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The United Tasks of Healing and Witnessing:  
The practice of combined ethics within Médecins Sans Frontières  
By Emma Waters

Senior Honors Thesis performed in the Department of Romance Languages at the  
University of Vermont

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## List of Abbreviations

**AMA** – American Medical Association

**BMA** – British Medical Association

**CRASH** – Centre de Réflexion sur l’Action et les Savoirs Humanitaires

**FAR** – Forces Armées Rwandaises (Rwandan Armed Forces)

**ICRC** – International Committee of the Red Cross

**IGA** – International General Assembly

**IHFFC** – International humanitarian Fact Finding Commission

**MSF** – Médecins Sans Frontières

**PHR** – Physicians for Human Rights

**SAR** – Search and Rescue

**WMA** – World Medical Association

## Introduction

The focus of this study will be the advocacy practices of the organization *Médecins Sans Frontières*, which is an independent provider of medical relief and other forms of humanitarian aid. Since 1971, MSF has carried out medical humanitarian missions to aid in reducing the suffering of populations due to disaster or armed conflict, delivering care irrespective of a patient's identity. MSF developed its distinction as an organization devoted to engaged humanitarianism after breaking off from the International Committee of the Red Cross (ICRC) due to a fundamental disagreement with the ICRC's more traditional and confidential form of humanitarian aid. MSF has continued to emphasize the need for advocacy, whether by speaking out, refusing to provide aid, or denouncing the abuses of political entities or other humanitarian organizations. The organization has developed the idea of witnessing as a "cultivated practice" that reflects MSF's humanitarian judgment (Givoni 56, 57, 67). This study will examine MSF's witnessing practice with consideration to three related ethics.

First, this study will examine the foundational history of witnessing. From Holocaust literature and scholarship, we will derive a set of ethical lessons on testimony. This will allow us to contextualize MSF's witnessing practice and evaluate its testimony. Next, we will develop an understanding of Camus's ethic of resistance as presented in *La Peste*. We will use this ethic as a guide to understanding MSF's use of witnessing as a form of resistance. Finally, we will use our knowledge of MSF's ethical roots to understand their relationship to MSF's practice of medical ethics.

## Foundations of Witnessing

Within the context of our current society, we expect that as we move through time we are leaving behind a constant trail of history. The important events, tragedies, as well as simple details of our ways of life are being documented. Such an expectation did not exist in the minds of Europe's Jews as the 1940s began. Before World War II, the Warsaw Jewish community was the largest in Poland and Europe, second only to New York City globally (United States Holocaust Memorial Museum "Warsaw"). When, in 1940, the Germans required all Warsaw Jews to move to the Warsaw Ghetto, there were an estimated 400,000 living in a 1.3 square mile section of the city (USHMM "Warsaw"). This population was forced to realize the fact that their community was not and likely would never again be as it was in the past. Thus, an important history was born out of the desire to bear witness to the existence of a population that might cease to be.

A key piece of the history of Holocaust testimony comes not from survivors, but from those who knew that they would not survive the Warsaw Ghetto. The Oyneg Shabes archive was a clandestine project overseen by a group of Jews in the Warsaw Ghetto, headed by the Jewish historian Emanuel Ringelblum. The group fought and risked their lives to preserve a record of Jewish life in the Warsaw Ghetto. The archives of Oyneg Shabes, including essays, diaries, and other materials documenting life in the ghetto, were buried in cans and cement underground to be protected so that they would bring an understanding of the situation of Warsaw and its inhabitants to future generations (Kassow 1-2). These testimonies recording the lives and thoughts of those who would likely not survive the Holocaust represent the first wave of Holocaust witnessing. The

motivations and significance of such witnessing will be discussed further as this chapter continues. First, let us turn to the question of witnessing.

Following the end of World War II came what Annette Wieviorka refers to as the “advent of the witness.” Wieviorka cites the Eichmann trial, which concluded in Israel in December of 1961 (USHMM “Adolf Eichmann”), as a key event precipitating the advent of the witness. Adolf Eichmann had helped to plan and carry out the deportation of millions of Jews. When he was tracked down in Argentina after the war and put on trial in Israel, hundreds of witnesses testified against him. Many of those witnesses were survivors whose testimonies were followed in the broadcast of the trial across the globe. Wieviorka describes the unprecedented nature of this trial in its use of vast witness testimony, as well as its use as a lesson in history (Wieviorka 57). The Eichmann trial put individual experience and testimony at the center of the world’s perception of history. This centralization of the witness lasted beyond the Eichmann trial into what Wieviorka refers to as the “era of the witness” (96). This era refers to the following years in which collections of individual recollections became a valuable form of historical knowledge.

The remainder of this chapter will examine the development of and motivations behind different forms of witnessing. The following will also pay particular attention to concerns regarding the practice of witnessing that grew out of reactions to the Holocaust. Finally, this discussion of the practice of witnessing will consider how motivations, challenges, and successes of witnessing relate to witnessing by *Médecins Sans Frontières* (MSF).

To begin this discussion of witnessing, let us look at a variety of formal and informal factual testimonies. In an essay entitled “Jews’ Diaries and Chronicles”, Amos

Goldberg addresses the phenomenon of personal accounts from the time of the Holocaust. Goldberg expresses his understanding of Holocaust diaries as an essential element of the testimony that led up to Wieviorka's "era of the witness." Diaries were by far the most common form of writing taken up by Jews during the Holocaust. During the later years of the Holocaust, diaries in the form of memoirs became increasingly common. Goldberg points out that such autobiographical work in times of crisis stems in part from the fact that individuals are forced to rethink their identities within a shifting world (398).

Goldberg traces the evolution of the autobiographical diary from writing "responding to the question 'who am I?' to seeking to answer the questions 'what have I seen?' and 'what are the external forces determining my and my community's fate?'" The phenomenon of the individual account seems, at first, to set such diaries apart from the testimony of MSF because MSF is an organization made up of thousands of individual experiences. However, these personal documents and MSF testimony are quite related in their mission. Both grapple with horrible realities and reach for reasons, perhaps with the intent of in turn achieving change. An important difference between the two forms of testimony is that persecuted Jews wrote primarily to reach some understanding of their own with little hope that that would alleviate their situation, while MSF seeks to develop an understanding for the world in order to incite change (399).

These diary entries show that there is an inherent power to recording history in real time. The truth of an experience can be warped over time as a larger cultural narrative is developed that alters memory and recollection. Wieviorka recounts the story of a man who testified years after the war about his time as a child in concentration



camps. He testified with the help of a diary that he kept during his internment. His interviewer noted that he often skipped pages. When asked to explain, he claimed that he skipped these pages because he had no recollection of their contents and that they could not have been a part of his experience. Wieviorka argues that this man's inability to connect what he had written in these passages to his memory is related to the passage of time. We can extend this argument to understand that the closeness of a memory to its recording greatly enhances its richness and completeness (137).

Wieviorka also points out that the tone of testimony has changed over time. Directly following the war, testimony often focused on vilifying the Germans, while in later decades, the function of testimony transitions to fight denial of the Holocaust (138). MSF represents a direct proximity to the events about which it testifies, the movement's testimony co-occurring with the events that it seeks to explain. It seeks to share information about situations as its volunteers and patients experience them in order to bring about change that they see as necessary. MSF identifies perpetrators and combats denial about horrific events, such as the Rwandan genocide, which will be discussed below. However, MSF seeks to set itself apart from other medical humanitarian organizations by seeing itself as a movement rather than a bureaucracy ingrained in set procedures. As such, it constantly adjusts and evaluates its decisions in order to continue to be effective. Therefore, the practice of immediate testimony does not mean that MSF workers do not reassess past work in order to inform their future practices. Our goal of this section is to understand better the values and motivations of MSF witnessing to consider whether or not there have been times when testimony on behalf of the organization has been limited or misleading. Ultimately, the intent of this analysis is to

determine how MSF can be effective in its witnessing and still act foremost as a group of physicians committed to treating patients. We will consider whether or not MSF has the foresight to know what the goals of their testimony should be. Who should testify in the name of MSF? Would the words of patients and the population, rather than those of their caretakers be more powerful? These are all questions that will allow us to gain an understanding of the practice of witnessing.

Much as MSF must evaluate its forms of testimony, Goldberg examines the limitations of different forms of Holocaust testimony. Goldberg indicates that there is some limitation to using what he calls “synecdochical diaries” in which a single person’s account represents a larger story. Goldberg points out the challenges in integrating synecdochical diaries and historiography. He explains that in historiographical writing, “much is lost in the process of generalization and construction of contextual and causal contiguity.” He contrasts such generalization with the parameters of diaries as “the authentic embodiment of a multiplicity of directions, forces, voices, and silences that cannot be circumscribed or reduced” (403-404). Individual accounts, while unable to deliver an encompassing narrative, are able to provide insight into human experiences associated with a larger narrative. In generating their testimony, MSF is not limited to a particular form of expression.

The benefits of combining the encompassing personal entry and the distilled historical account as exemplified by the Holocaust sets forth a model of how to effectively witness a crisis. While a personal narrative allows a certain fullness to be expressed, it does not do as much as a historical record to explain the why and how of a larger event. In order to effectively witness, MSF must be able to identify the root causes

of events. This leads one to surmise that the goals of the MSF movement require a historically accurate and concise explanation in order to provoke understanding, action, and change. Although the reality of trauma is that its “ungraspable character eludes any disciplined articulation,” MSF must find the clearest of words to parse through the chaos of atrocities that its members witness (Goldberg 405).

While diaries were the most common form of writing during the Holocaust, others wrote in order to preserve an understanding of a population of humanity or with the hopes of being successful witnesses to a crime against a population. In his book *Who Will Write Our History?*, Samuel Kassow explains that, “to write was to resist, if only to bring the killers to justice,” but also that “to write was to assert precious individuality even on the brink of death” (7). These two motivations taken together indicate that testimony emerged from those who needed to make sure that there was a record that they and their people had been there and that they mattered. They should not be forgotten. They were people who existed, who deserved more time, and those responsible for their suffering should not go unpunished. This concept of witnessing as a form of resistance will be examined further in the following chapter.

Gustawa Jarecka was an author living in the Warsaw Ghetto and whose essay was found in a milk can in 1950. Amidst many other sentiments she declared, “We are noting the evidence of a crime.” It was very clear to her that this evidence would not stop the fate of Warsaw Jewry, but Jarecka hoped despite the absence of hope that the records of Oyneq Shabes might “be hurled like stones under history’s wheel in order to stop it” (6-7). Jarecka’s hope that human testimony might turn humanity away from a path of cruelty

and blindness rings out still in testimony seen today. Her motivation may be similarly detected in the historical statements and acts of MSF and in their recent communications.

Goldberg also cites a passage from the writings of Gustawa Jarecka. The passage flows with the idea of the provision of evidence for future condemnation of the persecutors of her people. She says,

One can lose all hopes except for one – that the suffering and destruction of this war will make sense when they are looked at from a distant, historical perspective. From sufferings unparalleled in history, from bloody tears and bloody sweat, a chronicle of days of hell is being composed, in order that one may understand the historical reasons that shaped the human mind in this fashion, and created government systems which made possible the events through which we passed in our time. (403)

Here, Jarecka seems to foresee what Wieviorka calls the advent of the witness. With her own and others' writings as evidence, she can imagine a future that contains events such as the Eichmann trial. That is to say that she envisions a time where witness testimony holds power. She also imagines a future in which the horrible times of the Holocaust will be seen for the "days of hell" that they were and the mistakes that allowed for it will be understood. She sees a potential for teaching and understanding in her record of such horrible times. Goldberg points out that Jarecka's understanding of her writing invokes a future that determines the present. Goldberg explains that in such a time of catastrophe "the future will enable our existence in retrospect" (403). Jarecka wrote in order to keep her present from being erased from time. In this same way, the presence of MSF in dire conditions is emboldened by the possibility of improved conditions for those who they

aid. The hope for change is what motivates MSF teams with the belief that their work will leave behind an improved state of health and humanity.

Most records kept during the Holocaust put their authors in danger, especially organized records such as the Oyneg Shabes archives. From the great risks taken to save the diaries, laments, essays, poems, fiction, and final wills of those who knew that they would most likely become victims of the genocide that we now call the Holocaust, we understand that Emanuel Ringelblum and his fellow clandestine collectors of documentation saw great value in what they collected. Ringelblum referred to such records as writing “from inside the event” and valued them as more complete as compared to limiting selective memory (Kassow 13). These writers understood that if they and their people were to be remembered as they were and as they wished, they needed to take their history into their own hands. Like MSF, they understood that in order to make sure that a story is understood properly, one must tell it. In order for a larger history to contain all of the story’s components, they must be written.

In the decades following the Holocaust, witnessing took the form of retrospective testimony, often collected by interviewers for video testimony projects such as the Spielberg Project or the Yale Archive. Thousands of interviews were collected in order to “allow the survivor to speak” and in order to record a generation of memory before it passed out of reach (Wieviorka 108, 111). Such interviews challenged the tendency to remain silent and protect oneself from the pain of memory and protect others from facing the implications of such a painful history. Wieviorka quotes Dori Laub, a founder of the Fortunoff Video Archive for Holocaust Testimonies saying, “it is a mistake to believe that silence favors peace. The ‘not telling’ of the story serves as a perpetuation of its

tyranny.” Laub offers this argument for the need for survivors to speak of their experiences and thus become witnesses. He argues that silence results in the “contamination of the survivor’s daily life” (109). Similarly, MSF sees silence as a factor that perpetuates the illness or tyranny to which its members bear witness. As James Orbinski explained in his 1999 Nobel Peace Prize acceptance speech, “silence has long been confused with neutrality, and has been presented as a necessary condition for humanitarian action. From its beginning, MSF was created in opposition to this assumption. We are not sure that words can always save lives, but we know that silence can certainly kill.”

Lawrence Langer touches on the resistance against silence in his essay “Recent Studies on Memory and Representation.” He points out the importance of the location of the Holocaust memorial in DC, reminding the reader that it stands as a symbol of the connection between millions of murdered individuals and a country that denied them entry before their extermination (87). The recounting of such details, the ones that bear heavy regret, is essential to prevent a forgetful story of glory. The U.S. must not simply remember its success at the end of World War II, but also the failure to protect the humanity of these individuals among others, such as the Japanese interred in camps. The memory of visa denials to Jews escaping Nazi crimes runs parallel to the complicity of the French Vichy regime in Nazi Germany’s persecution policies and ultimately then the Holocaust. This era of history provides a powerful lesson, demonstrating that when the glory of a government is extolled without memory of such horrific failures, when certain details are left to silence, a nation loses the opportunity to learn about and correct its own weaknesses. Silence increases the danger of repeated failures by nations to protect their

people and the human rights of other people within the global community. MSF seeks to prevent such forgetfulness by pointing out the failures of nations in which it intervenes and of nations that fail to respond to the injustices witnessed in other nations.

With regard to retrospective testimony, Wieviorka addresses a challenge when relating such testimony to “history” as we understand it. She shares the reflection of a former inmate, Henry Bulowko, who had both testified and been an organizer of associations for former Jewish inmates in France. He explains his surprise when he heard historians at a conference articulate that former inmates of concentration camps were “documents.” While they proceeded to specify that they saw inmates as “living documents,” Bulowko describes his internalization of this moment. He says:

I suddenly saw myself transformed into a strange animal caged in a zoo with other rare species. Historians came to me, told me to lie down, turned me over and over as you turn the pages of a document, and asked me questions, taking notes here and there... The term used at the conference seemed to me infinitely shocking.

One can go from being a “former inmate” to a “witness,” then from “witness” to “document.” So then what am I? Who are we? (129)

A significant motivation behind collecting testimony, which itself may be regarded as a document, is to understand and preserve human experiences of the past. However, to regard a person as such a historical document detaches that individual’s experience from their humanity. Wieviorka argues that “each person has an absolute right to her memory, which is nothing other than her identity, her very being” (132). A person’s memory constitutes everything that a person knows of the world, and thus everything that they know of themselves within it. In light of this understanding of the link between a person’s

identity and their experiences, we must also analyze what it means for a doctor to view a patient as a document. For a doctor to view a patient as evidence, perhaps of a crime committed by a government against a portion of its population, detaches that patient from their humanity. In view of this, MSF must take care to prevent such a detachment.

Another important consideration in relation to a person's memory and experiences is how they are represented. Anytime that one recounts an experience of one's own or in another's stead, choices are made about what details will be shared and how they will be framed. When one testifies for oneself or on behalf of another, information is expressed with a specific purpose in mind. No matter how worthy this purpose, it is important that the information shared remains faithful to the reality of the events that it describes. As will be discussed below, there is danger both in presenting events in a way that softens reality and in a way that renders reality spectacular. Such forms of representation diminish our understanding of how events truly occurred and how they have impacted humanity. This damages the integrity of an act of witnessing, thus damaging the power of testimony to bring about impactful change.

Reflections on representative forms of recollection following the Holocaust reveal important concerns about preserving the reality of a crisis. Let us consider the sentiment expressed by Elie Wiesel in response to the 1970s television series *Holocaust*. In her book *The Era of the Witness*, Wieviorka describes the general disapproval of the series, saying that many found it to greatly romanticize a time that was so utterly far from romantic. Wiesel wrote in the *New York Times* that "the witness feels here duty-bound to declare: what you have seen on the screen is not what happened *there*" (99-100). The historical drama clouds the treachery of the Holocaust in poetic drama. Wiesel indicates



that to have seen or lived through such injustice leaves one with a duty to communicate it as something no softer than what it was. Wiesel also suggests that there is damage in dramatizing the Holocaust in a way that disconnects it from what actually happened. He calls for a reinforcement of the connection between what individuals experienced and the world's perception of the Holocaust. Let us revisit Laub's words - the statement that "the not telling of a story serves as a perpetuation of its tyranny" (Wieviorka 109). We can extend our understanding of this statement to mean that the softening of a story also serves as a perpetuation of its tyranny. Such a softening of our memory of the Holocaust would prevent us from moving forward, rather than simply away from this tragedy. A softened representation of history allows events that are naturally impactful and difficult to process to be taken in more easily without confronting a person with their full and moving force.

