pin down the exact nature of their role forces the question of whether expanding their agenda in this way compromises their ability to meet their primary aim, to provide quality medical relief. Rony Brauman, a physician with MSF-France, reiterated this primary aim, even in light of MSF's historical emphasis on bearing witness

> It requires some kind of political sense to be managed properly in order to be able to keep your action going in the field, and to do something outside in order to put the pressure and be useful in another, on another hand. But if

> you're not accomplice of, let's say, oppression in general, well, then your main job is to bring relief. It's not to denounce, not to inform. You're not a journalist.

The integration of social and political concerns into the medical ethic of responsibility must be carried out with a degree of caution. Looking at the French doctors as an example, is their primary medical responsibility of healing the sick is impeded by adding human rights issues to the medical agenda? Arguably, such a broad expansion of medical duty may force doctors to 'spread themselves too thin' in trying to maintain a dual allegiance to their individual patients as well as 'the sick' in the universal sense, while at the same time keeping up with the additional duties of acting as diplomats, peacekeepers and human rights advocates. Claudie Durand of MDM-France explained how this original goal can be forgotten by organizations preoccupied by broader social and political interests

> It is difficult not to lose yourself. And it's difficult when you're dealing every day in the meetings, this country and this country. You're totally within the geopolitical movement and current affairs. You feel important. You're not. You have to be able to go out and say, like please calm down, calm your egos, and we're just, you know. If we can - and him in particular, the Executive Director who is also doctor. He always says in that case, "If I save one life, I'm OK, I'm fine. If all this is for one life, I'm fine. I have no problem." . . . because he's a doctor. And this is why it's very important, in my opinion, to have these medical people with us, because they always bring it back to the reality, to their reality of patients and doctor, relation of patients and doctors.

The ability of the doctor, as described above by Ms. Durand, to hold onto the 'reality' of meeting the health needs of individual patients, even within a politicized relief context, is essential in balancing the multiple roles humanitarian medical relief seeks to fill in contemporary conflict situations. Even with the added demand of political responsibility, "each doctor must honor his or her traditional contract to help his or her own patient. Doctors must not allow the larger social issues to undermine that solicitude. Ethically responsive doctors will find themselves more and more at the intersection of social and individual ethical values, impelled to act responsibly in both spheres."[37] It can be difficult to act responsibly in multiple spheres, especially when those goals may conflict.

In some cases these roles can be carried out with great complementarity. There are many examples in which medical relief organizations have managed to integrate these multiple roles successfully, as illustrated by the following interview excerpts.

Rony Brauman of MSF-France

When you're in Somalia, for instance, there's a war, there's a famine, which is a consequence of the war, because of displacement of populations, you say, "Well, there's a war. Two, three, four hundred thousand people have been removed from their villages, from their fields, and so they can't feed themselves, so there is a threat of famine. There is malnutrition. Then there is a famine." You try to raise awareness, to mobilize public opinion, humanitarian bodies to send food and so forth. There is absolutely no contradiction between what you say and what you do. It's complementary. It's unique to be, to have public access, to be able to act in the field. So there is a real complementary approach.

Joelle Tanguy of MSF-USA

In April, 1994 the genocide happened in Rwanda, and we had - we sent a team on the ground. We exchanged the teams and we had a long-term program with them, a team for the emergency program. We were staffing actually the ICRC hospital, and they were the staff right there. They were doing medical work and ambulance searching the patients throughout Kigali. And at some point we said it's a genocide, we have to tell. And we decided we would go on public television, a prime television in France, accusing the French president of being an accomplice of this genocide. This was going to be big news down there in Rwanda. And we had to discuss with the team, are we staying or leaving, or what do you want to do? It was the first time we managed to be extremely vocal and stay, because in the past we had a paradigm which was we have to either stay and be quiet or leave and speak out. And I think that '94 for us was a very important time because we

managed to be extremely vocal, accusing a major government of accomplice, of being an accomplice of genocide, to which we were witness on the ground and helping the victims, [inaudible] basically at the hands of a militia, and still maintained a presence. And I think if we can work on that and expand, we'll be winners.

Claudie Durand of MDM-France

We have an example in Afghanistan, where we started doing this. And when we finally came out and actually said the things that we had to say, nothing happened to us. And we managed to change the policy of the Talibans regarding the discrimination of women in the hospitals. So it did happen, but because we were relayed - first of all, there was consultation, collaboration among all the NGOs, including MSF. So in France we were ICF, MSF and us. And we wrote one letter. We did one lobby dossier . . . yes. And we presented ourselves as the NGOs working in Afghanistan . . . So I think we gained a lot in credibility. And we sent this lobbying paper to lots of institutional representatives in France, but also in the UN and in different countries. And I think we were relayed by the politics, the political people. And we were asking basically these governments who were funding Afghanistan not to fund any program where we had seen that there was discrimination. And actually we got surprisingly a letter, three pages, by the French Minister of Foreign Affairs, who totally agreed with us, and who said that they were already doing this. And I think probably other countries did this. And which gave a big pressure to Taliban which at the end. I don't believe we did that alone, but I think it's us plus this plus that that does give a result at the end.

