IN THE CROSSHAIRS

ARE OUR HOSPITALS TARGETS FOR TERRORIST ATTACKS?

BY JOHN EDEEN, MD

»WITH THE INCREASE IN TERRORIST ACTIVITY by ISIS around the globe and the influx of Syrian refugees and ISIS cells into North America, we have to ask ourselves: What will be their targets? And how will they attack?

In his book *When Terror Returns*[1], John Giduck describes the optimal target site for a high-magnitude hostage siege. It would be a structure that could quickly be secured and defended by a small team. It would allow large vehicles to approach with the terror team and weapons. It would have little security and contain a sufficiently sized central location to hold hostages. It would possibly be in an elevated position with a large expanse of ground surrounding it. It would contain a victim population of desired composition whose scheduled presence was predictable or easily ascertainable via rudimentary intelligence gathering.

Giduck describes four types of attacks: Decimation Assault, Mass Hostage Siege, Synergistic Attack and Symphonic Attack.

In a Decimation Assault, the terrorists must be able to get their weapons on target and activate them. Most commonly, this is an explosive attack. It might also be a lone wolf or small cadre of attackers with firearms (rapid mass murderers). This type of attack inflicts maximum damage in a short time. Because of its limited time frame, it results in a short media focus. Last year's attack in San Bernardino, California, is an example of a Decimation Assault.

The second attack type is the Mass Hostage Siege. This involves the taking of a number of hostages and holding them for a period of time. This allows for an exponential increase in the terror of the incident and results in large media exposure. The aim is often a high body count, ransom or political negotiations. The attack on the Bezlan School in Russia on Sept. 1, 2004, is a prime example of the Mass Hostage Siege. The typical hostage siege has six phases: attack on the building, control of hostages, fortification, stabilization to delay counter attack, negotiation, and rescue or assault by government forces.

The third type of attack is the combined Decimation and Mass Hostage Siege. This type of hybrid attack is known as a Synergistic Attack. The events of Sept. 11, 2001, are an example of a combined attack. The terrorists combined hijacking airliners containing multiple hostages with a Decimation Attack of flying the hijacked airplanes into occupied buildings. In a larger metropolitan area, diversionary attacks would be used to delay police and other emergency responders. The most likely targets are schools and hospitals. Also, megastores, like WalMart, SuperTarget and Super KMarts, make good targets.

The final and most complicated attack is the Symphonic Attack. This involves multiple targets struck simultaneously. The attack in Mumbai, India, in November 2008 was one of these complex attacks. Ten terrorists made multiple coordinated attacks against a railway station, multiple hotels, a hospital and a Jewish community center. This type of assault requires increased intelligence-gathering, planning, target selection, training of the assault team and complex execution.

HOSPITALS AS TARGETS

Denis Fischbacher-Smith and Moira Fischbacher-Smith studied the vulnerability of public spaces in the United Kingdom and focused on hospitals in particular.[2]

There is an assumed level of trust that a hospital is a generally safe environment. This is combined with a belief that no one would ever consider attacking a hospital. These assumptions are flawed. Hospitals have easy access to buildings and public areas. A Mumbai-style attack on a hospital could generate mass casualties in a confined space. Further damage using low-level nuclear material might make a hospital unusable for many years and cost large sums of money to decontaminate.

Health care centers and workers concentrate on how they will respond to the aftermath of an attack, but they don't see themselves as targets. They are part of critical infrastructure and are core elements in any civil contingency planning for mitigating the effects of any mass-casualty crisis, and disruption in services acts as a force multiplier for the damage caused elsewhere.

Information technology is a valuable source of intelligence. Computers are vital in security monitoring; they control access and contain data on hazmat locations and supplies. If hacked, they contain information on key modes of attack or pathways within the system to cause failure. Customers of the system constitute a potential target group and a means of testing the permeability of the site.

Doctors might be actors in the terrorism and might have accomplices in the hospital. The role of doctors in the attacks on the Tiger Tiger nightclub in London and the Glasgow Airport leaves little room for doubt that staff working within a hospital has the potential to be involved in terrorism or other malicious acts.