This is pertinent not only as it relates to history, but also to contemporary trauma. In order to justly represent a story, it must be represented in all its force, without being warped by gentleness of expression. When MSF chooses to speak and bear witness to injustices, it has to decide how to present its testimony, striking a careful balance between resistance and spectacle. This means faithfully portraying what volunteers experience in order to justly record and advocate with the understanding that silence does not guarantee peace or improvement and may in fact inhibit it. Silence is often indirect collusion. The challenge that arises moving forth from this conclusion is in determining how MSF, as an organization of physicians, can balance honest and undiminished reporting with the priority of medical treatment.

The above discussion of Holocaust testimony provides us with lessons that we will consider when moving forward to evaluate how MSF testifies. First, historical accounts most faithful to the events are written as such events occur. Recording only part of a story can lead to damaging denial. Denial can best be combatted and events are best understood when encompassing personal entries are combined with the identification of the root causes of events. Active witnessing in such a way allows one to work through horrible experiences, knowing that one's testimony will survive into the future. Silence – a failure to outwardly bear witness – perpetuates tyranny. Breaking silence allows us to learn from and improve understanding of an experience. In breaking silence and recording events, one must be sure to preserve the union of an individual with their humanity, rather than representing them as documentation. The representation of experiences must be composed without dramatization that disconnects the testimony from the actual experiences of those who are being represented. Such a disconnect diminishes the validity of testimony and its power to have an impact.

Let us now apply this understanding to several recent and historical instances of MSF testimony. First, an examination of MSF's recent testimony on behalf of migrants, many of whom are Syrians, taking dangerous overseas routes to reach Europe will reveal that the organization combats denial of the humanity of migrants by providing an opportunity for these people to break the silence surrounding their own stories. This is also a situation in which MSF combines individual testimony with more overarching testimony by the organization. MSF's response to a United States airstrike that struck the organization's trauma center in Kunduz, Afghanistan in October of 2015 presents MSF's limited knowledge of the situation and seeks clarity as to why the hospital was not

inherently safe. We will see that MSF's leaders bear witness on behalf of the organization in order to enforce life-saving policy. We will be able to contrast the use of organizational and individual testimony in these two cases to understand why MSF chooses each form. Finally, MSF's departure from camps of Hutu refugees in Zaire and Tanzania in 1994 and 1995 as well as from migrant detention centers in Malta in 2009 will allow us to understand what drives MSF to leave a population of patients and frame its departure as a form of witnessing. We will consider whether or not this turns the patient into a form of documentation, and whether or not that can be justified.

Upon examining MSF testimony surrounding the migrant crisis in Europe, which in 2015 saw an influx of more than a million migrants and refugees from multiple countries primarily due to the conflict in Syria, we begin to understand that MSF advocates in a multifaceted way (BBC "Migrant Crisis"). In an article reporting on the capsizing of a ship carrying an estimated 700 migrants in the Mediterranean Sea in August of 2015, reporters Philip Pulella and Steve Scherer explain that these waters have become "the world's most deadly border area for migrants," with 2,000 deaths as of August of 2015. MSF was involved in the rescue operation that sought to help these migrants safely to shore (Pulella and Scherer). The organization tweeted during the operation through its Twitter account @MSF\_Sea, which the organization has used to communicate about the migrant crisis extensively.

The information shared includes quantitative updates as to the numbers of individuals saved and estimates of how many migrants the ship was likely carrying. It also includes images that give faces to the victims of the migrant crisis, such as one with the caption: "This precious one year old child from Palestine was almost lost today." This

photo of a young child – the picture of innocence – appeals deeply to one’s sympathy and desire for justice. These pieces of information provide a large-scale picture of this crisis as well as an understanding of the multitude of troubling experiences at the core of the situation. MSF faces this dehumanization with refusal to accept that such conditions are simply a part of the human experience. The organization practices this refusal both by making unacceptable situations visible and by seeking to overtly value each patient by recognizing the innate right of each person to receive care. Such an ethic of refusal draws from the ethic of Camus, a connection that will be further developed in the following chapter.

Along with factual updates and images of those in need, MSF shares with the world the words of individuals receiving MSF aid. For example, from one migrant, the words: “I’m not a terrorist. We are humans. Where’s the humanity? Where’s the world?” This patient speaks to a deep unease about Muslim migrants and the subsequent disregard of abuse and hardship to which MSF bears witness. His words underline the sense that Muslim people today are framed as a population to be feared, thus damaging the natural empathy of those in a position to provide aid. It shrouds a population in suspicion, creating controversy that slows aid. By continuing to share testimony such as this patient’s, MSF seeks to challenge this unease. A website published on November 10, 2015 by MSF provides quote after quote from stories of migration told by MSF patients to members of its Mediterranean Search and Rescue (SAR) mission. These stories are accompanied by the first name, age, and country of origin of their tellers, as well as some photos or videos of refugees as they share their stories with MSF SAR volunteers (MSF “Photo Story: Provide Safe Passage”). This style of presentation breaks down

generalizations about this population of people in crisis and reveals the desperation and vulnerability of a diverse population of individuals without other options. The organization seeks to reveal the persecution of these people and combat the disregard for their human rights that prevails in part due to fear of terrorism.

In other tweets from the @MSF\_Sea account, MSF denounces “the lack of decency across [the] EU on one of the defining issues of our age,” saying that it “is extraordinary given the continent’s history.” Here, MSF references the historical failure of European nations to come forward and sufficiently aid another population in peril. MSF suggests that the attitude of unease surrounding today’s arrival of refugees in Europe is reminiscent of wariness towards Jews in Europe in the first half of the 20<sup>th</sup> century. Just as Holocaust diaries provide us with a record of the day-to-day horrors faced by Jews during their internment, MSF provides the world with access to the indecent conditions and daily perils of migrants. This argument does not seek to equate the migrant crisis to the Holocaust, which is widely seen as a singular event. However, the Holocaust teaches a profound lesson about the risk of silence and inaction. MSF is applying this lesson and speaking out strongly to prevent denial of the need for action on the current migrant situation by invoking the continent’s shameful history.

MSF pairs its ongoing record of this crisis with direct appeals to nations with the power to improve safety and make decent the living conditions of those at risk. In a letter sent to many EU nations and to newspapers across Europe (see Appendix A), MSF strongly stated: “We are treating the medical consequences of the journey...but all of our work amounts to filling the gaps left by states unwilling or unable to fulfill their responsibilities.” The organization testifies in its letter that decisions made by EU nations

have even worsened the situation, saying that “fences and forced fingerprinting only push people to choose more clandestine and dangerous routes,” calling the dangerous journey and poor conditions for migrants a “policy-made human tragedy” (MSF “EU: your fences kill.”). To MSF, the first priority must be the preservation of human life, and it promotes action by governments with the insistence that human life should take precedence over national security protocols. With regard to forced fingerprinting, we must consider the fact that the migration of at least one suicide bomber involved in the November 13, 2015 terrorist attacks in Paris was tracked back to his entry from the Middle East to Greece using his fingerprints (Ryan, Faiola, and Mekhennet). In light of this information and the attacks in Paris, concerns that migrants from the Middle East could pose a grave security threat solidified (Troianovski and Walker). In its letter to the EU, MSF argues that “categorisations of ‘migrants,’ ‘refugees,’ or ‘asylum seekers’ do not adequately or fairly describe the reality that pushes people to embark on long and dangerous journeys” (MSF, “EU: your fences kill.”). These terms are impersonal and enable people to disengage their basic understanding of shared values amongst all people. By voicing its concern about these terms, MSF underscores the importance of recognizing our own values and needs in others. This recognition should prevent European nations from turning uprooted individuals away. To turn such people away condemns them to retrace their steps to homelands that they left because conditions there were unlivable. National security fears the threat to native Europeans posed by terrorists like those who struck Paris on November 15. If governments tighten and close borders due to the danger posed by such individuals, then MSF’s letter suggests that they are guilty of ignoring the innate value of those seeking refuge and become accomplices to their pain.

Through its letter to European nations, MSF insists that lives must be cared for in a way that recognizes each person's distress and treats them with decency. To underscore the importance of seeing migrants as human beings rather than as a number of bodies seeking to cross borders, MSF sent a life jacket recovered from a rescued migrant with each letter. In the letter, MSF writes:

This poor quality life vest was the only security a man, woman, or child had whilst trying to cross the sea to Europe. These jackets sometimes feature handwritten prayers for a safe passage, or phone numbers of relatives and friends to be contacted in case the person wearing it does not make it. This is a reminder that the people embarking on these journeys are fully aware of the risks they are undertaking, and the sheer desperation motivating them to put themselves and their families in so much danger.

In sending this tangible evidence, MSF testifies to the necessity of migration and hopes to dispel the fear and mistrust associated with the individuals and families driven to sea by desperation. MSF refuses to allow for continued ignorance by those in a position to act. The organization hopes that if the public is made aware – such as by reading MSF's letter or by reading stories of migration – of the very real human suffering, they may require their governments to act. MSF appeals to an ethic of revolt against trauma and harsh conditions, which will be further addressed in the following chapter regarding the ethic of Camus.

Our examination of MSF's witnessing via testimony to government bodies with the power to improve migrant lives reveals that it contains some appeal to an individual's sense of revolt, while also pointing to possible root causes of the increasing problem,

such as an increase in fenced borders. While it is crucial that MSF is able to name the factors that directly harm individuals, the organization is able to deeply empower its message through the integration of this information with personal accounts of the individual lives being affected. The sharing of individual stories allows for an understanding that grows out of the “multiplicity of directions, forces, voices, and silences” that Goldberg describes.

Next, we will turn to the organization’s response to the recent airstrike on an MSF-run hospital in Kunduz, Afghanistan, after which it demanded an independent investigation. In early October of 2015 an MSF hospital in the city of Kunduz in northern Afghanistan was hit repeatedly during a U.S. airstrike as planes passed over multiple times. According to Jason Cone, the U.S. Director of MSF, the hospital “was a well-known facility and [MSF had] fully communicated that it was a functional hospital full of patients and staff” (Brink). During this airstrike, more than 20 people were killed in the hospital, including patients and their caregivers. In a piece on MSF’s demand for an independent inquiry into the U.S. attack, journalist Eleanor Beardsly explains that the Geneva Conventions “protect hospitals as neutral places” (Chappell). This raises the question of how this tragedy was allowed to happen. In a speech addressing the proper response to the attacks, MSF’s International President Joanne Liu referred to the strike as “an attack on the Geneva Conventions” and asked “that the U.S. government consent to an independent investigation led by the International Humanitarian Fact-Finding Commission (IHFFC) to establish what happened in Kunduz, how it happened, and why it happened.” Liu goes on to explain that this investigative arm of the Geneva Conventions has existed since 1991, but has never been activated. She attributes this



disuse to the fact that one of the seventy-six signatory states must sponsor the investigation and says that “up to now [governments] have been too polite or afraid to set a precedent.” Liu argues that this attitude “create[s] a free-for-all and an environment of impunity” (Liu). MSF showed determination to bear witness to the consequences of this perceived negligence by refusing to become collateral damage and let the tragedy at its hospital be overlooked as a potential war crime.

In demanding an independent investigation through the use of systems that are already in place, MSF insists that, rather than simply accepting deep condolences and moving on, it will bear witness. Jason Cone, the director of MSF in the U.S., asserts that to prevent situations such as this one, “we don’t need anything new...[because] there are laws of war, the Geneva Conventions.” Through insistence on the proper use of the safeguards of International Humanitarian Law, MSF reminds the world of their important role in the protection of civilians and combatants who are no longer engaged in hostilities. Cone argues that, “the best way for the U.S. government to respond is to accept a commitment to an independent investigation,” suggesting that it is also the responsibility of the U.S. government to preserve the value of the Geneva Conventions by honoring them (Brink). As was discussed in the above examination of Holocaust diaries, author Gustawa Jarecka hoped that the testimony of the Oyneg Shabes archives might serve as a stone under the wheels of history as they rolled towards tyranny. Similarly, MSF testifies as to the importance of preserving the value of the Geneva Conventions in order to avoid a future where they are meaningless.

In a report by journalist Michele Kelemen regarding the legal process of declaring the U.S. attack on the hospital a “war crime,” she cites Robert Goldman of the

International Law Department at American University who says that “it will be difficult to make a case that this was an intentional attack on a protected place – rather than just a case of poor intelligence and negligence.” Here, Goldman suggests that the investigation is unlikely to yield a guilty verdict. However, that does not mean that the investigation on the whole would not be worthwhile. To that effect, Kelemen cites John Bellinger, the former legal adviser to the State Department who argues that, “the U.S. will have to show that it takes international law seriously if it wants to claim moral authority to continue to criticize countries like Syria” (Kelemen). Bellinger suggests that if the U.S. submits to an independent investigation, it can prove its respect for the standards to which it holds other nations. Since Keleman published her report, the U.S. army has revealed that the attack was a result of “avoidable human error,” though it has not been classified as a war crime (Nordland). Even if MSF’s accusations are unlikely to be proven, the act of pushing the issue as far as MSF has is pushing others to comment on and consider the failures that led to this tragedy.

MSF’s demand for clarity in this case addresses the possibility of conflict between military analysis and certain humanitarian exceptions. It has been the case since MSF’s founding that any injured person is to be treated as a patient at MSF hospitals. Any weapons are to be left outside and all persons are to be treated as human beings inside MSF hospitals. In MSF’s preliminary Internal Review published on November 5, 2015 (see Appendix B), the organization explains that, “MSF teams did not ask which armed groups patients belonged to,” but that “it was clear...based on observation of uniforms and other distinctive identification, that a number of wounded combatants were being brought to the hospital” (5). MSF seeks to ensure that its hospitals are not targeted due to

the possible treatment of “terrorists” within. In order to maintain the humanitarian exception that protects all patients regardless of their identity, military bodies must also respect such a prioritization of human life above identity. Here, MSF’s testimony is presented mainly on behalf of MSF as a whole because it is not the identity of the individuals within the hospital, but the fact that a hospital was attacked, that MSF seeks to address.

In a statement released by Colonel Brian Tribus of the U.S. Army with U.S. forces in Afghanistan, he said that, “the strike may have resulted in collateral damage to a nearby medical facility” (BBC, “Kunduz”) MSF shares deep concerns about this attitude, saying through their @MSF twitter account: “We cannot accept that this horrific loss of life will simply be dismissed as ‘collateral damage.’” MSF suggests that there is a greater problem than collateral damage when military strategy is developed such that a hospital is put so readily at risk. To address this institutional issue, MSF chose to pursue collective witnessing. By testifying on behalf of the whole organization and with the voices of its leaders, MSF was able to bring media attention to the attack and increase the pressure on leaders to produce a clear timeline of events. However, MSF had to be wary of attracting media attention that might portray events in a spectacular manner. By testifying in a more formal manner, rather than with the vivid and emotional testimony of individuals, MSF was able to avoid rendering the trauma of the airstrike spectacular, instead showing the world that the life and dignity of their patients must come before military strategy.

As mentioned above, individual testimony was not the focus of the organization’s communications surrounding the event. However, MSF does combat the conception of

their staff and patients as “collateral damage” with a personal account and personal information. One nurse’s vivid narrative, shared the day after the attack, reveals the initial shock and horror of the attack. The immediacy of the telling prevents the memory from being softened by time and prevents the gravity of the destruction of the attack from being dismissed. An article providing a short obituary for each staff member lost presents the respect for each life that MSF expects other parties, such as the U.S. military, to honor. Unlike migrant crisis witnessing, MSF did not share patient testimony in this case. Testimony was likely unnecessary to generate sympathy with respect to the death and injury of medical humanitarian workers. The decision not to focus testimony on other patients may have been a political choice, as some of those patients were combatants who would not evoke the same sympathy as medical staff or civilians. Instead, the organization chose to highlight the fact that all patients everywhere are protected, reminding the international community of the humanity required even in war.

Tweets about the event shared on the @MSF account include several images that present the terror in the hospital, while the phrases that they are paired with are formal statements made by MSF officials. These statements condemn the hospital attack, bear witness to the loss of patients and caregivers, and call for action in the form of independent investigation. In its initial Internal Review of the attack, MSF shares a description of what happened in the hospital both during and leading up to the attack “to counter speculation and be transparent” (1). This forthright account exemplifies what MSF seeks to incite in an investigation about what went on outside the hospital. An initial reaction to the U.S. Military investigation written by MSF-Belgium’s director Christopher Stokes says that it “leaves MSF with more questions than answers.” Starting

with MSF's example of a thorough account, it demands that testimony recount all known details. MSF requires that the story be fully told, seeking to prevent denial, break silence, and stand in the way of future opportunities for negligence. The organization testifies to preserve the humanitarian exception that protects them and many other organizations. In order to bring attention to the widespread implications of neglect for this protection, MSF is wary of the limitations of "synecdochical" accounts as discussed with regard to Holocaust testimony. The choice to highlight a more collective experience fits with the goal of testimony to prevent the collective suffering that would come from an increase in neglect of the Geneva Conventions.