However, in many complex emergency situations, engaging in multiple roles becomes problematic when the competing goals and values of acting and speaking out are mutually exclusive. Each of the individuals quoted above was also able to give a counterexample in which meeting all or even any of these aims was not possible. Rony Brauman brought up the difficulty of an extreme situation such as genocide saying, "Now, when you are in

another situation, where what happens is that the power or legal power or counter-power is killing the people you try to treat, then it's another issue. Then there is a real contradiction. This is what's happened in Cambodia and Ethiopia and Rwanda and a number of - not that many situations, fortunately." Speaking out against political authorities in a war zone can jeopardize the safety of volunteers and entire operations. Joelle Tanguy described "the big dilemma that we have, and we have to learn, the major learning curve that we have to approach now as a community is how to be able to be politically aware, identify a situation as unacceptable, be vocal about it, and be ready to risk expulsion." Claudie Durand explained how the decision between maintaining the operations to bring material relief and speaking out against an oppressive authority can be "a real dilemma, and sometimes it's a real choice to say, 'We will bear witness, and we know that we have to get the hell out of the country if we don't want anything to happen to us.'" Attempting to achieve the two distinct objectives of both supplying material medical relief and acting as political advocates, though they share the same ultimate goal of improving the health and well-being of war-affected communities, may require activities that are logistically contradictory.

One means of addressing this apparent contradiction has been to approach it philosophically. In trying to secure access to vulnerable populations, some relief organizations have tried to divorce humanitarian action from any political meaning, getting back to the initial Red Cross model which relied on the 'neutral' ideological status of medical care. Claudie Durand explained that "we believe that by pressuring the government and trying to distinguish the access to the population from the political decision to intervene in a country that we will succeed." Yet at the same time, these relief groups are also trying to use the new political power of the humanitarian community to lobby for the social and political changes which they identify as root causes. In a context which has finally embraced the political and social determinants of health, it becomes difficult to reassert simultaneously the separation of politics and relief on one hand, and the clear linkage of politics and health on the other. To begin to address the difficult challenge of defining an

appropriate role for medical relief in the new humanitarian environment of the post-Cold War period, organizations must first make some difficult decisions regarding the guiding principles which form the foundation of their action.

ETHICS

In complex political situations, even a clear and noble intention may not point to an obvious course of action, and the only way to make rational decisions is to act within a moral framework that reflects the complexity of balancing many conflicting ideals. The ideological dilemma of humanitarian assistance is a difficult one; in his paper on the evolution of humanitarianism in the 1990s, Hugo Slim described this problem

> Underneath the crisis of theory in NGO practice in war, there lies perhaps a more fundamental crisis of values. Usually manifest in the apparent clash between humanitarianism and human rights, this problem of values is essentially that of being forced to choose between responding to the right to life or the right to justice and the broader values of civil and political rights. This tension is essentially the healthy frustration which comes from realising that saving life is not enough when wider human rights endanger that life in the first place and continue unabated with, without or even because of humanitarian relief. Such a tension in values is perennial to the humanitarian project and is expressed in the twofold concern of humanitarianism with assistance and protection. Striking a balance between the two at once is at once the art and the agony of true humanitarianism.[38]

This 'crisis of values' is perhaps particularly acute for medical professionals operating in the arena of humanitarian relief, as the added demands of their professional ethic potentiate the moral dilemmas. To understand the confusion over role of humanitarian medical relief we must critically examine its underlying ideological framework. Looking at what motivates humanitarian action alongside its positive and negative consequences is the first step in dissociating the false ideal that what may represent the best in human intention necessarily leads to the best in human activity.

With the momentum of the humanitarian movement and the rapid growth of the development and emergency assistance industry in the post-cold war period, it can be difficult to ascertain the often subtle ethical issues buried beneath layers of moral outrage and good intentions. Without the ready ideological justifications of the Cold War, the

warrants for intervention must be re-examined according to other standards. The dilemmas in understanding humanitarian intervention are characterized by some of the most essential aspects of ethical problem-solving: conflicting goals, ideals, loyalties, or needs; ethical values in question, such as respect for persons, non-malfeasance, and justice; emotional stakes for involved parties; and the requirement to make moral choices about how to act.[39] Within the framework of ethical analysis, there are few easy answers; "with reference to attitudes to forcible humanitarian intervention in the West, every major political and ethical tradition can be seen to have been deeply divided on the issue."[40]

To defend humanitarian activity which, except for the work of the ICRC, often falls beyond the scope of international law, medical relief agencies lay claim to the law of conscience. They maintain that "there is a moral system wholly independent of the social practices involved in the constitution, recognition, and exercise of government, so that the moral citizen who has to resort to it in order to justify his obedience to the government and its laws can reach conclusions about what he should do without taking those practices into account."[41] There exist many different incarnations of such moral codes: political ethics of democracy and free-market capitalism, sociocultural ethics of religion and moral philosophy, or professional ethics, such as the Hippocratic Oath. Humanitarian actors in complex emergencies, and physicians in particular, point to a moral authority that supplants international law when that international law is inadequate to protect against the massive suffering of citizens at the hands of their own government or countrypeople.