Next, let us consider another situation in which witnessing at the organizational level was used. In the following case, patients are not used as a source of testimony, but rather as evidence of crime about which the organization testifies. This brings us back to Henry Bulowko's concerns about placing too much emphasis on the value of an individual's experiences as a source of knowledge. Bulowko's concern was that to put too much emphasis on an individual as a source of evidence constitutes a disregard for their dignity (Wieviorka 129). We have already considered that an individual's experiences can represent a powerful source of knowledge in the form of evidence of a crime. However, if MSF regards the circumstances of their patients' lives as evidence, they run the risk of placing the power of that evidence above their patients' humanity. Let us turn to a case in which MSF used the inability to treat patients as a way of presenting this evidence.

Following the Rwandan genocide in 1994, MSF took action in Hutu refugee camps in Zaire to contain an outbreak of cholera. After controlling the outbreak, it

became clear to volunteers that the camps were firmly controlled by “refugee leaders responsible for the genocide.” From the camps, these Hutu leaders sought to take back Rwanda. MSF’s Laurence Binet defines the “refugee leaders” methods as “a massive diversion of aid, violence, propaganda, and threats against refugees wishing to repatriate” (see Appendix C) (Binet 8). All volunteers and MSF sections found this situation to be unacceptable and the first response was to call on other bodies that might alter power dynamics in the camps. When the UN Security Council did not respond to the request of MSF and other NGOs that they deploy the international police force, MSF had to choose between withdrawing and leaving behind patients or continuing its work and effectively bolstering the power of the genocidal henchmen over the refugees. MSF had to decide if it could leave a population in distress and, if choosing to do so, how it would turn its departure into an act of witnessing (Binet 8-9).

In late 1994, the French section left camps in Zaire and Tanzania, publicly explaining their refusal to legitimize and strengthen the “refugee leaders” through their material aid (Binet 9). Through its departure, MSF France refused to provide care – a decision that they labeled as an act of witnessing (Givoni 10). Belgian, Dutch, and Spanish sections of MSF remained, unconvinced that every possible step had been taken to alter the situation in the camps. When their efforts of “humanitarian resistance” and further attempts to engage the aid of the international community failed to improve the situation, MSF Belgium and MSF Holland also left in the end of 1995 (Binet 9).

Departure from the refugee camps in Zaire and Tanzania represents MSF’s refusal to be complicit in the activities of those who were responsible for directly and systematically targeting a population for genocide.

MSF's attitude toward the presence of combatants, as set forth by the situation of the genocidal henchmen who controlled the camps, can be seen for its lasting impact if we return briefly to the more recent Kunduz airstrike. MSF's reason for leaving Kunduz was the destruction of its hospital and the compromised safety of its volunteers. The departure was not framed as an act of witnessing since some MSF doctors continued their work in the region. This is not where the similarity lies. The similarity is seen in U.S. Director Jason Cone's response to the suggestion that "terrorists" had been taking cover in the MSF hospital that was struck. He spoke strongly of MSF's policy when it comes to involvement with dangerous combatant groups, saying:

We do not run our hospitals around the world allowing combatants to enter our facilities and militarize them. That would be a red line for us. It puts both our patients and staff at risk, and we would never accept that under any circumstances. (Neuman)

In the medical world, it is essential that the safety of patients and their caregivers be preserved. Some increased uncertainty must be anticipated in a medical humanitarian mission, especially in an area that has experienced conflict or disaster; however, as Cone points out, allowing persecutors to take charge is not an acceptable condition for medical treatment. This enduring refusal to coexist with persecuting parties can be traced back to MSF's refusal to treat patients in Zaire and Tanzania.

This withdrawal of aid was publicly explained so that it could stand as a public protest to tyrannical control in these camps. MSF hoped that, because it had communicated that it was leaving behind populations in need, those in the international community who had failed to intervene thus far would finally be moved to action. MSF

left because the misuse of its aid rendered the organization complicit and it could not remain active in the area. Rather than treating patients in these camps individually in terms of their medical needs, those medical needs were used as data to prove the unacceptable nature of a situation. The transformation of the suffering of these potential patients into evidence occurred only because it was the final possible effort. It is acceptable to the organization's ethics because the requirements for independent medical treatment could not be met. The use of untreated patients as evidence was MSF's last means of helping them by preventing denial of the effects of the Rwandan genocide and demanding recognition of the refugees' humanity.

In more recent years, MSF again chose departure as its strongest form of communication. However, in the case of MSF's departure from detention centers in Malta, the decision served to bear witness to inhumane conditions, rather than a misuse of MSF aid. In an article MSF explains that between August 2008 and February 2009, the organization provided care for more than 3,000 migrants and asylum seekers in the small Mediterranean nation. Many of them were housed in detention centers, where MSF felt that its ability to provide care was "limited by the living conditions in the centers." MSF repeatedly brought the issue of these poor conditions to the attention of the Maltese authorities. Despite this, MSF attests that it saw no change (MSF, "Migrants, Refugees, and Asylum Seekers"). In fact, a Maltese Ministry of Foreign Affairs official was quoted in January 2009 saying that, "detention is tough on the individual and conditions could be improved, but for us it's a blessing that people get disgusted and want to leave" (Mainwaring 4). This statement shows that the Maltese government actually saw the poor living conditions in its detention centers as a useful deterrent. In response to this attitude



and the failure of the Maltese authorities to act, MSF suspended its intervention in Maltese detention centers in March of 2009 and openly denounced the poor conditions and corresponding risks to which its former patients had been exposed in a report titled “Not Criminals” (MSF “Migrants, Refugees, and Asylum Seekers”).

This move by MSF sent a strong message to the Maltese authorities. In addition to the condemnation communicated through MSF’s departure, the “Not Criminals” report reveals a variety of testimony, vividly shaming Maltese detention centers for the international community to see (see Appendix D). While MSF took this opportunity to speak out about the need for better conditions, it also left patients with even less access to care. As we consider the failure of MSF’s attempts at inciting change in Malta prior to its departure, we understand that the organization needed to find another form of witnessing if they were to be effective. In some cases, countries respond to MSF’s demands for better migrant healthcare. For example, in the same article, MSF describes a situation in the cities of Puglia, Calabria, and Campania in Italy. After MSF expressed deep concerns, authorities in these cities carried out emergency support for migrants by attempting to ensure basic living conditions under MSF supervision (MSF, “Migrants, Refugees, and Asylum Seekers”). It is clear that MSF’s testimony can motivate governments to act, but in the case that testimony is unsuccessful while MSF is present, MSF must find a way to continue resistance. MSF put resistance against neglect by the Maltese authorities before continued medical practice because to allow its deep concerns to be ignored would have served to perpetuate denial and impunity. According to the organization’s report, MSF could not continue to practice traditional caregiving because its fight for health was completely obstructed by the conditions that it faced (“Not Criminals” 3)

One might argue that MSF's choice of departure turns suffering patients into documentation of the government's failures. This might be the case if MSF had presented its former patients simply as figures and statistics exemplifying the problems in Maltese detention centers. The "Not Criminals" report does systematically present requirements outlined by the UN, the Ministry for Justice and Home Affairs, and Maltese Prison Regulations and then describe the ways in which Maltese detention centers fail to meet these standards, including statistics and figures about patients treated by MSF. However, this information is supplemented throughout by patient testimony as it relates to the issues addressed in the report. For example, the report includes the testimony of an Eritrean woman who recounts her horrible mistreatment in a Libyan detention center. Remembering her arrival in Malta she says, "as soon as I realized I was going to be kept in a detention center again, I lost hope and became severely depressed." This woman tried to hang herself twice after her arrival before the Maltese authorities recognized her as a vulnerable person and transferred her away from the detention center ("Not Criminals" 7). These personal statements are not diluted by the formal report, but rather give power to its message while also grounding that message in the experiences of those being represented. The recounting of events through the words of those who endured them ensures that they aren't being rendered spectacular through their retelling. Patient testimony also serves to tie the organizational testimony back to humanity, preventing patients from being seen solely as statistical evidence. This careful combination of personal testimony with specific identification of problems and a call for specific solutions allows MSF to most effectively combat the effects of the attitude of impunity and denial of the Maltese authorities. According to an MSF article from July 2009, the

Maltese authorities began to address some of MSF's concerns after negotiations with the organization. MSF resumed its work in one of the Maltese detention centers, Ta'Kandja, after the government began to make improvements fulfilling some of MSF's requests, including living and hygiene conditions that "allow [MSF] medical interventions to be effective" ("Malta: MSF Resumes Activities"). Despite this success, Ta'Kandja is only one of Malta's three detention centers ("Not Criminals" 2). Change in Malta is clearly a slow process, but MSF has shown as long as it can continue to find ways to testify to the world, denial will not be final.

Looking back on this chapter, we see that history allows us to understand the profound effect of the placement of the individual first-hand account at the center of historical evidence. Such accounts reveal the complexity of a situation and keep our understanding of it rooted in our regard for humanity. As a result, our understanding of events becomes linked to sympathy and a sense of justice. An examination of MSF witnessing practice reveals some of the ways in which MSF uses first-hand testimony to purposefully bear witness to suffering, understanding the link to humanity that such testimony carries. In light of lessons and concerns about witnessing that arise from the study of Holocaust testimony, we begin to seek out the limits of acceptable witnessing. A careful consideration of Camus' ethic of refusal and regard for humanity, which was also influenced by the atrocities of the Holocaust, will further inform the development of these limits and confirm the importance of vivid and faithful testimony.

## Camus and an Ethic of Resistance

The previous chapter developed a set of ethical guidelines that grew out of Holocaust literature and scholarship and which influenced MSF. Camus, who lived through that time period, presents a similar ethic in his 1947 novel, *La Peste*. This novel will be the focus of this chapter. While the previous chapter explores the importance of testimony in our ability to remember and learn from difficult or impossible events, Camus's story will allow us to explore the refusal that motivates those who testify. This ethic of refusal resists acceptance of cruelty and suffering as a natural aspect of our existence. This seems obvious upon first consideration, but as Camus shows, it is not always a simple endeavor. Camus demonstrates that the dilemmas we face daily, particularly in crisis situations or when standing up to cruelty, expose the resister to pushback, personal dilemmas, and even threats to personal safety. Refusal as Camus describes it is steadfast despite these trials.

In *La Peste*, the enemy that kills is an illness. The enemy does not make choices and, therefore, does not respond to reason. The message that Camus conveys through this story is not about the enemy. It is about how we deal with the enemy. It is about how we put refusal into practice despite the ease of accepting the status quo and taking what we see on the surface to be the whole truth. We will find that in *La Peste*, Camus promotes action in favor of protecting humanity over the hatred of a common enemy. We will consider how MSF testimony can achieve the goals laid out in the previous chapter while also promoting and acting in accordance with Camus's ethic of refusal. First we must develop our understanding of this ethic through a discussion of *La Peste*.

Camus's novel, published just two years after the end of World War II, presents the transformation of a city under siege. While the enemy in *La Peste* is not human, the story is commonly viewed as an allegory for the Nazi Occupation of France. Camus's novel addresses resistance against a cruel enemy that transforms a city and the lives of those within it. Camus's understanding of such resistance was born out of his own rebellion, including writing and editing for the resistance journal *Combat* during the war. Such resistance through breaking silence is essential for the sake of humanity because silencing dissidence and eyewitness testimony is the tool of oppression. Camus presents the recognition and critical analysis of tactics of oppression as key elements of working against them.

The protagonist of Camus's novel, who reveals himself at the end of the story as the narrator, is the doctor Bernard Rieux. Rieux's story begins as a plague breaks out in the city of Oran, Algeria, where he and a group of fellow doctors and town leaders must act to resist the increasingly aggressive sickness and mounting death tolls. Sanitation teams are formed to implement increasingly intense prophylactic measures to slow the advance of the disease through the city. Like MSF, Camus's Rieux fights the spread of disease through medicine and finds historical value in the evidence that he records. This text, enriched with ideas from Camus's related works, will provide us with an understanding of how and why people resist. We can apply this understanding of resistance to case studies of MSF testimony in order to continue to critique MSF's approach to witnessing.

In the previous chapter we considered the damage that can come from experiencing deeply unsettling events in silence. Speaking out about events both as they

are endured and retrospectively are important measures to combat silence and forgetting. In the case of historical records, writing from a time of agony preserves an understanding for posterity. Writing from inside an event can also create the impetus for readers of written testimony to act to stop the perpetrator. It also allows others to perceive the horror that is underway and invites them to join in resistance. Taking the time to record history may open ones eyes, compelling one to act with more informed future practices. As discussed in the previous chapter, the way that we speak out has a great impact on the usefulness of the act. In *La Peste*, Camus describes an ethic of facing harsh realities that should be followed when silence is broken. When Rieux first encounters a young journalist, Raymond Rambert, reporting on the living conditions of Arabs in Oran, he asks him if he will be able to report what the doctor has to say without any reservations. He explains that that is the only reporting that he can support (16). This exchange addresses the problem of partial stories as Rieux raises the concern that Rambert has the potential to reinforce and even increase an attitude of complacency amongst his readers in failing to fully report on the living conditions of the poor in Oran under French rule. This guideline is further developed later on when Rieux, as the narrator, explains that “the soul of a murderer is blind” and that “there is no true goodness without as much clarity as possible” (131). Rieux suggests that transparency naturally promotes actions motivated by good intentions, in part because it becomes more difficult to conceal injustice. This passage also more deeply addresses the damages caused by silencing the truth. When Rieux describes the soul of a murderer as “blind,” he refers to blindness that comes from disregard for the value in another human being, the value that connects the murderer to the victim. Rieux warns against this attitude of dehumanization that is

dangerous not only for an individual, but for society. Cruelty can become integrated in society when we proceed with a blind acceptance of the way a system works. When Camus refers to the blind soul of a murderer, he suggests that we are more apt to condone actions when consequences are accepted as inevitable. As human suffering is often seen as a fixed, global reality, those who see a way to instead promote human value must speak out. This is more so the case when speaking of genocide, which came to light with the discovery of the death camps in 1945. Camus wrote of the importance of dispelling blindness just as the world was becoming aware of the Nazis' methodical program of mass murder, which the most powerful world leaders failed to confront.

In addition to demanding that a clear understanding be developed about all the factors contributing to an issue, Camus calls for a vivid representation of events. He demonstrates the importance of presenting details so that they do not just get lost as abstract ideas in the mind of the reader. They must be evocative enough, while faithful to reality, to have a definite impact on the audience. Though a disaster might seem incomprehensible to those who are not experiencing it, it can be presented in a way that a person can relate to and understand. At the initial onset of the plague, Rieux reflects on the lives taken by past plagues, focusing on one that struck Constantinople in the sixth century A.D. and is said to have taken ten thousand lives in one day. The doctor imagines the difficulty one might have in finding meaning in such an unwieldy number. Instead, he asks us to imagine ushering people out of five full cinemas and into one part of the city to be killed (41). This mental image is far more relatable than a number on a page and, as a result, it has a far greater emotional impact. Later on, through his narration, Rieux explains that, though he prefers "the society of the living" it is necessary to discuss the

burials that took place during the plague. He goes on to say that while one could “cover one’s eyes and refuse it, evidence has a great force that will bring everything to light in the end” (171). In bearing witness to the mass burials of the plague, despite the pain of thinking about them, Rieux asks us to accept that understanding his story means opening our eyes to the ugly details. It is important to gain an understanding of cruelty in order to dare to imagine a kinder reality. It is by understanding the cruelty of reality that we begin to feel the refusal that compels us to work to diminish such cruelty. Taken together, these passages require that testimony be expressed in vivid enough detail to evoke an emotional and conscious, informed, and intelligent response.

At the end of the novel, after revealing himself as the narrator of the story, the doctor explains the motivations that lead him to record it. He says that he chose to write “so as not to be one of those who keeps quiet, to testify in favor of the plague-stricken, to leave a memory of the injustice and violence that befell them, and to say simply that what one learns amidst a plague is that there is more in men to admire than there is to despise” (296). Parts of Rieux’s purpose follow the ethic of resistance to silence that we outlined above, such as the urge to speak out against oppression and to provide a full account of the suffering experienced and the intrusive measures taken to protect the population of Oran. Through Rieux’s desire to recount details of victims’ experiences and of the impersonal prophylactic system, Camus echoes the sentiment that emerged upon our examination of Holocaust testimony. This sentiment of indignation, which demands a recollection of the ugly way that death and life came to coincide, requires that a story be told so as to do justice to those who did and did not survive, as well as to prevent ignorant forgetting.



In addition to his ethic of resisting through a dedication to complete and effective testimony in *La Peste*, Camus promotes the recognition of what is human in others and the solidarity that this recognition engenders. This ethic is played out in the internal struggle of Rambert. The young reporter is trapped in Oran, away from the woman he loves, after prophylactic regulations quarantine the city. After spending weeks pursuing a clandestine route out of the city, Rambert decides to stay and continue his work with the sanitation teams. He tells Rieux that, “there is shame in being happy and completely alone” (203). Despite his ongoing feeling that he was a stranger in the city, he says, “this story concerns us all” (204). Rambert implies that it is shameful to recognize the suffering of others and shut it out as one seeks refuge in the pleasures of life. His last minute decision not to leave represents the awakening of refusal in him. He refuses to turn his back to the misery of others. Through Rambert, Camus shows that in recognizing one’s shared humanity with those who suffer, a sense of solidarity is formed that fuels resistance.

Camus returns to the importance of common human values in *The Rebel*, as he describes the motivations of rebellion. He says that, “if men cannot refer to common value, recognized by all as existing in each one, then man is incomprehensible to man” (23). In order to feel solidarity with another, we must recognize the common values that make us human. The recognition of inherent human value is essential to prevent widespread disregard and, as a result, massive disorder. Some amount of solidarity is necessary to preserve human society. Recognition of common values brings us to defend each person’s right to have those values respected. In explaining his decision to stay in Oran, Rambert explains his transition from feeling himself a stranger to the city to feeling

solidarity with the quarantined people. He says, “now that I have seen what I have seen, I know that I am from here, whether I like it or not” (204). After exposure to the suffering of Oran’s citizens, Rambert acknowledges that it is unconscionable to tolerate such conditions. When he says, “I am from here,” he acknowledges that regardless of his origins, he is touched by the experiences of the people of Oran in a way that he cannot ignore. This realization compels him to commit to solidarity and resistance. Camus’s Rambert demonstrates that when one admits that innate values demand that we act with respect for the dignity of others, we feel solidarity that motivates us to maintain a struggle against injustice.