Medical Ethics and the Moral Imperative

A central tenet of medical practice is the professional mandate to alleviate bodily suffering and traditional humanitarian medical relief works from the same moral imperative. When Dunant proposed the creation of national relief societies to care for the wounded in wartime in his book *Recollections of Solferino*, he makes

> an appeal to everyone who, impelled by a feeling of true humanity, might be willing to devote himself at once to this welfare work. It would consist in giving first aid and care on the battlefield as soon as war broke out, in cordial agreement with the military authorities and under their direction, and, in the rear, to care for the wounded in the hospitals until their recovery. [42]

This plea rests on the warrant that the care of the sick and the wounded constitutes a moral action demanded by 'true humanity'. Dunant does not specifically call on the professional obligations of the physician in this passage, but instead relies on symbolic power of medical needs to evoke the moral obligation associated with the work of the doctor as healer.

Broadening this concept from an individual level to an organizational level, the idea of the moral imperative is used to validate the actions of medical relief agencies in responding to the physical needs of suffering populations, and its interpretation and formulation have evolved to fit the ideals of humanitarian actors who use it. The ICRC frames their interpretation of the moral imperative as the 'right of initiative' granted in the 1949 Geneva Conventions, "In the case of armed conflict not of an international character . . . an impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties of the conflict."[43] Its presence as a neutral party, and in fact its very existence reinforces this moral imperative. Hernan Reyes, MD of the ICRC explained, "Right of initiative of the ICRC statute says, you know, we can offer our services and apply by analogy all the humanitarian principles that are enshrined in international humanitarian law . . . we have this right of initiative, which allows us to work, and which is what we're practically using all over the world now."

The French doctors more explicitly brought the moral imperative of the individual physician and the medical profession as a whole to bear on the work of humanitarian relief. They introduced a more active interpretation of the moral imperative which compelled physicians to take on medical relief abroad. At the heart of the French doctors movement lies the notion of the physician's duty to intervene, which stems from their original

criticisms of the ICRC and motivated Kouchner and the other young doctors to create MSF. The principles underlying the duty to intervene, as set forth by MDM in a conference prospectus, include:

- Human suffering must never be accepted by any person as the inevitable price of the functioning of nations.
- Individual medical practitioners and private non-governmental relief agencies have the right to intervene on behalf of communities in distress without the sanction of their home government or the authority of the country in question.
- International medical relief must be provided irrespective of political considerations or the political agenda of a given country.
- Medical assistance and humanitarian relief to vulnerable communities supersedes considerations of national sovereignty.
- The suffering of the people is not the sole province of governments.[44]

Though this list effectively covers the different logistical perspectives of the duty to intervene, it is more interesting to examine the reasons behind this sense of responsibility. Michel Foucault suggests that the duty to interfere arises out of a difficulty in accepting what is seen taking place. His discussion of humanitarian obligation insists that witnessing the subjugation of others "creates an absolute duty to rise up and confront those in power. One must refuse to accept the arbitrary division of tasks, one which assigns indignation to individuals and reflection and action to governments."[45] This argument applies to all of humanity, not only doctors. The humanitarian duty to interfere, as with Dunant's call to arms in *Recollections*, is not limited to the medical profession. Even so, society's expectations of the medical community to respond to the call of human suffering far exceed its expectations of any other group, professional or otherwise, excepting, perhaps, the church. One explanation of this phenomenon, expressed by H. Thomas Ballantine, a physician and professor at Harvard University, suggests that "physicians are a privileged group given 'high rank' and, under the ancient principle of noblesse oblige, have a special duty to promote the welfare of others."[46] This may account for a portion of the obligation

imposed upon doctors by society, but it seems that in fact, most of society's expectations of the medical community arise from within the profession itself. Realizing the unique nature of its service, medicine created for its members a tradition of ethics that it claimed to uphold, and the world has come to demand nothing less.

In the western medical tradition, the moral imperative of the physician can be traced as far back as the Hippocratic writings. As the ethical core of medical profession, they "deal with what are called deontological concepts, concepts that arise from a sense of duty and the obligatory doing of things because they are, quite simply, the right thing to do." [47] This idea of medical responsibility is also suggested by perhaps the most ubiquitous document in all of medicine, the Hippocratic Oath. The Oath includes the pledge "I will use my power to help the sick to the best of my ability and judgment; I will abstain from harming or wronging any man by it." There is not, however, any explanation of whether the physician's responsibility extends only to individual patients or to the sick of society. Modern notions of medical responsibility suggest that "the sick" excludes no one in need of care, but at the time of Hippocrates, "there was no generalized sense of a duty to patients or to society beyond the private pledges made by individual physicians to individual patients."[48] The Hippocratic Oath contains no evidence of any obligation of the doctor beyond the responsibility to fulfill his end of the business contract. Mike Toole of MSF suggests