While Rambert eventually feels the undeniable solidarity that drives him to struggle for improvement in Oran, it is Rieux who makes it his life’s work. As the sickness accelerates its advance through Oran and an effective serum has yet to be produced to combat it, Rieux converses with Jean Tarrou, a friend and fellow leader of the sanitation teams. Tarrou points out, and Rieux agrees, that Rieux “is out of his depths” in dealing with the events of the plague (125). Tarrou asks the doctor, “How can you show such devotion even as you do not believe in God?” Rieux explains that, “if he believed in an all powerful God, he would stop his healing...but he believes himself to be on the path to the truth in struggling against creation such as it was formed” (127). Rieux suggests that if he believed in an omnipotent creator, he would not need to heal and could leave healing in the hands of God. Instead, he sees creation as something that is naturally flawed and so he seeks to improve it through his work. After finding himself helpless to stop the suffering of a young child infected with the plague, Rieux tells the priest, Paneloux, that, “he will refuse to his death to love this creation in which children are

tortured” (211). Rieux cannot accept letting people suffer because “it is God’s will.” Rieux recognizes the cruelty of the conditions to which human beings are exposed and his devotion to continuing his work comes from the possibility of diminishing the pain that such conditions inflict.

Rieux demonstrates that the drive to continually struggle against suffering comes from a commitment to justice, rather than from a belief that he can reach a solution. We will consider several passages from *La Peste* that together describe a refusal to accept that people will die no matter what we do. Acceptance of casualties as the status quo diminishes resistance. After thinking on the meaning of the word “plague” and remembering what history had to teach him about its meaning, Rieux finally settles his mind on the key to his ethic. He says, speaking as the narrator, that, “what was essential was to continue to take care in his work” (44). He later explains this idea to Tarrou, saying: “For now, there are many ill and they must be cured. Later, they will reflect on this time and so will I. But for now, the most important thing is to heal them. I defend them as I can, that is all” (127). Rieux understands the system within which he works and recognizes that combatting the plague requires refusal as relentless as the plague itself. He does not have time to think about what might have been done to prevent the events at hand, instead reaching out to those around him to use their skills to join in the struggle.

Though Rieux admits to Tarrou that the plague has surpassed his healing experience, he continues to do what he can with the skills that he has. A failure to do so would be to bend his knees to death and accept defeat. In his 1951 essay, *The Rebel*, Camus elaborates on this rebellion against death despite the failure of optimism. He writes:

Man indefatigably confronts evil, from which he can only derive a new impetus. Man can master in himself everything that should be mastered. He should rectify in creation everything that can be rectified. And after he has done so, children will still die unjustly even in a perfect society. Even by his greatest effort man can only propose to diminish arithmetically the sufferings of the world. But the injustice and the suffering of the world will remain, no matter how limited they are, they will not cease to be an outrage. (303)

Camus explains that the world will never cease to experience injustices, but the rebellious will always see them as an outrage. Because of this, the fight will continue in favor of humanity. According to Camus, human suffering must not be something that we get used to seeing and begin to accept as collateral damage in the form of innocent lives. Refusal endures because as long as there are people who accept the sacrifice of innocents, some amount of injustice will remain. Camus's explanation of the ethic of rebellion here echoes Rieux's explanation of his devotion to treating the ill despite the worsening situation. The lack of an overall solution does not excuse the rebellious from continuous intervention.

In addition to reducing suffering and refusing to bend one's knees to injustice, the unwillingness to be an accomplice to killing is another motivator that Camus includes in the constant struggle against the plague. The refusal to become an accomplice requires one to put the prevention of cruelty before matters of administration and bureaucracy. What is most important is to take action to protect the innocent. Hesitation gives a sickness or another enemy time to do irreparable damage. As the doctors in Oran begin to

realize that the sickness they are dealing with might be the plague and begin considering prophylactic measures, one doctor says: “We must know with certainty that we are dealing with the plague.” He is concerned that certainty is necessary for the extreme measures that the law requires be put in place in the time of a plague. Rieux is quick to refute this mindset, saying instead that, “the question has nothing to do with how dire the measures are, but if they are necessary to stand in the way of the death of half of the city” (52). Rieux’s frustration becomes evident as he asks others to consider life above policy and how the public will receive it. Camus indicates that in extreme circumstances, the primary concern should be saving lives and preventing suffering. Wasting time before taking action lends time to the enemy or illness at hand.

Taking immediate action is just one way Camus demonstrates a refusal to be complicit in killing. Tarrou recounts the story of his past to Rieux, describing his realization that, as a judge, his father was associated with killing. He describes his loss of peace and his renunciation of all that kills or justifies murder (242). He tells Rieux, “there are both terrors and victims in the world, and one must expend all effort not to be with the terrors” (243). Tarrou’s ethic demands rigorous consideration of the consequences of our actions and what actions we are willing to condone. In order to avoid falling in with terror, we have to examine the consequences of our decisions and actions. Good intentions do not guarantee life-affirming results. Despite his seemingly simple commitment to avoid terror, Tarrou is a complex and flawed character. Following the above passage, Tarrou explains to Rieux that he hopes to become a saint (244). The desire to become a saint is an unsaintly cause, as sainthood comes from the humble act of seeking to serve one’s fellow human beings, rather than from seeking greatness. Camus

juxtaposes Tarrou's flawed motivations with Rieux's statement that "what interests [him] is to be a man" (245). The doctor acts as a human being with no intention to set himself above the rest through his actions. Both men work to stop the spread of the plague, but Camus presents to us Tarrou's somewhat self-aggrandizing intentions.

When Tarrou takes ill just as it seems that a new effective serum may have defeated the plague, Rieux considers what actions will be truly life affirming for his dear friend. His decisions with regard to Tarrou show that there are different degrees of refusal, and he must decide which is reasonable. Instead of sending Tarrou into isolation as the law requires, the doctor cares for him in his own home. Rieux's rebellion against the quarantine rules shows his refusal to put his friend in an impersonal system that separates people from their loved ones as they suffer. This begs the question: why does Rieux not demonstrate such refusal in the treatment of all of his patients? In order to combat suffering, Rieux must be reasonable in his resistance. In battling the plague, he has to rely on the system and make compromises. He treats each patient with care within the limits of prophylactic measures in order to protect the common good. In the hospital, he resists against the spread of the plague, one patient at a time. When it comes to Tarrou, the plague's last victim, the medicine has no effect. Faced with his friend's death and suffering, Rieux, for the first time in the novel, treats the individual patient. He makes sure that he is comfortable in his final hours, knowing that he does not risk endangering the common good. When Tarrou dies, Rieux performs one final act of resistance against the plague for the sake of his friend. He gives him a proper burial, showing respect for his friend's human dignity (273-281). Through Rieux's treatment of Tarrou, Camus shows us that resistance may take different forms when it is put in service of the individual or of an

entire population afflicted with an epidemic. In specific circumstances, resistance will face unique limits while aiming to reduce suffering. As we will see in our case studies, one must decide whether or not the system within which one is working is acceptable and valuable to the goals of resistance. Commitment to benevolence must be paired with commitment to understanding a situation and the possible forms of resistance in order to increase the impact of refusal. In Oran the system was required for the well-being of the population, whereas Rieux could tend to his friend's individual needs in the confines of his home after the enforced quarantine had ended.

Whatever shape our resistance takes, it is necessarily borne out of an acceptance of a common value within all people. In *The Rebel*, Camus discusses the solidarity that is derived from this respect for the value in others and unified resistance to forces that do harm to shared human values. He explains solidarity as a limit to rebellion, saying:

Man's solidarity is founded in rebellion, and rebellion...can only find justification in this solidarity. We have then, the right to say that any rebellion which claims the right to deny or destroy this solidarity simultaneously loses its right to be called rebellion and becomes in reality an acquiescence to murder. (22)

Camus describes the limit to rebellion as a point where the value inherent in other human beings is recognized to prevent one from causing suffering for the sake of some cause. Killing for one's cause is unacceptable, because the only true reason to rebel is against suffering. To single a person or type of person out as unworthy of just treatment denies the solidarity that Camus views as essential to rebellious action.

While Camus calls for recognition of shared values in all people and the struggle for justice that this recognition incites, he does not promote veneration of those who carry out this struggle. For example, when the sanitation teams are first formed and Rieux, as the narrator, prepares to discuss them, he explains that he does not wish to assign to them undue importance. He is careful because “in holding good actions in extremely high regard, we indirectly empower malicious forces.” When good actions are too highly revered, Rieux says that, “we are led to believe that they are rare, thus lending validity to the idea that cruelty and indifference are more common motivators than goodness” (131). The men, who work to heal the sick and grapple with enforcing measures to prevent the spread of the plague, are presented as ordinary individuals who feel compelled to use what skills they have to slow down the advance of suffering. In telling this story, Camus demonstrates the rebellion that can spur to action any man who is forced to face the incredible pain of others. In a conversation with Tarrou about finding peace and his comfort with the unfortunate, Rieux says; “I have no taste... for heroism and sainthood. What interests me is to be a man” (245). He sees his work against the terror of the plague as part of his life as a human being, not as something worthy of idolatry. Camus gives us Rieux as an example of someone for whom goodness is the norm and malice is something to be refused. The refusal to idolize goodness supports Camus’s argument that rebellion can be common to all men and women.

Moving forward from this analysis, let us consider the key aspects of Camus’s ethic discussed above. In this way we can consider a set of principles with which to evaluate witnessing by MSF. Camus’s ethic of refusal to bend one’s knees to injustice demands vivid and faithful testimony that promotes understanding and touches our



emotions and intellects before unjust treatment of the innocent. It must be as fully informed as possible so as to dispel damaging ignorance. This refusal is born out of the recognition of inherent human values common to all people and the solidarity that recognition of such values inspires. Resistance does not rely on the promise of a final resolution, as Camus explains that injustice will never be fully eradicated and all we can do is commit to struggle against it with what abilities we possess. The rebellious will never entirely overcome injustice. In rebelling against injustice, we must place actions to reduce suffering ahead of matters such as administration and bureaucracy, which might cause a delay in action and lend time to cruelty. As Rieux shows, we must understand the system through which we must work to seek a cure and alleviate suffering. This enables us to understand if suffering can be better and more quickly reduced by changing the system or by working within it. Finally, resistance must never engage in or condone the killing of innocents. This destroys solidarity and invalidates the original impetus for rebellion.

This nuanced ethic of rebellion certainly poses challenges in its field application. We will revisit the MSF case studies discussed in the previous chapter and determine whether or not the organization practices resistance, as described by Camus, through its actions and testimony. Much like Dr. Rieux, MSF deals first and foremost with caring for suffering individuals, while also informing the decision makers. In the case of MSF, the organization informs the international community. Neither MSF nor Dr. Rieux is responsible for fighting any enemy, although MSF often identifies human factors that amplify the witnessed suffering. The possibility of change for both MSF and Rieux

comes from the ability to heal and from the possibility of awakening rebellion in others who can bring about change.

First, let us consider MSF's response to the migrant crisis that has brought many refugees and asylum seekers to Europe. As we discussed in the previous chapter, MSF testimony through its own web page and through social media has helped migrants share their own written and audiovisual accounts, thus allowing for the organization's overarching testimony to be enriched by individual perspectives. These individual perspectives accomplish Camus's requirement that testimony be vivid enough to evoke a deep understanding of injustice. In vividly describing the plague, Rieux had only words at his disposal. MSF is able to enrich its written testimony with striking visual testimony. The abstract idea of 700 migrants on a ship becomes a sharp reality when images of the overcrowded ship are paired with the words of people who were driven to board such ships by the prevalence of violence and insecurity in their homelands. The same is true with regard to the destruction of the Kunduz hospital and the intolerable conditions of the Maltese detention centers. In making such images available to the public, MSF reveals the shameful conditions that innocent people are exposed to and refuses to let a lack of awareness of suffering contribute to its continuation.

By sharing migrant testimony, MSF breaks through the general complacency before a growing population of uprooted people by underlining their value as human beings. In the previous chapter, we discussed two examples of this. The first was MSF's tweet about a one-year-old Pakistani child who was rescued on the Mediterranean Sea. This message about a young child highlighted the innocence of many migrants. MSF asks the world to see that the lack of access to safe passage puts many innocent people at risk

and relies on what Camus called the internal ethics of refusal before the suffering of innocents. In sharing this piece of information, MSF seeks to arouse a sense of refusal in others. The second example of MSF's resistance against complacency was a quote from a man whose own questions seemed to ask for solidarity from the world. MSF quoted a man who questioned where the world was and insisted that he was not a terrorist. He seemed to trust that if people believed him to be innocent, they would naturally understand his human value and act to reduce his suffering and the suffering of others like him.

MSF attributes the lack of tangible support and solidarity available to migrants not only to a failure to understand the cruelty driving so many people to take such dangerous routes, but also to slow and insensitive bureaucracy. In its letter to nations of the European Union, MSF makes pointed accusations, saying, “[Policies of deterrence] have turned a foreseeable and manageable influx of people fleeing for survival into a policy-made human tragedy... The current approach of ‘non-reception’ and closed borders is causing death, injury and chaos” (MSF “EU: your fences kill.”). In *La Peste*, Rieux urges the implementation of immediate measures to slow the plague and protect the population of Oran as soon as he realizes what may be at hand. In its letter, MSF tells the EU that they failed to take action at the initial signs of a massive migration, and they now have death and injury as proof of the damage that will continue without immediate action. MSF argues for a safe and legal passage to the EU because it argues that the alternative is not fewer migrants, but rather more death. MSF bears witness to this possible future, refusing to accept that such continued suffering is the only option. MSF shows the damage that can happen when bureaucracy slows life-affirming action. There

is a limit to MSF testimony in that no matter how complete a picture is created or how vivid the information shared, MSF cannot force the engagement of those who read its stories. When Rieux explains his care for his patients, saying, “I defend them as I can, that is all,” he describes not only his continued rebellion, but also his limitations. Like Rieux, MSF must continue its work. For the organization, this means bearing witness and lobbying for change while providing medical aid when possible. While MSF is limited to these two methods of demonstrating refusal, to give up would be to fail in its rebellion.

In the case of the bombing of MSF’s trauma center in Kunduz, Afghanistan, providing medical aid was no longer possible. Here, MSF was confronted with a situation where, according to Camus’s ethic, it had to speak out for several reasons. First, the organization saw a system where innocent lives were allowed to become collateral damage. In *La Peste*, Rieux treats patients within a system where loved ones are separated and bodies are disposed of in mass graves. It is all he can do to treat patients within this system, only resisting such cruel facets of the system in the case of his friend Tarrou. However, the humanitarian exception that protects patients and those caring for them is essential to MSF’s ability to continue its work. Thus, to continue this work, MSF had to bear witness to the importance of valuing the protection of each innocent life. Within Camus’s ethic, this understanding of the value of human life is the basis for solidarity.

Also following Camus’s ethic, accepting the killing of innocents destroys such solidarity. Following the Kunduz bombing, MSF testified to exactly this effect when its leaders voiced concerns that the Geneva Conventions needed to be upheld. Geneva Conventions are essentially an institutional force that requires the respect of innocent

lives. If they are not respected then the agreement of nations to coexist with a basic level of cooperation is called into question. Again, there is a limit to MSF's testimony. All that the organization could do was advocate strongly to demand that solidarity be preserved, telling the story of what had happened so that others could understand its concerns.

When MSF's international president, Dr. Joanne Liu, questioned the international environment in which no country was willing to activate the investigative arm of the Geneva Conventions to call for an independent investigation of the Kunduz attack, she indicated that bureaucracy was a part of the problem. She pointed to an "environment of impunity" where nobody was willing to take action (Liu). While MSF could not enforce the Geneva Conventions itself, it did continue to insist that bureaucracy not stand in the way of efforts to reduce suffering worldwide. MSF promoted the use of an investigative body that could condemn U.S. military decisions, enforcing the importance of the protection of innocents. Camus also calls for condemnation that does not hesitate to upset the public opinion. In Rieux's conversation with Rambert, he explains that he can only support unreserved reporting. In seeking an investigation separate from any of the actors connected to the Kunduz attack, MSF also tried to avoid the potential damage of incomplete testimony. The organization delivered a petition to the White House in December 2015 signed by over 547,000 people who called for President Obama to consent to an investigation by the IHFFC. MSF points to this petition as a "groundswell of public support for the principle that even war has rules" (MSF "MSF Delivers Petition"). The enforcement of these rules requires the willingness to condemn U.S. military decisions. While MSF has yet to achieve the impartial investigation that it has demanded, the organization has succeeded in bearing witness to and spreading a message

about the importance of condemning impunity and enforcing the rules that protect innocent people.