> It is tempting to explain this motivation on the basis of the traditional medical ethic of providing assistance to all those in need. However, this ethical principle on the whole has been applied to the health needs of individuals in the immediate environment of the medical practitioner. Earlier this century, Dr. Albert Schweitzer was one of the most articulate spokesmen for the idea of extending this medical ethic to include those of remote and different cultures. However, he used arguments based on a belief in European superiority that would find little sympathy in today's world.[49]

From existing texts, it is difficult to support an allegation that such a responsibility falls within current conceptions of medical ethics. The individualistic nature of the Oath suggests

no basis for the medical responsibility to intervene, but this absence may be more indicative of the inadequacy of the Oath than of the lack of an actual ethic in support of social action. Though the Hippocratic Oath remains the cornerstone of the Western ethical tradition, "it is increasingly apparent that the ideas conveyed about the physician are simplistic and incomplete for today's needs. In some ways it is even anti-pathetic to the social and political spirit of our times...In a day where the remote effects of individual medical acts are so consequential, we cannot be satisfied with an ethic which is so unexplicit about social responsibilities."[50] Though no textual support for the principle of the duty to interfere can be found within the Hippocratic Oath, clearly the Oath, written to address the medical concerns of a different era, cannot be considered an all-inclusive medical ethic for the modern physician. The revised AMA principles of 1957 recognize a need to expand the doctor's responsibility beyond the scope of the individual patient, and state that "the responsibilities of the physician extend not only to the individual, but also to society, where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."[51] More modern attempts to codify medical ethics may provide some measure of support for the physician's broader social responsibility, but still they fall short of a complete ethical justification of the duty to intervene.

The ethical principle behind the duty to intervene is that of beneficence, also a key principle in the field of bioethics. Despite the harsh and sensational claims against power nations and NGOs, in its most distilled formulation the drive to intervene derives from the honest desire to make a positive difference in the lives of others, as described above, the moral imperative is a powerful one. "Humanitarian action seeks to decrease the numbers of those in need and ameliorate their suffering;"[52] compassionate individuals are bound by moral compulsion to provide assistance where it is greatly needed. Medicine is the paradigm of an occupation which aspires to relieve the suffering of individuals, and the

merit of that primary aim is what elevates the practice of medicine even in the face of failure. Sir William Osler wrote

> 'Tis no idle challenge which we physicians throw out to the world when we claim that our mission is of the highest and of the noblest kind, not alone in curing disease but in educating the people in the laws of health, and in preventing the spread of plagues and pestilences; nor can it be gainsaid that of late our record as a body has been more encouraging in its practical results than those of other learned professions. Not that we all live up to the highest ideals, far from it - we are only men. But we have ideals, which means much, and they are realizable, which means more.[53]

In support of humanitarianism, remember that "at the heart of the humanitarian impulse is the desire to relieve immediate life-threatening suffering. Springing from that impulse is the international humanitarian enterprise, the organized global effort to meet the needs of the world's people at risk"[54] An outgrowth of the moral tradition of virtue theory, the notion of the altruistic humanitarian impulse suggests that if agencies and individuals who provide emergency assistance are doing so with philanthropic motives, they will make appropriate and ethical choices.

Human Rights

Medical ethics brought to the ideology of relief the paradigm of an ethical framework which superseded all outside national, cultural, and religious interests and could thus be elevated to the level of universal applicability. The Hippocratic precepts of medicine are the doctrinal core of this universalizable moral structure which underlies the moral imperative described above. As one medical historian articulated it, "There is a moral law which is universally valid, and it is this moral law that pervades the philosophies of Hippocrates."[55] Regarding the universality of the moral tradition and methods of medical practice among physicians Sir William Osler wrote

> Of no other profession is the word universal applicable in the same sense. The celebrated phrase used of the Catholic

> Church is in truth more appropriate when applied to medicine. It is not the prevalence of disease or the existence everywhere of social groups of men to treat is that betokens this solidarity, but it is the identity throughout the civilized world of our ambitions, our methods and our work. . . To prevent disease, to relieve suffering and to heal the sick - this is our work; The profession in truth is a sort of guild or brotherhood, any member of which can take up his calling in any part of the world and find brethren whose language and methods and whose aims and ways are identical to his own.[56]

Humanitarianism, has established itself with an almost identical ethical universalism. The Red Cross declares its universality in the formulation of its fundamental principles. Jean Pictect, the director of the Henri Dunant Institute, wrote in his commentary on the Fundamental Principles of the Red Cross, "The doctrine of the Red Cross is permanent. It is the expression of long term wisdom, indifferent to the ebb and flow of popular opinions and ideologies of the moment. It outlived those who created it and this lasting character is perhaps a sign of its superiority over everything that happens here on earth."[57]

In the last 50 years, since the creation of the Universal Declaration of Human Rights, theories of human rights have been identified as the 'new' moral and legal common ground. Within this rhetoric of human rights lay the important question of their universality. Does respecting the rights of individuals and supporting the just claim to personal autonomy mean to interfere on the behalf of others under the banner of human rights? Or does charging in with a foreign agenda of due liberties impose a biased external morality which ignores and disrespects existing cultural mores? If we agree that the greatest good is to respect the rights and freedoms of others, how does the international community best honor that ideal?

Article two of the Universal Declaration states, "No distinction shall be made on the basis of political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty."[58] Questioning the universality of human rights requires going beyond UN definitions and looking at the issue not just as an angle of international

legislation, but as an independent moral problem. In *Humanitarian Intervention: An Inquiry into Law and Morality*, Tesón presents a well developed discussion of the ethical argument that human rights be understood as universally applicable. He maintains that an essential feature of moral discourse itself is its universalizability, and therefore with regards to human rights

> individuals must be treated as equally entitled to basic rights regardless of contingent factors such as their cultural surroundings. . . The place of birth and cultural environment of an individual are not related to his moral worth or to his entitlement to human rights. An individual's claim to basic rights cannot be ignored by his being born in one society rather than in another, for one deserves neither one's cultural environment nor one's place of birth. . . if the initial conditions are not morally distinguishable, the requirement of universalizability fully applies to statements about individual rights, even where the agents are immersed in different cultural environments.[59]

Predating modern exegeses of the terminology of human rights, Locke articulated the principle that before all social and cultural differences every human shares a natural and inherent "right of freedom to his person, which no other man has a power over."[60] This declaration, which forms the foundation of human rights theory as we know it, certainly suggests universality. But it is with the semantic transition from Locke's *natural* rights to the contemporary label of *human* rights where the unequivocal universality based on the solitary qualification of being a *human* being is ensconced. This reinforces the seemingly teleological argument that "if the only relevant condition for enjoying certain rights is being human, and if this property does not admit of degrees, there cannot be differences of degree in the extent to which the rights in question are held."[61] Thus framed in natural rights theory, the question of universality can also be approached from another angle. The moral ideal of respect for persons is codified by Kant's categorical imperative to "act so that you treat humanity, whether in your own person or that of another, always as an end and never as a means only."[62] 'Categorical' implies that this applies to all people and in all situations. One rights philosopher suggests that "a list of human rights can be seen as a political specification of what it means to treat all human beings as ends."[63] This

universality of human rights resonates in the western ethical traditions of natural rights and respect for persons, compelling us to take action to protect the rights we all share. What follows from these moral theories is the ethical imperative to empower autonomous individuals in the enjoyment of those rights.

The contrary ethical argument is that of cultural relativism. What is striking about the definition of humanitarian intervention articulated in the beginning of this paper, is the last part in which Tesón, as discussed earlier himself an ardent supporter of universal rights, describes a beneficiary population of individuals "who themselves would be rationally willing to revolt against their repressive government."[64] Because it is usually taken on assumption that we are acting on behalf of others who 'rationally' share the UN defined views of universal individual rights, this qualification is liberally interpreted by most government and private agencies who get involved in complex emergencies and internal wars. First, it is essential to define what is meant by the term cultural relativism, which is "the position according to which local cultural traditions (including religious, political, and legal practices) properly determine the existence and scope of civil and political rights enjoyed by individuals in a given society."[65] In her discussion of human rights relativism Adamantia Pollis points out important distinctions between the West's focus on civil and political rights, the Socialist focus on social and economic rights, and the Third World's focus on rights of self-determination and economic development[66]; she maintains that "the historical experience, sociocultural patterns, ideological underpinning, socioeconomic structure, political order, and articulated goals, their interrelations and interactions, are the context within which human rights are formulated and within which they operate."[67] The argument for culturally sensitive interpretations of rights has also a pragmatic aspect in that, "it is hubristic to try to export western ideas of freedom to places with different traditions and levels of development. Attempts to introduce western political models into poor countries have a habit of coming unstuck: look at Africa and Cambodia."[68] From an ethical standpoint, does a Universal Declaration of Human Rights

with its roots deep in European and American political philosophy imply the moral superiority of the value system of the developed west? Cultural relativism responds to that charge by deferring with full and equal respect to the different values and priorities of cultures and traditions that the 'UN's rights' might not truly represent.

If the criticisms of humanitarian interventions seem unreasonably harsh, it is because the moral impetus to intervene seems so self-evident at times that it drives people and organizations to action before they fully think through the consequences. Putting these impulses to the scrutiny of ethical reasoning clarifies some of the hidden realities of humanitarianism. Such an inquiry may then inform an improved international humanitarian response which maintains the global relief system as one valid solution to the difficult problems of complex emergencies, but in a more thoughtful and coordinated way which aims to work with local customs rather than around them or above them and improve administration of intervention programs, such that agencies may act with more sensitivity to the impact of foreign food, goods, service, and values on vulnerable populations.

Defining Principles

As an instrument of international action and even policy, humanitarian relief raises core ethical concerns from the personal to the professional to the political realm. As Françoise Saulnier of MSF-France stated, "You cannot rely just on the heart of the volunteer, you know, because . . . its the organizations that lead and not the people, and organizations do not have hearts, they only have pockets." The distinction is that "Where personal morality derives from the characteristics of single individuals and depends on the cultivation of personal virtues such as faith, hope, charity, and discipline, political morality depends on the structured interactions of persons - depends, that is, on institutions."[69] How does the humanitarian community begin to address the complex problem of creating such a theory of institutional ethics?