Returning to consider the difficult situation in which MSF found itself in refugee camps in Zaire and Tanzania after the Rwandan genocide, we see another challenging situation enabled by impunity. In the previous chapter we focused on MSF's decisions after it became clear that refugee leaders were also individuals responsible for the Rwandan genocide. Before addressing this, we will take a step back to understand how these leaders were allowed to assume such an important role amongst refugees. In Laurence Binet's account of the situation in Zaire and Tanzania, he examines the testimony of many MSF leaders describing their experience throughout MSF's years in the camps. Binet shares the testimony of one MSF France administrator who explains that in Tanzania, MSF was eager to implement effective assistance following "breaks in the food pipeline" the previous year that led to malnutrition in Burundian refugees. He explains MSF's initial blindness to the intricacies of the situation in the camps of Rwandan refugees, saying, "I had never seen so many people, or such a big emergency. We just dived head first into it all...I could see that the refugees were organized, but I didn't realize they were killers." Binet also quotes the MSF France Program Manager who says that MSF volunteers were afraid of a terrible health disaster in light of the "poor state of Burundian refugees in Tanzania, Rwanda, and Zaire," saying that "when the camps were first set up, all the team's energy was focused on that issue" (Binet 12). This case demonstrates the damage that can come from the failure to practice fully informed resistance. As MSF failed to see past the group of refugees to the harmful dynamic of tyrannical leadership within that group, it allowed time for such leadership to establish

itself in the camps. However, it also demonstrates that MSF makes use of its own historical records, learning from its own failure to successfully provide proper nourishment to Burundian refugees. While such intense focus towards proper healthcare prevented MSF from seeing problems within the camps, it simultaneously shows a determination to make improvements based on previous challenges. While MSF's initial blindness gave killers license to hold power in the refugee camps, we can also understand from MSF's recognition of this failure that the ignorant granting of such license will be much less likely in the future.

While it is encouraging that MSF is unlikely to be so blind to the inner workings of its camps in the future, we see here a manifestation of the damage that Camus warns against with his ethic of opposition to damaging ignorance. Let us return to Rieux's statement that, "there is no true goodness without as much clarity as possible" (131). In the context of a medical emergency, the degree of possible clarity is variable. It is likely so variable in the context of MSF's work that volunteers often work only with the information, such as the physical needs of patients, that is right in front of them. They deal with the problems in front of them rather than taking the time to dig for more. However, if the organization is committed to complete rejection of collusion with murderers so as not to invalidate rebellious efforts, it must seek clarity even in states of emergency. If the organization had better understood the organizing forces within its camps from the outset, it might have been able to act more quickly to prevent such a power structure from solidifying.

Instead, the MSF Holland Coordinator in Tanzania describes the effects of the presence of genocide leaders in the camps, saying: "We found bodies in the latrines... At

the end of two months, there were no longer any Tutsi left in the camp. The survivors had fled; they returned to Rwanda or they were massacred” (Binet 13). As the situation was later summarized in an international meeting of MSF Operations Directors, “the refugee camp [had] become a haven for the FAR (Rwandan Armed Forces), shielded by the civilian population.” It was also noted during this meeting that “the amount of aid being distributed [was] more than needed, and a well-organized black market [had] been set up” (Binet 14). As is evident from this collection of details that outline an appalling reality, MSF was very openly grappling with the situation in the camps at an internal level. Since such a power structure was able to develop, we must now look at how it was dealt with once it became evident, as it is clear from the evidence above that MSF was deeply disturbed.

As discussed in the above analysis of Camus’s ethic, rebellion cannot rely on the cessation of all injustice. It relies on a commitment to continually reducing suffering with what tools one has while diligently avoiding collusion with forces that condone the killing of innocents. As the previous chapter discussed, MSF struggled with the decision to leave the refugee camps, the French section departing first in late 1994 and the rest of MSF departing a year later after attempting to change the dynamic in the camps through “humanitarian resistance” and further attempts to engage with the international community (Binet 9). Prior to any departure, MSF spoke strongly to the international community. The ability to impartially address the world is one of MSF’s most important tools after medicine and humanitarian aid. For example, via a press release from MSF International, the organization condemned the leadership taken by genocidal henchmen amongst the refugees, calling “for the deployment of a small international police force



within the camps” and concluding that “a crisis on such a huge scale not only requires but also expects a response on the part of UN member states” (Binet 31). MSF used the tools at its disposal. It shared the reality of the situation in the camps plainly and asked for others with the proper abilities to intervene. It provided aid to patients, but feared that it was also aiding those responsible for the killing of innocents and perhaps even supporting their desires to take over Rwanda.

As we discussed in the previous chapter, MSF left the camps in Zaire and Tanzania because of the refusal to carry on as an unwilling accomplice to murderers. MSF’s departure was not the same as the organization bending its knees in defeat. It used this departure as an outcry of refusal against the impunity of the unprosecuted killers of thousands of innocent people. For example, MSF Belgium announced an information campaign upon its departure to demand “justice for the killers” still present in the camps (Binet 89). In this case we see the extreme challenge to those who seek to practice refusal against the suffering of innocents. MSF left a refugee population, though it was no longer experiencing a medical emergency, with less access to reliable care. It had made use of its forthright testimony and sought help in bringing justice to the refugee camps, and it had failed to bring about the required change. MSF turned to departure as its final tool of action because the alternative was to accept the disregard of the international community and work amongst killers.

Finally, we will return to examine the injustices of the Maltese detention centers and MSF’s response to them in light of our understanding of Camus’s ethics. Let us recall that MSF chose to bear witness to the unacceptably poor conditions in detention centers by first repeatedly calling on Maltese authorities to make improvements, and then, after

this failed to incite change, by suspending its intervention in Malta and speaking out about the atrocious conditions in Malta in its “Not Criminals” report. In Malta, MSF was dealing with a government that did not respect the population of people held in detention. The government saw the disgust of migrants before the conditions in the centers as a useful disincentive to remaining in Malta. MSF was not afraid to condemn the attitude of Maltese authorities. In fact, the organization’s choices in terms of its written testimony follow Camus’s ethic quite closely. MSF was persistent when the Maltese government failed to make changes, continuing to push for improved conditions with testimony, but turning this time to address both the world and the Maltese government through its official report on the situation.

The “Not Criminals” report presents evidence that lays out a clear set of issues in Malta, presenting even the most unpleasant details. In addition to sharing these details in the formal manner, the organization supplements the report with first-hand patient accounts of the horrors that they faced before reaching the detention centers and the poor conditions they found upon arrival. MSF asks us to see not only a set of issues, but also the population of people who are affected. We recognize, through their words, their innate humanity. The patient testimony shared by MSF arises from the voices of migrants who have experienced great hardships and continue to do so. Hearing these people’s stories from their perspective illuminates the fact that they are suffering human beings in need of help. This understanding that MSF facilitates is necessary in order for solidarity to grow.

The Maltese authorities denied solidarity with their attitude of indifference to those suffering in detention. MSF found itself working within a system that was governed

by those who seemed to deny the innate value of the people that MSF sought to care for. MSF was faced with the choice of working within the system, or working to change the system. It had to determine which option would allow it to most effectively treat patients. In reading the “Not Criminals” report, we can come to understand the factors that led MSF to decide that it could not work within the detention centers as they were. For example, the report found that “detention conditions in Malta [could] be directly linked with the most frequent morbidities seen in MSF’s consultations with detainees” (“Not Criminals” 16). MSF was trying to treat patients at the same time that the conditions that the government was exposing them to were making them sick. In addition to the conditions in the detention facilities, the government’s system worked against MSF’s efforts in other ways. For example, MSF discovered that due to a lack of sufficient isolation rooms in the hospital, positive TB patients were started on treatment and then returned to detention centers, exposing non-infected people to these patients (“Not Criminals” 18). Such factors show that, rather than preventing the spread of disease, the system for treatment in the detention centers often allowed it to proliferate.

So, rather than perpetuate the impunity of a government that would let such conditions continue, effectively ensuring that MSF would always have suffering patients to care for in Malta, MSF chose to say “enough.” In choosing to suspend its activities in Maltese detention centers, MSF demonstrated that it would not cooperate with a government that refused to respect basic human values and medical ethics, the topic of the next section. Through MSF’s clear resistance to continued neglect, it demonstrates the power of informed criticism, successfully beginning a process of change in at least one of Malta’s detention centers.

At the outset of this chapter, we began to discuss an ethic of refusal to accept cruel and unjust treatment of innocents. Through an examination of *La Peste* along with analysis of parts of *The Rebel*, we found that this ethic is nuanced, with specific guidelines for strong resistance that seeks to reduce suffering. Through our re-examination of several MSF case studies, it became clear that MSF works diligently to practice an ethic of refusal that is in keeping with Camusian ethics as developed in *La Peste*. Rarely is MSF testimony followed by an immediate change of circumstances. However, the organization continues to provide medical aid where it can while simultaneously decrying discrimination, corruption, impunity, and cruelty that might otherwise pass on in silence. In this way, MSF continues to do the work that it can to condemn and reduce injustice while adhering to medical ethics, to which we now turn.

### The Medical Code of Ethics

In the final section of this study, we will consider medical ethics, as adherence to a medical code of ethics is widely perceived as a physician's duty. In the previous two chapters, we evaluated the manner in which MSF has borne witness to and resisted against several complex and deeply troubling sets of circumstances. We have considered MSF's testimony and advocacy via two related ethics, the first derived from an examination of the motivations and importance of firsthand testimony and the second from Camus's literature promoting an ethic of refusal. While these examinations revealed the complexity of MSF's choices, both ethical lenses affirmed MSF's decisions to speak out or take action while framing such action as a form of testimony. We will now turn to

consider MSF advocacy through the lens of medical ethics, as well as the congruence of medical ethics with the two ethics already discussed.

In the organization's charter, MSF states that its "actions are guided by medical ethics and the principles of independence and impartiality." With this statement, the importance of medical ethics as a key guiding force for MSF's actions becomes clear. Medical ethics are also, naturally, the foremost guidelines for the medical practice of physicians working with MSF. The charter goes on to explain these three central pillars of medical ethics, independence, and impartiality, followed by an explanation of the act of bearing witness. MSF's explanation of this additional dimension of its mission is as follows:

The principles of impartiality and neutrality are not synonymous with silence. When MSF witnesses extreme acts of violence against individuals or groups, the organization may speak out publicly. We may seek to bring attention to extreme need and unacceptable suffering when access to lifesaving medical care is hindered, when medical facilities come under threat, when crises are neglected, or when the provision of aid is inadequate or abused (MSF "Charter").

This principle shows MSF's understanding of the importance of circumstances outside of medical aid with regard to the organization's ability to actually administer healthcare. In placing witnessing as a new dimension of its charter in 1999, MSF made an important move to ask its staff and volunteers to incorporate a respect for human rights within their primary medical goals. As we will further consider shortly, the addition of witnessing

complements MSF's other guidelines, as the core values of medical ethics are complemented with MSF's active advocacy.

For MSF, medical ethics describe more than just what goes on between a doctor or medical organization and its patients. This approach to the situation surrounding a patient's medical problems is supported by WMA (World Medical Association) and BMA (British Medical Association) literature on the relationship between the medical profession and human rights. BMA literature will feature prominently in our discussion of the incorporation of human rights with the medical profession because the organization has studied many relevant issues in a variety of medical settings worldwide. Its international approach to the topic is relevant to MSF, since it is active in a variety of settings around the world. The French Order of Doctors has a "Code de Déontologie Médicale" that is very similar to the ethical codes of other medical associations that have been looked at for this study (AMA, BMA, WMA). However, it does not refer to human rights or international work (ONDM "Code De Déontologie Médicale"). We will return to develop our understanding of the integration of human rights with medical ethics following a discussion of the basic principles of medical ethics.

One of the most well-known guidelines of medical ethics is the Hippocratic Oath. Though the core values of the oath remain important, it is a common misconception that most doctors take this oath upon graduation from medical school (Loudon 414). However, according to the BMA, "in Western medicine, the Hippocratic tradition is still usually seen as the most fundamental underpinning of the moral values shared by doctors" based on the idea that "a doctor's primary and most fundamental duty is to benefit the patient and avoid harm" (6). Indeed, the codes of medical ethics published by

major medical associations show the widespread nature of these foundational ideas. For the sake of this study, we will work primarily with the WMA's Declaration of Geneva, which was developed as a sort of modern Hippocratic Oath. The adoption of the Declaration of Geneva was, in part, a response to the scrutiny to which medical ethics were subjected in the wake of World War II (BMA 5-6). It was important to reestablish guidelines within medical professions in order to reestablish the public trust. It was particularly important to reinforce the guideline of impartiality, following the discovery of the persecution of human beings in concentration camps due to their ethnic origins, nationality, and sexual orientation. We will discover how the WMA's Declaration of Geneva complements the ethics described in the previous two chapters. They were also shaped by the need to confront the fallout from World War II. It is also fitting for us to consider this particular ethic in relation to MSF's work because it focuses on standards accepted internationally.

The Declaration of Geneva first highlights a dedication to "the service of humanity," guaranteeing that a patient's health will be a physician's "first consideration." Accompanying this placement of the patient's health at the forefront is a commitment to act with "respect" for patient information and honor for the "noble traditions of the medical profession." The importance of impartiality in one's medical practice is also emphasized, with the vow that no "considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor" would get in the way of a physician's prioritization of patient health. Finally, the Declaration of Geneva indicates that physicians will not become involved in any violations of "human rights and civil liberties" (WMA

“Declaration of Geneva”). This confirms for us that the primary goal of medicine must be to heal patients, no matter their identity, and to avoid any engagement that might hinder this goal or bring further harm to patients.

MSF’s charter proclaims adherence to medical ethics, also emphasizing “the duty to provide care without causing harm to individuals or groups.” The organization also promises to “respect patients’ autonomy, patient confidentiality, and their right to informed consent” (MSF “Charter”). Both the Declaration of Geneva and MSF’s founding documents place the individual receiving care at the fore. They both also state firmly that physicians must avoid bringing harm to their patients. These two principles are natural components of medical ethics, but they also serve to link medical ethics to the ethics discussed in the previous sections of this study. In the first chapter, we discussed the importance of the central role of the individual witness as a source of understanding. This ethic that emphasizes the value of the testimony of individuals agrees with the prioritization of the individual in a medical context. It becomes clear, therefore, that MSF’s commitment to bear witness to patients’ individual experiences, is also in line with its commitment to medical ethics.

We discover a more complex relationship between Camus’s ethic of resistance developed in the second chapter and medical ethical guidelines that call for avoidance of action that might bring harm to one’s patients. Rather than be content with beneficent actions towards those in need, Camus’s ethic calls for the active resistance of forces that are responsible for or threaten to bring about suffering. As discussed in the previous section, and as we see in MSF’s explanation of witnessing as part of its mission, MSF believes that such active resistance is required when circumstances pose a direct threat to



innocent people or stand in the way of medical aid. MSF must have access to those in need, which may require the denunciation of systemic or human factors that stand in its way, in order to put patient health first. This active resistance also calls for the recognition of any human rights concerns by medical professionals. Therefore, we see that this second ethic pushes beyond the requirements of medical ethics, asking that doctors act to prevent others, not just themselves, from doing harm. This leads us to ask whether or not MSF's dedication to resist through action and conversation shifts the nature of its adherence to medical ethics. We will explore this question with regard to specific cases of MSF advocacy.

MSF shows the value of working within an organization so that doctors can integrate the treatment of patients with the promotion of these patients' human rights. As an illustration, the BMA prefaces its handbook, *The Medical Profession and Human Rights*, with lessons from the experiences of Dr. Wendy Orr, a member of its steering committee. Dr. Orr regularly faced human rights challenges in her position as a District Surgeon in South Africa. Her experience serves as a compelling argument for the relevance of human rights in medical work (xiii). She says that "doctors will inevitably be faced with human rights challenges" that "most doctors are not adequately prepared to deal with," and that these doctors are "more likely to... successfully [take a stand] if supported by other doctors and/or the organized profession" (xvi). Orr raises the concern that generally trained physicians are not prepared to deal with, or perhaps even recognize the human rights violations that they will likely face in their practice. Her concern suggests a failure of traditional medical training to adequately address the fact that doctors will inevitably become witnesses with no guidelines for how to adequately or

effectively bear witness. To consider doctors unprepared to deal with that which they witness assumes that it is the duty of the physician to stand against human rights concerns. Orr asks us to accept that human rights concerns are the business of the physician. Medical ethics place individual health as the primary concern and, as human rights issues often stand in the way of health, it is essential that doctors can understand and try to address these issues. This leads us to realize the elevated importance of a deep respect for and understanding of human rights in the work of MSF, as MSF physicians have an increased likelihood of exposure to human rights violations.

The BMA explains its hopeful rationale for the union of medicine and human rights. It points out the potential of the position of doctors in society to allow them to identify and sound alarms about human rights abuses that impact health (xxvii). The BMA also makes the argument that “from the perspective of medical ethics,” health professionals are obligated to understand and work to fulfill the needs of any “disadvantaged groups” with whom they work, enlisting the aid of professional organizations or political representatives when necessary (xxx). We can imagine that the arithmetical reduction of suffering that Camus calls for in *The Rebel*, in this case taking the form of resistance against human rights violations, can be best achieved when there are many people who are well placed in society to perceive and report such violations. Resistance is most effective when the source of harm is quickly identified and the aid of those who can most effectively combat it can be promptly enlisted.

Overall, the intentions of healing patients and preventing any further harm that might come to them through medical care are core to the mission for doctors under medical ethics. The achievement of these goals is greatly bolstered by simultaneous

awareness of human rights. The WMA, BMA, and an alliance of medical human rights groups have put forward the proposal for a United Nations Special Rapporteur on the Independence and Integrity of Health Professionals to monitor conflict situations and ensure that medical professionals are able to treat patients on any side of a conflict (WMA “World Health Professions Alliance”; BMA 54). This proposal, supported by many health and human rights organizations, further represents a desire and need to integrate medical ethics with a humanitarian understanding and safe reporting avenues so that doctors can do their work. Doctors cannot be expected to make changes on their own to protect human rights, but they are uniquely placed in society to recognize the need for such change and the subsequent benefits to public health of addressing it.