Though they are by no means representative of an international moral standard *per se,* international law and protocol nonetheless take on the function of serving as the primary guardians of global peace and security. The principles of the ICRC are explicitly defined, its legal scope of activity described in detail by the Geneva Conventions. The rights and responsibilities of the Red Cross societies worldwide, and humanitarian groups in general, are legally codified in several multinational compacts. Legislation which impacts humanitarian intervention in complex emergencies centers on the Geneva Conventions and Additional Protocols and the Universal Declaration of Human Rights. International Humanitarian Law is codified in the Geneva Conventions and Additional Protocols, with enforcement monitored by the International Committee of the Red Cross. Also called Hague Law after the headquarters of the international court, it was originally concerned only with the protection of armed forces and prisoners. Though later expanded to include provisions for civilians and non-uniformed soldiers, the emphasis on multi-national conflict does not effectively address the protection of individuals victimized in civil wars by their own governments.[70] Ratified by the UN in 1948, the Universal Declaration calls for a global commitment to the protection of individual rights. It can be seen that "the law of human rights borrows its language from moral philosophy . . . the statesmen who drafted the UN Charter were motivated in part by the moral imperative to restore human dignity and to give it legal status, and indeed that moral concern permeates the subsequent development of human rights law."[71] Though it has been suggested that paragraph six of the preamble, which reads "Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for the observance of human rights and fundamental freedoms," implies that member states take all necessary action to defend these principles,[72] in fact, the Universal Declaration is more symbolic than binding, and makes no provisions for its own enforcement. Having grown from a political tradition of respect for state sovereignty, the powers of the United Nations and its member states are delimited by the constraints of the Geneva Conventions and the Universal

Declaration, neither of which provides a sufficient framework for dealing with the internal crises the international community now faces. If the credos of governments and the UN have limitations which make them unresponsive to the needs of the global community, those concerns must be addressed so that the back door of humanitarian aid does not remain the only recourse to complex emergencies and internal conflicts.

As history has demonstrated the limitations of these documents in addressing the particular political realities of post-Cold War conflict, so too has practical experience shown the limitations of such codes and contracts to inform truly ethical decisionmaking. One medical historian supports this position with the statement that "ethics is not reducible to custom or professional consensus or traditional codes and oaths, as useful and indispensable as these may be in many professional contexts."[73] Even as they have rejected many aspects of the formal legal codes which delimit the work of humanitarian actors, faced with the new ethical minefield of responding to complex political emergencies, many NGOs are beginning to repeat the exercise of creating specific guidelines for humanitarian relief provision. The utility of such codes is that they provide a self-generated standard of behavior, freeing humanitarian action from having to be judged by more difficult to quantify and often more rigorous standards. Regarding such codes of conduct, Pierre Laurent of MDM-France observed that

> If you take the code of conduct of ICRC, a lot of NGOs signed this code. But when you speak with those NGOs and, for example, in last year there was a meeting on ethics and humanitarian assistance in Dublin, and under auspices of ECHO, European Community Humanitarian Office. And it's interesting because they think - they have temptation to think that this type of approach is only a luxury approach, you know? And I say it's the opposite. I mean the most - the easier things to do is to build an organization, and to have good practice, good standards, technical standards. Technical things. The most difficult is to have a soul and to breathe, and to renew those philosophical principles.

A similar critique has been made of the medical community, in which standards of ethical decisionmaking are embodied in the Hippocratic Oath and precepts; "medical ethics as

conceptualized an written by physicians had a very practical bent, concerned not as much with discerning first principles as formulating maxims for practice."[74] Critical thinkers within the humanitarian community are beginning to realize the pressing demands to engage with the unique logistical and ethical realities of each situation and not just hide behind the easy validations of codes and practice guidelines. In their textbook of bioethics, Beauchamp and Childress explain

> Professional codes are beneficial if they effectively incorporate defensible moral principles and rules in the relationships they govern. Unfortunately, some professional codes oversimplify moral requirements or claim more completeness and authority than they are entitled to claim. As a consequence, professionals may suppose that they have satisfied all moral requirements if they have obediently followed the rules of the code, just as many people believe they have discharged all their obligations when they have met the legal requirements.[75]

This danger of confusing guidelines with morals when facing difficult decisions was reiterated by Mr. Laurent in talking about humanitarian practice. He said, "You need to be philosophically strong if you want to have capacity to enter after in the complexity of the situation . . . It's easy to build a document and to say, 'OK, we want to respect these things, this is . . .' and at the end you sign the paper. But it's not reality because the ethics is something alive." Identifying the limitations of codes and guidelines leads us to consider how we can begin to develop an ethical theory of humanitarian relief which incorporates established codes and principles with the kind of active moral discourse that befits a task as complex as post-Cold War medical relief.

CONCLUSION

THE PROBLEM WITH SOLUTIONS

Uncovering the ideological interplay of medical practice and humanitarian relief provides the foundation for a critical look at some of the limitations of our current models of relief provision. The new context of post-Cold War conflict is challenging these paradigms, forcing a reconceptualization of the traditional Western medical ideas of health and ethics in humanitarianism. Many of the medical relief agencies embraced this new responsibility and hopefully added a social and political dimension to their medical activities overseas. Unlike conventional relief strategies which only mitigated the effects of war, their new mandate looked to root causes in search of a cure. This shift represented a break from the anachronistic body-based conceptualization of health toward a more comprehensive understanding, but it fell short of freeing humanitarianism from the limitations imposed by a medical paradigm. Rather than breaking from the medical model with this new attention to social and political determinants of health, they simply expanded the medical model of disease theory to encompass the 'disease' of bad politics. Biologist and essayist Lewis Thomas played with this analogy of politics and illness, writing, "Disease usually results from inconclusive negotiations for symbiosis, an overstepping of the line by one side or another, a biologic misinterpretation of borders."[76]

Medical sociologist Turner suggests "A classic illustration of the medical model is the germ theory, derived from the scientific medical work of Pasteur and Koch in the nineteenth century; their work established a scientific basis for the emergence of medicine as a profession equipped with a satisfactory knowledge basis."[77] Turner's analysis of medical reasoning proposes that modern medical theory views 'real' disease as a mechanistic malfunction is which the causes can be identified and the effects treated. The physician's reasoning process is described by Dr. Sherwin Nuland, who explains, "I proceed on the principle that a disease can be effectively treated only when I as a doctor

understand its causes in a particular patient, its site of origin, the internal havoc it creates, and the course which the process is likely to take whether treated or not. With that knowledge, I can make a diagnosis, prescribe a program of treatment, and predict an outcome."[78] The broadened agenda of humanitarian medical relief actually represents a triumph of this kind medical reasoning as applied to politics. Physician relief groups correctly identified that disease had important social and political root causes and took action in working towards treatment. This was not the panacea they hoped it would be; the realization that health is as political as it is biological does not mean that the same intellectual process which is used to diagnose and treat biological bodies works for national and cultural bodies.

Throughout history, physicians have learned their errors in diagnosis and treatment at autopsy, and such has become the unfortunate case for medical relief in the twentieth century. The complexity of finding comprehensive solutions to political emergencies has forced humanitarian professionals to reconsider the ethical implications of their failures and what their role in political conflicts ought to be. In the literature, humanitarian experts disagree on the solution to this dilemma. Some suggest more political savvy, others less social action. Some point to the need for sustainable relief measures, others criticize developmentalism. Almost every actor and observer comes to the humanitarian table with a different answer. In taking on this project, I too had hoped to uncover some novel approach to humanitarian medical relief. Instead, what I found was that humanitarian theory and practice have been stifled by their faith in medical paradigm of disease theory which is so singularly focused on cure. The need for agencies and individuals to have possession of the 'right answer', whether by legal, pragmatic, or moral justifications, has bound the imaginations of the humanitarian community. What emerged in interviews and literature as the biggest obstacle to the provision of rational, socially just, and politically responsible medical relief was this overwhelming preoccupation with The Solution.

How is the solution the problem? The growth of the humanitarian industry has added an element of competition to relief provision, in which different organizations with different ideas of the right Solution must meet in the field. When the ICRC was essentially the only humanitarian actor, the belief that the ICRC model was the only right way to provide relief was not so problematic. Since the succession of French Doctors from Red Cross humanitarianism, the ICRC has lost its monopoly on relief provision, both in ideology and in field presence. Many groups are competing for space in the most visible crises, and they support their position with claims of having the best approach, the best model, and the best solution. The ICRC has international law on its side, other groups have different professional, ethical, national and other validations for why their way is the Solution.

This kind of competition has also made having the Solution a financial necessity. With their appeals to a higher moral conscience than international law, humanitarian relief providers have tried to sever themselves from the powerful governments of the rich donor nations. Perhaps unrealistically, they aspire to a purity of purpose untainted by national economic and political interests. Many agencies insist that at least 51% of their financial support come from private individuals, and this has led to frantic competition for donations. Actually having the best solution in the field then must take second place to seeming to have the best solution for a public audience of potential donors. The unfortunate reality of publicity is that agencies become accountable not to populations or even to principles but to public opinion. This ultimate democratization of humanitarian principles has degenerated into 'voting with their dollars', as humanitarian actors must 'sell' their organizations' solutions to the public to earn funds for their activities.

The problem with competing solutions is that such competition severely impedes the coordination necessary for humanitarian relief to work in the field. As long as agencies must jockey for space and compete for public support, NGOs will continue to lay claim to the single best solution to validate their presence and their actions. Having to be the group

in possession of the Solution negates the potential for cooperation, the possibility of having many mutually reinforcing and complementary solutions in which agencies need not agree on the 'best' role for medical relief, just the best way each organization can play its part.