Streamlined avenues for reporting human rights concerns are essential to the ability of a doctor to effectively speak out. The BMA recognizes this fact, saying that, “[doctors] cannot be assigned unlimited obligations and [may] have to rely on their representative associations to lobby on specific human rights issues which impact on health” (39). The combined force of health professionals and organizations with human rights expertise is also supported by the work of Physicians for Human Rights (PHR). The organization relies on the partnership of health professionals with human rights organizations for communication about health violations with international courts, the United Nations, and other regional unions. The organization finds that medical evidence, such as the results of autopsies, medical and psychological examinations, and epidemiological research, is more powerful due to the authority of physicians (PHR). When physicians work with organizations to address human right issues, the power of testimony can be increased.

Such a combination of those with a deep understanding of healthcare and those with experience in advocacy and cooperation with other organizations is built into MSF's organizational structure. MSF members who experience potentially unethical situations in the field confer with members who are experienced with the organization's witnessing practices – and, according to Dr. Bruce Leavitt of UVM Medical Center, final ethical calls are usually made by senior members of MSF France (see Appendix E). Members of associations at regional, national, and international levels direct MSF, each adhering to MSF's Charter and key principles. There are twenty-four national or regional associations that are legally independent and registered under the law of the country in which they are based. To become a member of an MSF association, one must have completed two MSF missions or have logged a combined six months of field experience with MSF. Every association has its own board of directors and president. Each association may function differently, but their purpose is to discuss current and relevant issues at meetings. These topics are then brought to the International General Assembly (IGA) that meets annually and is comprised of two members from each association, two representatives elected by the individual members of MSF International, and the International President. The purpose of the IGA is to “[safeguard] MSF's medical humanitarian social mission, and [provide] strategic direction to the MSF movement.” The IGA also assigns duties to an International Board that meets at least eight times a year to “fulfill governance duties” (MSF “Associations”). This structure allows for the concerns of all individual members to be voiced and, if necessary, brought to the IGA for discussion. This means that individual voices might lead to change that is supported by the MSF movement. As MSF

is independent and does not answer directly to any exterior organization, as confirmed by Dr. Leavitt, it has the freedom to realize change through the structure described above.

MSF's structure allows individual physicians to become effective witnesses. Standing as a group that advocates rather than asking individuals to testify on their own likely has a tremendous impact on the ability of doctors to speak out and increases the power of such advocacy. The BMA agrees that such communication helps expand the reach of testimony through "[construction of] networks with other professionals, human rights organizations and the media to draw attention to the warning signs" (53). MSF physicians can both maintain patient privacy and be outspoken in condemning circumstances in which patient wellbeing is violated because of the support and guidance of the organization as a whole.

In addition to forming safe and reliable avenues for reporting, the BMA recommends that organizations make available for examination case studies of human rights abuses that they have addressed (500). The recording of case studies is also supported by ideas addressed in the previous section of this study, such as the ability of recorded information to open one's eyes to the complexity of an issue and inform future practices. Again, we see support for MSF's approach, as the organization has multiple options for reporting the details of the cases that it attempts to manage. For example, CRASH (Centre de Réflexion sur l'Action et les Savoirs Humanitaires) is a project created by MSF in 1999 to "encourage debate and critical reflection on the humanitarian practices of the association, in order to improve its actions" (MSF "Crash"). A similar set of literature available for study is MSF's Speaking Out Case Studies, which reflect specifically on "the organization's actions and decision-making process during

humanitarian emergencies that have led it to speak out” (MSF “Speaking Out Case Studies”). These two resources are specifically designed to foster understanding and analysis of MSF’s previous efforts of resistance. These materials are a valuable resource to aid MSF’s staff and volunteers in integrating their practice with an understanding of human rights. Moreover, such open communication about MSF’s actions using a variety of testimony of those involved keeps an open dialogue. This enforces accountability and the opportunity for any questionable actions to be dissected and confronted.

This study has revealed that the core principles of medical ethics – the prioritization of patient health and the prevention of harm to one’s patient – are best practiced alongside respect for the protection of human rights. The core principles above also endorse the values of individual first-hand testimony and refusal to accept harmful circumstances that were discussed in the previous sections of this study. Doctors have a great potential to apply these principles to the humanitarian and medical treatment of their patients. Therefore, they must understand human rights and have safe and reliable partnerships that allow them to speak out when such rights come under threat. MSF is committed to the ethical treatment of its patients and has cultivated a practice of often outspoken witnessing that allows doctors to seek the maximum impact of the knowledge that they gain in their medical practice. Given the relevance of addressing the impact of human rights issue on health, we will now examine whether or not MSF’s responses to such issues are within the parameters of medical ethical guidelines.

Take for example MSF’s response to its experience with the hardships endured by migrants and asylum seekers in Malta. The BMA points out that, “health professionals are often early witnesses of evidence of abuse when they work in field hospitals, refugee

camps or as aid workers providing humanitarian relief.” This allows them to “assist the work of judicial institutions and draw public attention to breaches of international standards.” Finally, the BMA notes that when doctors choose to denounce conditions, they must “think through implications for their own patients.” The goal is for healthcare professionals to identify unacceptable treatment and conditions, while ensuring that patients will not become victims of reprisal (BMA 259-260). In the case of the Maltese detention centers, MSF doctors were unable to prioritize patient care by medical means, as the efficacy of medicine was seriously limited in the poor living conditions available to patients. With the guidance of its understanding of international standards regarding the minimum requirements for detention centers, MSF was able to advocate for patient care from the perspective of human rights requirements. In cases such as this where there are barriers to proper care, MSF’s humanitarian experience enables it to support doctors in pursuing such alternative avenues.

MSF’s concerns about conditions for patients in the Maltese detention centers are further validated by the BMA’s guidelines for the treatment of asylum seekers in *The Medical Profession and Human Rights*, which warns against the detention of asylum seekers except for in “exceptional circumstances” (399). It could be argued that, given the large influx of migrants and asylum seekers to Malta in 2008, the circumstances were exceptional. Over the course of that year, Malta received over 2,700 new arrivals, many of them arriving after long and dangerous journeys (MSF “Migrants, Refugees, and Asylum Seekers”). Malta had to find or create a place for these arrivals. Even with this exceptional influx of migrants, the BMA specifies that, “those who need to be detained should be treated to international standards in humane conditions” (400). Detainees

experienced overcrowding, poor sanitation, the mixing of healthy patients with those with infectious diseases, limited access to basic material goods, and other unacceptable conditions. Altogether, international standards were not met. As a result of the authorities' failure to adequately improve conditions, a subset of the population was excluded from effective treatment.

Considering medical ethics and their relationship to human rights, we can ask ourselves again whether MSF was right to leave Malta as an act of witnessing. Decisions like this are not subject to any authority outside of MSF, so members from the field site and members with more authority who step in to help with such decisions from the national associations must deliberate about what choice is best in order to fulfill the goals of the movement (Leavitt). We have established that the physician's first concern must be the health of their patients. Therefore, it seems contrary to this primary duty to leave a population with still-suffering individuals. However, it is important to note that the priority is health, not healthcare. Conditions may at times be such that healthcare is not the best route to health. To account for this, MSF has shifted its ethical guidelines away from purely medical ethics. The organization has evolved its understanding of treatment to include calculated acts of witnessing, directed at improving conditions that bear on patient health. In order to condone this departure from Maltese detention centers, MSF had to weigh the improvements likely to arise from this advocacy to have a greater impact on health than the continued treatment of patients subject to abject conditions.

Another important consideration in assessing MSF's decision to leave Malta is the ethical requirement that physicians avoid bringing harm to their patients. This act did not bring harm to patients in any way that has been reported. Instead, MSF's departure



was an act of advocacy against harmful conditions performed with the goal of reducing harm to patients and other individuals in the detention centers. Since conditions were not combatable with healthcare, MSF focused on reducing harm by drawing attention to serious issues and combatting the impunity of the government. As discussed in the previous section, there have been some positive changes to at least one of the detention centers since MSF's departure, which led to MSF's return (MSF "MSF Resumes Activities"). It is important to note that MSF may at times enlist the aid of other organizations or political representatives to advocate for a population that is mistreated. This option should be considered instead of departure if it could be an equally effective alternative. MSF only turned to departure after repeated attempts to incite change through communication with authorities while continuing to provide aid. Overall, in our analysis of MSF's departure from Malta, it becomes clear that MSF's combined humanitarian and medical practice has led it to develop a shifted medical ethic wherein advocacy is an indirect treatment option when traditional healthcare is ineffective.

Bearing in mind our discussion of the integration of human rights with medical practice, let us turn our attention to MSF's departure from refugee camps in Tanzania and Zaire. In the above discussion of human rights concerns encountered by physicians, we found that communication with other organizations, such as the United Nations and local authorities, can be an important measure. Additionally, making the management of these issues public makes the medical profession as a whole more capable of addressing similar issues in the future. As we have discussed in previous sections of this study, in the case of the tyrannical rule in refugee camps following the Rwandan genocide, MSF sought the aid of the UN Security Council and communicated with other NGOs working in the

camps (Binet 8). This communication shows that MSF sought aid and advice from other organizations involved with human rights prior to making their final decision to depart. After having left the camps, MSF made its communications about what was going on in the camps and the decision to leave the camps available to the public through the Speaking Out Case Studies site. This information may serve to improve other physicians' understanding of possible warning signs or courses of action in the field. Sharing such information improves the international understanding of how human rights concerns interact with medical and humanitarian aid.

While MSF's open communication about its decision to leave the refugee camps is beneficial to medical practice, we must examine whether or not its decision to leave the camps was permissible under medical ethics. Let us consider the WMA's Declaration of Tokyo, which stresses the importance of the neutral doctor. The Declaration of Tokyo exists primarily as an international ethical guideline for physicians faced with situations where they are at risk of becoming either directly or indirectly complicit in torture. Both torture and genocide are extreme violations of human rights with which doctors cannot be involved while maintaining the neutrality required by medical ethics. The WMA does not have specific guidelines for physicians who come into contact with genocidal leaders, so we will use relevant sections of The Declaration of Tokyo to guide our ethical analysis.

The WMA states that "the physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment." We can agree that leadership that seeks to eliminate a group of people based on their identity is inherently engaged in inhumane and degrading treatment. Therefore,

we will consider the ethical requirement that physicians avoid material aid that facilitates such treatment in our discussion of MSF's departure. The WMA's declaration also urges that "the physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose" (WMA "Declaration of Tokyo"). This statement advises against association with all motives that oppose a physician's care for suffering people.

Let us consider how these guidelines for physician neutrality are pertinent to MSF's decision to leave the camps of Rwandan refugees. As has been detailed in previous sections of this study, genocide leaders ran the refugee camps in Zaire and Tanzania where MSF provided aid. MSF understood that in working in these camps, it was "further strengthening the power of the [genocide leaders] over the refugees." MSF saw that "its aid [was] instrumentalized by leaders who [used] violence against refugees and [proclaimed] their intention to continue war in order to complete the genocide they had started" (Binet 8). It is clear from MSF's account that its provision of aid for use by the genocide leaders bolstered the leaders' power. The Declaration of Tokyo warns against such material aid for those who deny the dignity of others. While the Belgian section of MSF did attempt to "[loosen] the [genocide leaders'] hold over the aid," this was unsuccessful (Binet 9). It was not within MSF's power, as a humanitarian medical organization, to change the power structure in the refugee camps. Therefore, MSF could not change the negative impact of its well-intentioned aid. Indirectly supporting genocide leaders through its aid was unacceptable to MSF's mission to provide for a population displaced by genocide. MSF was not able to provide aid while maintaining the neutrality necessary for ethical practice. Given MSF's attempts to alter the situation in the camps

and to engage the UN in doing the same, MSF's eventual departure, carried out as an act of witnessing, was acceptable given the requirement of neutrality for ethical medical practice. Again, MSF's combined humanitarian and medical ethic calls for strong advocacy when direct aid is not an option. In the case of MSF's withdrawal from Rwandan refugee camps, its advocacy served as its alternative form of treatment.

In the two preceding cases, MSF's withdrawal of aid as a form of witnessing serves to illuminate the shift in medical ethics that comes with MSF's emphasis on human rights advocacy. These cases have required us to question the limits to MSF's activity under medical ethics. MSF's response to the European migrant crisis can help us understand the relevance of medical ethics to MSF's less controversial forms of advocacy. In this case, MSF combined its continued treatment of patients with outspoken advocacy for safer migrant passage. This advocacy comes from an extension of the duty to avoid harm, instead actively combatting harmful circumstances. There is no specific guideline available from medical ethics for how to approach evidence of unacceptable circumstances gained through medical access to individuals or populations. What is clear is that such evidence must be shared in order to draw attention to the issues at hand. MSF has created a network of communication through its letter to European leaders and the sharing of testimonials from refugees rescued by MSF on the Mediterranean. One important challenge is to balance the sharing of information to create public and political awareness and combat impunity with the potential of this information to come back against a patient's well-being. In the case of the migrant crisis, MSF speaks out very forcefully against the impunity of governments that it believes to be at least partially responsible for the poor safety of migrants reaching Europe. It shares testimony from

individuals, including images from which they might be easily identified. MSF has little cause for concern that the criticized European governments might retaliate and bring harm to patients. The organization would need to more carefully consider the public sharing of such severe communications in countries with a history of open violence against parts of their populations. For example, MSF did not share testimony from individuals who might have been at risk of reprisals in Rwandan refugee camps. MSF must continue to take care in its human rights communications in order to combat and not provoke harm. Overall, in the face of disturbing circumstances caused by the migrant crisis, MSF was able to practice its ethic of mixed medical and human rights considerations, both medically treating and calling for increased humanity in the treatment of migrants by the countries receiving them.

Finally, in the case of Kunduz, we see how MSF reacts in the face of breaches to international medical ethics. The ethics that MSF considers in this case address how the international community treats medical practice. As we know, MSF's medical work in Kunduz was halted by a U.S. airstrike that seriously damaged the trauma center where MSF treated anyone in need so long as any weapons were left outside. In line with traditional medical ethics, MSF continued to hold healing as a top priority after the attack, transferring critical patients to other health facilities ("MSF Internal Review" 12). MSF's outspoken response to this attack had to do with "one of the key principles of international humanitarian law," the guaranteed "protection of and medical care for injured combatants and civilians" (BMA 246). This component of international law is essential to the ability of doctors to practice medicine in conflict situations. It asks that both doctors and militaries put patient health before patient identity. When such

regulations are violated, it is important to speak out, because “it is widely agreed that the culture of impunity is one of the major obstacles to protecting civilians and health workers in conflict situations” (BMA 260). In speaking out against the U.S. attack, MSF asked the international community to reflect on the value of protection for healthcare providers and their patients in the context of conflict. It sought to underscore the need for diligence in the protection of hospitals in combat zones so that hospitals can continue to be neutral and safe places where doctors are able to prioritize patient health. In calling for an investigation of the attack on the Kunduz trauma center, MSF asked for the re-establishment of the ethical imperative that patients would be safe from intentional harm in a healthcare setting.

From the consideration of these four cases through the lens of medical ethics, it becomes clear that the ability to provide effective care to its patients and ensure that no further harm comes to them is a driving force of MSF action and advocacy. When these principles are threatened, MSF considers the most powerful way to demand the most effective treatment of its patients. It communicates with other humanitarian organizations and regional authorities to try and engage them in improving circumstances that cannot be improved through medicine. Advocacy through withdrawal, such as in the case of Malta, functions as a form of treatment when MSF cannot effectively treat its patients medically. Witnessing also functions as the only type of treatment that MSF considers ethical when it cannot provide aid without bolstering forces that in turn promise to harm those whom MSF treats, such as in the case of Rwandan refugee camps. MSF aids its own members and volunteers and other medical practitioners in understanding the complexity of human rights concerns that bear on health. It does so by producing public

reports about its own experiences in challenging circumstances. We have also established that it is important for MSF to consider the safety of its patients and healthcare providers so that these groups do not experience reprisals when it chooses advocacy as a means of treatment. MSF achieves an increased confidence and safety in its advocacy by speaking out through the voice of the organization, rather than asking individual doctors to stand up against human rights violations on their own. Overall, we find that MSF has developed unique humanitarian medical ethics that consider acts of witnessing when it judges these acts to be more powerful than the treatment that it can provide or when treatment is impossible.

## Conclusion

In each chapter of this study, we have explored a source of ethical guidelines – lessons from Holocaust testimony and scholarship, Camus’s ethic of resistance, and medical ethics. Discussion of each of these ethics has contributed to our understanding of the motivations behind the sharing of testimony. An understanding of these motivations has allowed us to better understand why witnessing has been included among the goals of the MSF movement. Each has also provided us with ethical principles in order to understand and assess MSF’s responses to circumstances that threaten the well-being of its patients. From analysis of MSF’s witnessing practice, an understanding of the organization’s motivations and ethical guidelines has emerged on which to reflect.

MSF’s actions and testimony are primarily driven by a commitment to independent medical ethics for the good of any patient who comes under the

organization's care. MSF supplements this focus with the intention to bear witness to and reveal to the world the disturbing circumstances to which its patients are subjected. There are many internal goals that lead MSF to speak out as it does. To begin, the organization is able to provide the most complete account of the circumstances and events that it witnesses in the field by testifying as events occur. MSF is also able to share the words of those who experience the suffering that it witnesses. In this way MSF can enrich an encompassing narrative with individual accounts. Testimony is rendered more impactful by this insight into the human experiences resulting from the harmful circumstances that MSF seeks to condemn. Moreover, by providing patient testimony, MSF avoids presenting patients' suffering as evidence disconnected from their humanity.