How is the solution the problem? Focusing on the solution requires the primacy of the goal over the process. For example, expanding the goals of humanitarian relief to include broader social and political concerns finally brought worldwide attention to the 'new' political significance of medical relief actors. In a phone conversation, Dr. David Heiden, a physician volunteer who has been working in the field of medical relief since the early 1980's, explained that although the practice of medicine in the technical sense is pretty neutral, medical relief had important social and political implications long before that political significance became the focus of international debate. Deciding when and where to provide medical aid, the social impact of aid distribution structures, and simply being a foreign presence in a conflict zone have always made medical relief politically charged. By this interpretation, all the rhetoric which centers on the 'new' political significance of medical relief is somewhat misleading in that its political significance has always been inherent in the process. Pierre Laurent of MDM-France alluded to this, saying, "When we are doing even a medical act, we are doing something political because we are in a way of, we are playing in the international community because we are working not only with one person ill, but with a community, with a country." What makes humanitarian relief so vulnerable to manipulation is this preoccupation with solution over process. While NGOs have seized on their place in the political spotlight of the international community, they have largely ignored the even greater political impact their presence and actions have on a local scale. The medical relief groups' frustration with securing safe access to populations without sacrificing their principles has led them look at the limitations of just doing medical work, rather than at the profound social and political impact that just doing medicine can have, even without 'bearing witness' or lobbying governments to take goal-oriented action.

Doctors are only just starting to understand the political consequences of their most basic actions, in both a symbolic and strategic sense.

How is the solution the problem? The need to have the Solution reinforces a power dynamic of outsider superiority that is no longer tenable in today's world. Returning to the medical models which pervade relief philosophy, this unbalanced interaction can be seen as reminiscent of the medical relationship of doctor and patient. Medical historian David Rothman suggests

> In fact, physicians shared a powerful tradition of ethical discourse that went back to Hippocrates and continued through modern times. It was at once high-minded, and even heroic, yet remarkably insular and self-serving too. Physicians almost exclusively defined the problems and arrived at the resolutions, giving the deliberations a self-contained quality. . . Predictably, too, the definition of what constituted an ethical problem and the choice of solutions reflected the vantage point of the doctor, not the patient - for example, what the physicians' rights and responsibilities were . . .[79]

Because the problems, the moral framework, and the solutions are all constructed from the physicians' perspective, it is not a morality responsible to its beneficiaries, but only to itself. Medical science has imposed a tyranny of expert observation in which the lived experience of the patient is notoriously undervalued.

With their focus on solving the dilemmas of access and aid manipulation, NGOs are unconsciously establishing a similar ethically driven control of the humanitarian relationship. As expert outsiders they define the problems using either ad hoc or structured methods of need assessment, they create the ethical validations from their own cultural value systems, and they debate solutions in the form of competing paradigms of relief. Working with populations in crisis can be an act of solidarity and empowerment. Though individual volunteers may try to establish relationships within local communities that reflect these ideals, most contemporary paradigms of relief provision, with their roots in 19th century ideals and their structures modeled on the classic doctor-patient relationship, are condescending towards their beneficiaries. Françoise Saulnier of MSF-France said, "We

are not this kind of super-parents taking care of kids. I think it's very important, and it's the kind of bias of humanitarian action conception in many Western countries." To be in possession of the Solution is to be in a position of power and authority. De Waal looks at how this power dynamic operated in humanitarian operations in Bosnia, in which "rather than seeing the Bosnian people as the essential resource to be mobilized in pursuit of solutions to political and humanitarian problems, the international organizations have presented themselves as controlling authorities, for whom the Bosnians are either passive recipients of largesse, or troublesome obstacles to the smooth operation of the international effort."[80] Coming into this interaction as the representative of the international community sets up a dynamic in which solutions to crises are not created organically from within, but defined and superimposed from without.

Preoccupation with access and the status of NGOs in the way humanitarian professionals conceptualize their mandate illustrate how this approaches humanitarian action from organizational rather than community perspectives. This obsession with what we are doing and why - accountability strategies, funding worries, field practices, moral imperatives and questionable motivations - centers analysis on ourselves. What must be brought to light is the experiential constructed reality of the individuals who are the recipients of relief and aid and who live in the historical moment we as outsiders are trying to understand and respond to with our resources and good will. Any methodology which purports to respond to the needs of a group of individuals in a specific cultural and political reality is misguided if it takes its structure from studies and analyses of ourselves and our actions. Modern humanitarianism has become more increasingly focused on building the power of agencies to act and take care of vulnerable populations in crisis at the expense of listening to how those populations conceptualize their own needs and helping them to solve them.

The structural and ethical framework of medical practice was presented as just one example of a paradigm which delimits how relief providers are able to conceptualize their

roles and validate their actions. Working from any Solution is a static approach; humanitarianism must be dynamic if it is going to address the varied and evolving needs of communities in crisis. Trying to find a new Solution to the practical and moral dilemmas of post-Cold War humanitarianism has become the greatest challenge for medical relief providers, but this singular focus has diverted attention from the unique experiences of communities dealing with the often combined effects of chronic conflict, political instability and material scarcity. Rather than concentrating energy only on defining Solutions in the form of paradigms or codes of conduct, we must also revisit Process if we are to respond the new challenges of post-Cold War conflict with effective, just, and responsible action. By interacting with the communities they work in, constantly reclarifying ideals and continually adapting field practice to reflect them, medical relief providers can begin to move away from the codes and paradigms to an ethical theory that is not a solution, but instead a guide, a process, and a foundation for debate.

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