MSF testimony preserves evidence and creates an important historical record. It prevents denial of events of the past and present. It breaks silence that enables injustice and impunity, instead illuminating the shared humanity among all people. Recognition of this shared humanity further inspires resistance. Outspoken testimony is an important form of resistance, as silence is a tool of oppression and also leads to forgetting that hinders our ability to learn from the past. Breaking silence and presenting the experiences of individuals allows us to honor those whose suffering prompted change. In order to truly honor these individuals, Holocaust literature teaches that evidence of suffering must be recounted faithfully, without dramatization, spectacle, or the softening of details so that they might be more easily processed. One must present evidence vividly so that its full power to evoke resistance is felt.

Camus's writing teaches us that MSF's resistance to suffering must be approached as a task without assured success. There is no end to injustice and cruelty, but



MSF continues to confront cruel and unjust circumstances by ethical means. Camus shows us that rebellion can be common to all people who recognize the common value of others, so that resistance can also be endless. MSF's resistance may take many forms, including reports on unacceptable conditions, the sharing of patient testimony, appeals to governing bodies, and refusal to provide aid until conditions change. According to Camus, resistance must never give way to blind violence, accept suffering as a necessary consequence, or support the motives of killers. MSF acts within these parameters or, in Camusian terms, limitations in order to remain faithful to the initial intentions of its resistance. MSF is mindful of its medical mission to act so as to have the greatest impact on its patients' well-being. This is possible when the organization seeks clarity in its understanding of circumstances and makes use of historical testimony to inform its practice.

MSF's resistance to injustice is a result of its respect for human rights and the realization that healthcare workers are uniquely aware of violations to these rights. By encouraging conversation within the organization about the ethical concerns of individual members and volunteers, MSF prevents a veil of silence from hiding injustice. It supports its members in bearing witness to harmful circumstances and bears witness at an organizational level through its public testimony and outreach to government officials and other organizations with the power to intervene. This organizational structure is important to MSF's ability to care for its patients, because healthcare and humanitarian aid cannot always be effective on their own. Sometimes continued aid is ineffective, insufficient, inhibited, or as MSF would contend, unethical. As Rieux's narrative demonstrates, government structures are slow to adapt and respond to crisis situations. As

Dr. Wendy Orr shows, doctors in the field cannot always remain apolitical. Following the Holocaust, silence is unacceptable. MSF has sought to be a nongovernmental organization that becomes politically engaged by speaking out against inhumane conditions and the impunity of the powerful. Through the practice of witnessing, MSF resists against breaches to human rights. MSF seeks to transcend borders and boundaries and open our eyes to the dignity and shared qualities of those different from us.

To be sure, MSF represents the cultural assumptions and value judgments of a wealthy, Western nation. This might invite criticism of its ethnocentrism or even neocolonialism. However, the world is a stage for the powerful. Most often, these powers are working for very narrow national interests. Organizations, such as MSF, have become powerful entities working in some of the most geopolitically contested regions in the world. Powerful forces require powerful counterforces; although French in origin and in executive oversight, MSF does seek to include the voices of the oppressed as well as the voices of doctors and humanitarian specialists throughout the world in its decision making processes.

## Appendix A

MSF's letter to the EU:

We send you this letter today, together with a lifejacket belonging to one of the 15,000 people rescued at sea by Doctors Without Borders/Médecins Sans Frontières (MSF) since May. This poor quality life vest was the only security a man, woman, or child had while trying to cross the sea to Europe. These jackets sometimes feature handwritten prayers for a safe passage, or phone numbers of relatives and friends to be contacted in case the person wearing it does not make it. This is a reminder that the people embarking on these journeys are fully aware of the risks they are undertaking, and the sheer desperation motivating them to put themselves and their families in so much danger.

We are treating the medical consequences of the journey, including hypothermia and dehydration, but also acute conditions requiring medical evacuation such as septic shock, pneumonia, and wounds inflicted by abuse and violence. We are trying to improve living conditions for people stranded in Greece, Italy, FYROM, and Serbia. But all of our work amounts to filling the gaps left by states unwilling or unable to fulfill their responsibilities.

Many people are fleeing war, oppression, and torture. Others are fleeing poverty, persecution, and human rights violations. All want a safer and better life. But their exit routes are growing scarcer, while refugee hosting countries such as Lebanon, Turkey, and Jordan become more overburdened. The world is faced with the worst displacement crisis since World War II. The conflict in Syria shows no sign of abating. Yet Europe is closing its borders.

Categorizations of "migrants," "refugees," or "asylum seekers" do not adequately or fairly describe the reality that pushes people to embark on long and dangerous journeys. Every person has a story to tell about why they were forced to risk their lives to reach Europe. When people need medical care, food, water, and shelter, they should receive this assistance regardless of their legal status.

When your ministers gather this Monday for yet another summit on the so-called "migration crisis," bear in mind that the decisions adopted in previous summits have so far largely failed to improve the situation. Some measures have made the situation worse: fences and forced fingerprinting only push people to choose more clandestine and dangerous routes. Lives continue to be lost at sea, in the back of trucks, and in makeshift camps where people live in unacceptable conditions in the heart of the European Union. It is time to put an end to these policies of deterrence. They have turned a foreseeable and manageable influx of people fleeing for survival into a policy-made human tragedy on Europe's beaches, borders, train platforms, and motorways. They are jeopardizing the right to seek asylum. The current approach of "non-reception" and closed borders is causing death, injury, and chaos.

Europe is faced with an increasing number of people seeking assistance and protection. These people are only a small portion of the millions who are fleeing intolerable suffering. No matter the obstacles, they will continue to come. They have no other

choice. The current policies are untenable in the face of this situation. The only way Europe can prevent a worsening crisis on its territory is to replace the smugglers by providing a safe, legal, and free alternative. We ask you to provide safe passage. Legal crossing of sea and land borders must be authorized for asylum seekers into and inside the EU. All forms of legal avenues allowing refugees to reach Europe must be put in place urgently. Efficient solutions to relocate asylum seekers from one EU member state to another must be found. Effective access to coherent asylum procedures and assistance should be provided at entry points, throughout Europe and along migratory routes. Swift registration and access to temporary protection should be provided upon arrival. Legal migration pathways must be created. Dignified reception conditions must be offered to all.

Make this life vest redundant. Provide humane, dignified, and safe alternatives.

## Appendix B

Excerpts from MSF's initial internal review of the 2015 airstrike on a Kunduz, Afghanistan trauma center:

Background:

In 2014, more than 22,000 patients received care at the hospital and 4,241 surgeries were performed. From January - August 2015, 3,262 surgeries were conducted.

MSF activities in Kunduz were based on a thorough process to reach an agreement with all parties to the conflict to respect the neutrality of our medical facility. In Afghanistan, agreements were reached with the health authorities of both the government of Afghanistan and health authorities affiliated with the relevant armed opposition groups. These agreements contain specific reference to the applicable sections of International Humanitarian Law including:

- Guaranteeing the right to treat all wounded and sick without discrimination
- Protection of patients and staff guaranteeing non-harassment whilst under medical care
- Immunity from prosecution for performing their medical duties for our staff
- Respect for medical and patient confidentiality
- Respect of a 'no-weapon' policy within the hospital compound

These commitments were discussed and endorsed by the militaries involved in the conflict, including all international military forces such as the United States, both the regular and special forces branches, ISAF and later Resolute Support command structures, Afghan National Army, National Police and National Security agencies as well as the military command structures of armed opposition groups. The local military hierarchy of all warring parties endorsed compliance by agreeing to a no-weapons policy within the MSF facility.

These agreements were brought into practice through the implementation of the no-

weapons policy in the KTC, relying on civilian, MSF-employed unarmed guards as well as an ongoing process of bilateral discussions with the community and all parties to the conflict.

The week before the airstrike:

Monday –

Heavy fighting between Afghanistan government and Taliban forces<sup>4</sup> took place in Kunduz city in the early morning on Monday 28 September. The MSF team launched a mass casualty plan in preparation to receive an expected large number of wounded patients.

MSF requested medical staff and staff essential for running the hospital to stay at the hospital to avoid commuting in the city and being unable to reach the hospital. At noon the same day, MSF national and international staff that were not essential for the running of the hospital were sent home.

As is standard practice, MSF teams did not ask which armed group patients belonged to. It was clear however, based on observation of uniforms or other distinctive identification, that a number of wounded combatants were being brought to the hospital.

When fighting intensified, MSF proposed to patients to remove any military identification or clothing from the hospital, as is our standard practice to reduce possible tensions in the hospital with both parties to the conflict being treated within the facility. MSF team received a visit of a representative from the Afghan government forces to organize the rapid referral of wounded government patients to another hospital. While the majority of the wounded Afghan government forces were referred, the most critical patients remained in the hospital. As far as our teams are aware, after this time, no more wounded Afghan government forces were being brought to the Trauma Centre.

Tuesday –

An MSF press release was issued stating that “the hospital is inundated with patients” and that “we have quickly increased the number of beds from 92 to 110 to cope with the unprecedented level of admissions, but people keep arriving. We have 130 patients spread throughout the wards, in the corridors and even in offices. With the hospital reaching its limit and fighting continuing, we are worried about being able to cope with any new influxes of wounded.”

Due to the increased intensity of fighting in Kunduz, MSF reaffirmed the well-known location of the KTC by once again emailing its GPS coordinates to US Department of Defense, Afghan Ministry of Interior and Defense and US army in Kabul. The GPS coordinates provided for the KTC were: 36°43'4.91"N 68°51'43.96"E (for the main hospital building) and 36°43'4.29"N 68°51'42.62"E (for the administrative office building within KTC).

Confirmation of receipt was received from both US Department of Defense and US army representatives, both of whom assured us that the coordinates had been passed on to the appropriate parties. Oral confirmation was received from the Afghan Ministry of Interior. MSF also shared the GPS coordinates with a UN intermediary who confirmed transmission directly to Operation Resolute Support.

Wednesday –

Out of 130 patients in the KTC on Wednesday, there were approximately 65 wounded Taliban combatants that were being treated. Starting this same day a large number of patients discharged from the hospital, including some against medical advice. It is unclear whether some of these patients discharged themselves due to the discussion to free some beds between MSF and the Taliban representative or whether there were general concerns about security as rumours were circulating of a government counter-offensive to reclaim Kunduz city. At the same time as patients were being discharged from the hospital, new patients were being admitted.

By Wednesday, MSF was aware of two wounded Taliban patients that appeared to have had higher rank. This was assumed for multiple reasons: being brought in to the hospital by several combatants, and regular inquiries about their medical condition in order to accelerate treatment for rapid discharge.

Thursday –

MSF received a question from a US Government official in Washington D.C., asking whether the hospital or any other of MSF's locations had a large number of Taliban "holed up and enquired about the safety of our staff. MSF replied that our staff were working at full capacity in Kunduz and that the hospital was full of patients including wounded Taliban combatants, some of whom had been referred to the MSF medical post in Chardara. MSF also expressed that we were very clear with both sides to the conflict about the need to respect medical structures as a condition to our ability to continue working.

A UN civilian/military liaison advised MSF to remain within the GPS coordinates provided to all parties to the conflict as "bombing is ongoing in Kunduz."

Friday –

On Friday, two MSF flags were placed on the roof of the hospital, in addition to the existing flag that was being flown at the entrance to the Trauma Centre.<sup>8</sup> The KTC was also one of the only buildings in the city that had full electricity from generator power on the night of the airstrikes.

Throughout the night before the airstrikes began, all MSF staff confirm that it was very calm in the hospital and its close surroundings. No fighting was taking place around the hospital, no planes were heard overhead, no gunshots were reported, nor explosions in the

vicinity of the hospital. Some staff mention that they were even able to stand in the open air of the hospital compound, which they had refrained from doing in the days prior, for fear of stray bullets from fighting in the neighborhood around the hospital. All staff confirm that the gate of the hospital was closed and that the MSF unarmed guards were on duty.

All of the MSF staff reported that the no weapons policy was respected in the Trauma Centre. In the week prior to the airstrikes, the ban of weapons inside the MSF hospital in Kunduz was strictly implemented and controlled at all times and all MSF staff positively reported in their debriefing on the Taliban and Afghan army compliance with the no-weapon policy.

From all MSF accounts, there was no shooting from or around the Trauma Centre and the compound was in full MSF control with our rules and procedures fully respected.

US aerial attack (early AM Saturday October 3, 2015) –

According to all accounts the US airstrikes started between 2.00am and 2.08am on 3 October.

Despite it being in the middle of the night, the MSF hospital was busy and fully functional at the time of the airstrike. Medical staff were making the most of the quiet night to catch up on the backlog of pending surgeries. When the aerial attack began, there were 105 patients in the hospital.

A series of multiple, precise and sustained airstrikes targeted the main hospital building, leaving the rest of the buildings in the MSF compound comparatively untouched. This specific building of the hospital correlates exactly with the GPS coordinates provided to the parties to the conflict (GPS coordinates were taken directly in front of the main hospital building that was hit in the airstrikes).

When the first airstrikes hit the main hospital building, two of the three operating theatres were in use. Three international and twenty-three national MSF staff were caring for patients or performing surgeries in this same main building. There were eight patients in the ICU and six patients in the area of the operating theatres.

Those who survived the US airstrikes were direct witnesses of the attack from the different locations inside the MSF compound.

MSF staff recall that the first room to be hit was the ICU, where MSF staff were caring for a number of immobile patients, some of whom were on ventilators. Two children were in the ICU. MSF staff were attending to these critical patients in the ICU at the time of the attack and were directly killed in the first airstrikes or in the fire that subsequently engulfed the building. Immobile patients in the ICU burned in their beds.

The MSF international staff members sleeping in the administrative building were woken

up by the sound of the first explosions. An MSF nurse arrived at the administrative building covered from head to toe in debris and blood with his left arm hanging from a small piece of tissue after having suffered a traumatic amputation in the blast. The MSF nurse was bleeding from his left eye and oropharynx. Immediate treatment was provided in an attempt to stabilize the nurse by the medical team in the administrative building.

Many staff describe seeing people being shot, most likely from the plane, as people tried to flee the main hospital building that was being hit with each airstrike. Some accounts mention shooting that appears to follow the movement of people on the run. MSF doctors and other medical staff were shot while running to reach safety in a different part of the compound.

One MSF staff member described a patient in a wheelchair attempting to escape from the inpatient department when he was killed by shrapnel from a blast. An MSF doctor suffered a traumatic amputation to the leg in one of the blasts. He was later operated on by the MSF team on a make-shift operating table on an office desk where he died. Other MSF staff describe seeing people running while on fire and then falling unconscious on the ground. One MSF staff was decapitated by shrapnel in the airstrikes.

After the US airstrike:

When the airstrikes ended the MSF staff reported a chaotic scene of wounded arriving at the administrative building with people in shock, vomiting and screaming.

Immediately after the airstrikes, some of the MSF medical team began life-saving medical interventions on the wounded. MSF staff collected what medical material they could and converted one of the administrative rooms into a makeshift emergency room, performing surgery on an office desk and a kitchen table. The medical team quickly tried to organise the patients and to triage the critical from the non-critical patients. Patients in a critical condition included MSF staff with traumatic amputation of the leg, open chest injury, and ruptured abdominal blood vessel, amongst other injuries. MSF medical staff attempted to stop the severe bleeding of some patients, treated shock due to hypovolaemia, inserted chest drains, and provided treatment for pain management. At least two MSF staff died while being operated on in the administrative building.

The MSF coordinator contacted ambulances from the Ministry of Public Health (MoPH) provincial hospital in Kunduz city to collect the wounded.

The MoPH ambulance arrived at the Trauma Centre at approximately 5.45am. Several staff reported that at the same time as the arrival of the ambulance, some Afghan Special Forces entered the MSF hospital while others remained at the main gate.

At between 7.30am and 8am, all MSF international staff and the ICRC delegate were evacuated to the airport. The Afghan National Army proposed that the MSF team be transported within their military vehicles. The MSF team preferred to travel to the airport in an identified MSF vehicle. The decision was taken for MSF to use its own vehicle and



for the Afghan National Army to drive in front of and behind the MSF vehicle.

Since 3 October, the hospital has remained closed following the destruction by US airstrikes.

Initial Conclusions:

MSF can conclude the following points, based on the facts reviewed in this initial overview of events before, during and immediately after the US airstrikes on 3 October 2015:

- The agreement to respect the neutrality of our medical facility based on the applicable sections of International Humanitarian Law was fully in place and agreed with all parties to the conflict prior to the attack.
- The KTC was fully functioning as a hospital with 105 patients admitted and surgeries ongoing at the time of the airstrikes
- The MSF rules in the hospital were implemented and respected, including the ‘no weapon’ policy and MSF was in full control of the hospital at the time of the airstrikes
- There were no armed combatants within the hospital compound and there was no fighting from or in the direct vicinity of the KTC at the time of the airstrikes
- The GPS coordinates provided to all armed groups were accurate and MSF teams in Kabul and New York made the relevant contacts to alert the parties to the conflict of the airstrikes.

Based on these conclusions, there is an urgent need for a widely agreed upon and unambiguous recognition of the practical rules under which hospitals operate in conflict zones. This means:

- A functioning hospital caring for patients, such as the one in Kunduz, cannot simply lose its protection and be attacked
- Wounded combatants must be treated without discrimination and cannot be attacked
- Medical staff cannot be punished or attacked for providing treatment to wounded combatants.

## Appendix C

Excerpts from MSF Speaks Out report on Rwandan Refugee Camps in Zaire and Tanzania from 1994-1995 (Note - This is a very small sampling from the overall document):

Introduction:

“In July 1994, Médecins Sans Frontières and other aid organizations mobilized to fight the cholera epidemic spreading among the refugees in Zaire. Once the epidemic was contained, the volunteers found themselves confronted with camps that were under the tight control of ‘refugee leaders’ responsible for the genocide.

The camps were transformed into rear bases from which the reconquest of Rwanda was sought, via a massive diversion of aid, violence, propaganda, and threats against refugees wishing to repatriate.

Although MSF volunteers from the different sections were all revolted by the situation, they were divided over how to react. Some thought that MSF ought to cease its activities in the camps; others believed that it was possible to improve the situation, and many argued that MSF should remain for as long as the refugees needed assistance, no matter what the context.

In November 1994, the NGOs present in the camps in Zaire called on the UN Security Council to deploy an international police force to separate the refugees from those responsible for the genocide. The appeal fell on deaf ears. In the absence of any signs of change in the context, MSF as a movement was forced to choose between continuing to work in the camps, thereby further strengthening the power of the génocidaires over the refugees, or withdrawing from the camps and leaving a population in distress. Several questions were posed:

- Is it acceptable for MSF to assist people who had committed genocide?
- Should MSF accept that its aid is instrumentalized by leaders who use violence against the refugees and proclaim their intention to continue the war in order to complete the genocide they had started?
- For all that, could MSF renounce assisting a population in distress and on what basis should its arguments be founded?

Each MSF section thought differently about how to respond to this dilemma: The French section, considering that a humanitarian organization has no mandate other than that which it imposed upon itself, refused to contribute to legitimizing the perpetrators of the genocide and to strengthen their power through material assistance in the camps. The medical emergency over, the French section withdrew from the camps in Zaire and Tanzania in November and December 1994 respectively, and publicly explained its position.

The Belgian, Dutch and Spanish sections chose to remain, considering that the refugees still required assistance and that not everything had been done to bring an end to the control exercised by the génocidaires. The Belgian section began a 'humanitarian resistance' strategy aimed at loosening the génocidaires hold over the aid pouring into the camps. The Dutch section endeavored to document the situation with a view to lobbying the international community to do more to resolve the problem.

Given the lack of improvement in the situation, in July 1995 MSF Belgium and MSF Holland decided to end their programs in the camps. These decisions were put into effect at the end of 1995."

Body of Report:

"Marked by the negative experience with Burundian refugees of the previous years, MSF volunteers concentrated their efforts on the technical quality of their aid, overlooking the political reality of this exodus. Few volunteers knew that the former Rwandan administration - the same group that planned the genocide - had encouraged the refugees' flight. Aid agencies organized the camps along the same administrative lines found in Rwanda, effectively leaving the former leaders in charge of the refugees."

“It was the first time that I had ever seen such a large influx of refugees. I had never seen so many people, or such a big emergency. We just dived headfirst into it all. For sure, there were problems in Rwanda. I had understood the exodus, I could see that the refugees were organized, but I didn’t realize that they were killers.”

- Nicolas de Torrente, MSF France administrator in Tanzania, November 1993 to June 1994 then MSF France Coordinator in Rwanda, August 1994 to March 1995

“No census had been conducted. Huge quantities of food were distributed which the leaders resold. The same trucks that brought food in went back out again full. I saw them in the market of Mwanza, the neighboring town. This wasn’t resale on a small scale, but huge quantities of food by the sack-full.”

- Nicolas de Torrente

“...security problems in the camp are worsening. Official estimates place the number of killings in one week at five (four lynchings and one person cut into bits). Are these revenge killings? Probably. An MSF Holland team witnessed the slaughter of the last victim... It is now urgent that the teams observe safety precautions more closely and avoid delaying their return home from the camp in the evenings.”

- MSF France Tanzania Situation Report, 13 June 1994

“Herewith, Médecins Sans Frontières would like to draw your attention to the recent dramatic deterioration of the security situation in Benaco refugee camp in Tanzania... First of all, we would like to underline that MSF has continued its operations [during the humanitarian strike]. MSF Rwandan personnel maintained MSF’s activities in the camps... Last Friday, MSF asked for a one-week reflection period in order to consider our position. MSF expatriate staff remained on standby. We are very concerned that UNHCR (United Nations High Commissioner for Refugees) did not appreciate the reasons behind this difficult decision. The security situation and the presence of alleged war criminals in the Benaco camp remain of critical concern to us. The presence of alleged war criminals has contributed to the rise of tension among the refugee populations in Benaco and has created serious conditions of insecurity. All efforts should be made to restore a secure situation in the camp. This can be achieved by a quick arrival of a security force of the Tanzanian police in the area and the prosecution of the alleged war criminals. As you may know, the Tanzanian government has competence to bring the war criminals to justice under the well-recognized principle of universal jurisdiction for war crimes. Furthermore, persons who have committed war crimes cannot be considered refugees under the 1951 Convention relating to the status of refugees. In this light, MSF shall assess the security situation during the coming two days. MSF will also monitor and follow up on actions taken towards alleged instigators of war crimes committed in Rwanda.”

- Draft of MSF Holland letter to UNHCR Geneva, 21 June 1994

“The Hutu government lost the war but maintains control of the population and economic resources via humanitarian aid. Hutu political and military authorities control all food distribution in the camps. This is a first: a State with its population and wealth, but

without territory. The interim government keeps its people as hostages and organizes all population movements. Using Radio Mille Collines and loudspeakers, it incites civilians to flee toward such-and-such a zone. Behind them, the militias and the army loot the abandoned cities. Some 400,000 people have arrived at the world's largest refugee camp in Benaco, Tanzania, driven there by their leaders. The humanitarian system was established based on a naïve discourse: 'Let's not allow famine to complete the genocide.' But it's the killers, not the victims, who are there. Between one-quarter and one-half of the Tutsis have already been wiped out... We've got to reassure people and help them to get back to Rwanda, where they don't face any risks. We've got to cut off the loudspeakers and arrest their leaders. But the refugees have a political noose around their necks... As long as their leaders remain free and continue to feed this bizarre fear of the Tutsis (who they have themselves killed!), we won't be able to save them.

- 'They're All Going to Die!' Interview of Françoise Bouchet-Saulnier, MSF senior legal adviser, with Jean-Claude Raspiengeas, *Télérama* (France), 27 July 1994

“Médecins Sans Frontières would like to reiterate that a crisis on such a huge scale not only requires but also expects a response on the part of UN member states, particularly Security Council members, and the EU countries. Such a response must be at both the humanitarian and the political levels. The humanitarian organizations must be able to rely on military logistical units to provide the heavy logistics that they are unable to cover themselves. Such a huge crisis requires that intervention is geared to the real requirements of the situation and is not made dependent on the opportunity for flattering media coverage of an individual country's generosity.”

- 'MSF protests lack of international response to plight of Rwandan refugees', MSF International Press release, 4 August 1994

“Besides sending volunteers on missions, MSF is trying to alleviate the situation in crisis areas through an intensive advocacy policy, implemented by the Humanitarian Affairs department. Governments, the UN, and other organizations have been systematically bombarded with letters demanding explicit (security) measures in the refugee camps and in and around Rwanda... Advisers for the protection of the refugees were sent to Goma and Benaco to report on the security situation.”

- Anita Baars, *Headquarters reaches boiling point*, *Ins and Outs*, September 1994

## Appendix D

Excerpts from MSF's "Not Criminals" report:

“MSF provided medical consultations and psychological support in these detention centres. We have drawn the attention of the Maltese authorities to the sub-human living conditions in the centres and pressured them to instigate change. However, despite late efforts taken by the Maltese authorities to improve the conditions for receiving asylum seekers and undocumented migrants, structural problems remain. The centres are still overcrowded and unhygienic, and the systematic detention of vulnerable people

continues.”

#### Population in Detention:

“In Malta, almost 60% of undocumented migrants and asylum seekers arriving in the last six months come from countries affected by conflict or widespread human rights violations. Nearly half of them come from Somalia. Others are from Sudan, Eritrea, Nigeria and other African countries. The majority of them are granted humanitarian protection (53.84 % in 2008) while an extremely small percentage are granted refugee status (0.52 %) by the Maltese authorities. However, they are all forced to spend months in detention centres while waiting for the Maltese authorities to deal with their applications.”

#### Conditions:

“The Maltese detention centres are extremely overcrowded. The maximum density for a refugee camp during an emergency is 3,5m<sup>2</sup> per person...[and] 12 out of the 18 detention areas fall above this ratio, in particular all the zones in Hermes Block where there is less than 3m<sup>2</sup> per person but also in all the areas of Ta’kandja which only opened last February. In addition, there are not enough beds for all detainees; some have to sleep on mattresses on the floor or even share a mattress.”

“Shower and toilet facilities are insufficient and often not functional. There is no hot water in most of the facilities. In some areas in Safi detention centre, there is an average of more than 40 persons per toilet. Until February 2009, in Hermes Block zone E, there was only one functioning shower for more than one hundred people. In most areas, living quarters are permanently flooded with water leaking from broken sinks and toilets. In some cases, wastewater escapes from damaged pipes situated on the upper floors leaving residents exposed to excrement and urine, especially those who have to sleep in the floor.”

“In October in Safi, sick patients were being isolated outside the warehouses under a tarpaulin, regardless of the rain and cold. These conditions are not fit for humans and certainly not for sick patients. The isolation area in Hermes Block is also used for punitive reasons mixing healthy people with patients suffering from infectious diseases. This is in complete contradiction with Rule 39 of the Ministry for Justice and Home Affairs’ note on entitlements.”

“Dire conditions in the isolation areas mean that many individuals conceal symptoms of infectious diseases to avoid being put in isolation. As a result, the population inside the centers, including pregnant women and children, is exposed to these diseases. MSF has drawn the attention of the Maltese authorities to the inhumane conditions in the isolation areas. MSF also offered to support the Detention Service in setting up a space with correct isolation procedures. However, despite this offer and repeated assurances that these rooms would not longer be used, MSF continued to find people detained in these isolation areas.

Last Autumn an MSF doctor found six people inside the two cells – all suffering from chicken pox at various stages. Two patients had fever and extensive skin diseases. Two patients out of the six had not seen a medical doctor and had been sent to the isolation rooms by soldiers. None of the patients had received medication. They had not been able to wash themselves. Some of their blisters were infected. The floors were wet and although it was winter and cold at night, the six detainees were not provided with sufficient blankets and clothes. No soap or other hygiene items had been distributed.”

“In Hermes Block women and children are held in close confinement with men in settings where violence among inmates is an ongoing threat and increases the risk of sexual abuse. The Detention Service has only three female staff.”

“Food is distributed three times a day but does not include sufficient vegetables and fruit required for a healthy diet. In addition there is no special food available for children and babies. Special diets for medical reasons (e.g. for patients with diabetes) are not always correctly provided.

A non-food item distribution – mainly providing items for personal hygiene – is planned for the beginning of each month. However this is not implemented regularly. Items for distribution are not standardized and are often missing. Detainees who arrive one day after a distribution has taken place have to wait for one month to receive basic non-food items.”

“Additional clothing is not provided by the Detention Service. A volunteer collects clothing for the detainees: one single person, not a member of any organization, is in charge of providing clothes to 2,000 migrants. The distribution system itself is questionable: plastic bags full of clothes are sometimes thrown by the soldiers inside the living areas, sometimes the clothes are passed through the iron bars in the doors of the detention centers, and people – including women and minors – have to fight among themselves for clothes.”

“Detention conditions in Malta can be directly linked with the most frequent morbidities seen in MSF’s consultations with detainees. 17 per cent of morbidities seen are respiratory problems linked to exposure to cold and lack of treatment for infections. Patients often require repeated consultations since symptoms persist in the cold environment in which they live. Dermatological diseases including scabies, bacterial and fungal skin infections account for nine per cent of the consultations, reflecting overcrowding and poor hygiene. Fourteen per cent of the consultations deal with gastrointestinal problems including gastritis, constipation and hemorrhoids which can be a result of a low fiber diet, lack of activity and high stress. Musculoskeletal complaints such as arthromyalgia can be linked to limited exercise and a cold uncomfortable environment. Cases of accidental trauma were seen in seven per cent of the consultations. These were mainly caused by frequent falling due to wet floors in the washing areas, combined with poor lighting and broken tiles which lie all over the floor.”

“In a group of 60 people who were healthy on arrival, MSF diagnosed 65 cases of illnesses transmitted inside the centers over the course of five months, such as scabies,

chicken pox and respiratory tract infections.”

“...there is no appropriate system for isolation and follow-up of patients with infectious diseases in the detention centers. Procedures for isolation are unclear and guards may isolate a person at their discretion. As a result, on several occasions, MSF doctors found people inside the isolation area with no sign of disease – they were incarcerated with sick people.”

“The screening process for TB consists of the initial triage examination on the day of arrival and the chest X-ray for all detainees. Positive TB patients should be admitted to the isolation rooms in the hospital to start treatment. However, due to the high occupancy rate, admission is not always immediately possible. Consequently infectious patients are started on treatment for active TB and sent to the detention centers where they remain in contact with other non-infected people.”

“Many detainees – especially Somalis and Eritreans – have suffered from conflict and/or torture and other abuses, raising particular concerns that the anxiety, fear, and frustration provoked by detention may prolong and exacerbate underlying traumatic stress reactions and thereby create long-term psychosocial disability. These people have escaped war and other traumatic events and expect to receive humanitarian protection. In these circumstances, detention may be experienced as particularly cruel and unjust and can become the trigger of psychological suffering. MSF’s psychological support, provided through individual consultations with the detainees, revealed the mental health impact on detainees of the harsh journey to Malta and their subsequent confinement in detention centres. 33 per cent of MSF patients reported the death of a family member as the most relevant event in their past and 21 per cent reported having been direct victims of physical violence prior to arriving in Malta. Many migrants have witnessed people dying while crossing the desert, or drowning during the sea crossing.

The difficult living conditions, overcrowding, constant noise, lack of activities, dependence on other people’s decisions, as well as the length and uncertainty of the period of detention and the ever present threat of forced repatriation, all contributed to feelings of defeat and hopelessness. This is aggravated for people who were already incarcerated in Libya, where many experienced torture and/or sexual abuse.”

“The patients seen by MSF were suffering from: symptoms of depression (30%), anxiety (25%), Post Traumatic Stress Disorder (PTSD) (9%) and psychosomatic disturbances (5%). There is a direct link between the length of stay in detention and the level of desperation reported. Sixteen out of seventeen patients who revealed suicidal tendencies had been in the centers for more than four months.”

“Legislation in Malta dictates that only pharmacists can dispense medication according to a doctor’s prescription. The detention centers have no pharmacy and therefore all medicines, prescribed by a doctor, have to be purchased in pharmacies outside the center and collected by the Detention Service personnel. This results in delays in the delivery of drugs to sick patients, ranging from several days to two weeks. Sometimes the drugs are not delivered at all and many diagnosed diseases go untreated.

Failing to provide drugs may contribute to the deterioration of the patient's condition, lead to repeated medical consultations and cause unnecessary suffering due to untreated pain.

MSF offered to set up a pharmacy in the detention centers and provide human resources for an initial period of six months, but the proposal was rejected by the Maltese authorities.”

Conclusions:

“Based on first-hand experience inside the detention centers, MSF has on several occasions expressed its concerns to the Maltese authorities about the unacceptable conditions in these centers, as well as the delays or failure in the dispensation of medicines and inadequate follow-up of patients with infectious diseases. Despite efforts made by authorities to rehabilitate one of the centers, the response is slow and totally inadequate to ensure that the basic needs of migrants and asylum seekers are met. Large-scale arrivals and the necessity to control influxes of migrants and asylum seekers does not justify a policy that keeps thousands of people in detention centers where conditions fall well below international and national standards and are detrimental to the physical and mental health of people.

MSF continues to voice concerns about the situation. MSF urges the Maltese authorities to take necessary action to improve the reception of people arriving in Malta.

International minimum standards for the reception of asylum seekers and for treatment of prisoners and Maltese national standards require that all detainees are ensured both the coverage of their basic needs and the respect for their fundamental human dignity.

The undignified conditions in the Maltese detention centers and the risk they pose to the health of migrants and asylum seekers compound the suffering of people who have already fled danger and hardship in their countries of origin and who have survived long and risky journeys overseas.”

## Appendix E

The following is a summary of a conversation with Dr. Bruce Leavitt of UVM Medical Center. Dr. Leavitt is a member of MSF's US association. He has worked with MSF on several missions as part of a surgical team:

In my conversation with Dr. Leavitt, we discussed the organization's structure and how it responds when faced with urgent decisions about what actions are appropriate and whether or not to speak out. Dr. Leavitt was clear that MSF does not answer to any outside authority and that this independence has allowed it to develop its practice of witnessing. He also explained to me that the organization asks its members to share MSF statements when speaking publicly on behalf of the organization. For example, Dr. Leavitt gave a talk in New Hampshire about MSF and was given a prepared statement about the Kunduz airstrike. In this way, MSF aims to be clear and consistent in its communications.



Dr. Leavitt shared with me an experience from a surgical clinic that MSF had set up just outside of a refugee camp in Nigeria. He said that wounded combatants from one side of the country's civil war would be sent to MSF by the other side. Patients would sign into the hospital. One patient signed into the hospital and then fled. The side of the conflict that was bringing these patients to MSF was furious and demanded that MSF provide them with the name of the escaped combatant. They said that if MSF did not comply, they would not send any more patients. This was a dilemma for MSF staff who did not want to enable the punishment of the man who had fled. However, the alternative was to cut off the access of all other combatants to the hospital.

MSF staff at the field site talked through the night, debating what to do. An MSF France representative was sent to Nigeria and this representative made the final call. He decided to give up the name so that MSF would not be barred from providing care to other injured combatants. This decision was controversial, and some volunteers left because of it. Dr. Leavitt explained that it is often the case that final decisions are made by MSF France.

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