Extreme care must be taken in the recruitment and selection of staff. Careful background checks must be undertaken to detect those with bogus qualifications. Despite the best pre-employment background checks, there is no predicting radicalization after screening and employment. A short list of terrorist physicians includes:

• Dr. Ayman Al-Zawahiri — surgeon/psychiatrist and Al-Qaeda mastermind

• Dr. Abdel Aziz Al-Rantisi — pediatrician and co-founder of Hamas

• Dr. Mahmoud Al-Zahar — surgeon and co-founder of Hamas

• Dr. Fathi Abd Al-Aziz Shiqaqi — surgeon and co-founder and Secretary-General of the Islamic Jihad Movement in Palestine

• Dr. George Habash — pediatrician and founder of the Popular Front for the Liberation of Palestine (PFLP)

• Dr. Wadih Haddad — doctor and leader within the PFLP

• Dr. Bashar Assad — ophthalmologist and president of Syria/state sponsor of terrorism

• Dr. Rafiq Sabir — emergency physician in Boca Raton, Florida, and Al-Qaeda terrorist plotter

• Dr. Mohammed Jamil Abdelqader Asha — neurologist and London bomb plotter

• Dr. Bilal Talal Samad Abdullah — doctor and plotter for London bombing and Glasgow airport bombing

• Dr. Nidal Hassan — Army psychiatrist and Fort Hood, Texas, murderer

THE HISTORY

In 2013, Dr. Boaz Ganor and Dr. Miri Halperin Wernli, of the International Institute for Counter Terrorism, wrote a white paper titled, "Terrorist Attacks Against Hospitals: Case Studies."[3] They looked at approximately 100 terrorist attacks against hospitals in 43 countries spread across every continent. Approximately 775 people were killed in these attacks, which took place between 1981 and 2013, and 1,217 others were wounded.

The large number of patients, visitors and medical staff ensure that an attack on a hospital will produce multiple casualties. It would also be expected that an attack on a facility dedicated to health and healing would receive extensive media coverage. An attack on a hospital is demoralizing to a community and increases anxiety due to the familiarity of the setting and the fear that such an attack could involve them or someone else close. Hospitals also hold materials and knowledge that can be put to use to cause further harm, such as medications, poisons, radioactive materials and biological cultures. Also, confidential health information can be hacked and used for nefarious purposes.

THE METHODOLOGY

A hospital can either be a primary or secondary target of attack. As a secondary target, such an attack can be used to distract response assets from another primary attack. As a primary target, we could see suicide attacks, bombings, kidnappings, shootings and even mortar or rocket attacks.

Examples include:

• Musgrave Park Hospital bombing, Belfast, Northern Ireland, 1991 — An IRA bomb killed two soldiers and injured a number of people, including two children.

• Kigali, Rwanda Hospital attack, 1994 — Tutsi patients, who were at the hospital for treatment, were systematically executed.

• Bujumbura, Burundi Hospital attack, 1996 — Hutu rebels killed four Tutsis, including a 6-month-old baby.

• Zaire-South Kivu, Democratic Republic of Congo Hospital attack, 1994 — A Tutsi subgroup, the Banyamulenge, killed 50 patients and hospital staff at two missionary hospitals.

• Mozdok, Russia Military Hospital attack, 2003 — A truck bomb driven by a Chechen terrorist exploded outside the hospital, resulting in 50 deaths and 80 wounded.

• Tikrit, Iraq Hospital Attack, 2011 — A suicide bomber blew himself up at the University Public Hospital of Tikrit, resulting in 11 deaths and more than 30 injured.

BUDENNOVSK AND KIZLYAR

The most costly example of a hospital attack occurred in Budennovsk, Russia, from June 14 to 19, 1995. Led by Shamil Basayev, 150 Chechen terrorists took 2,000 hostages and killed 129 civilians, 18 police and 18 soldiers. More than 400 others were wounded.

The attack occurred six months after Russia invaded Chechnya. The operation was intended to attack deep into Russian territory: A convoy, consisting of three large military trucks and a vehicle painted like a police car, set out for the Russian state of Stavropol. Terrorists dressed as police told the checkpoints that they were escorting Russian soldiers' bodies home. They made it through many checkpoints but were unable to pass a bribe at Praskayeva. The "police officers" were arrested and brought to the police station in Budennovsk. This triggered an attack on the police station and the local government offices. After a few hours, they regrouped at the city hospital.

In the initial assault on the city, more than 100 people were killed. While moving from the police station, up to 600 hostages were herded toward the hospital. Another 1,100 were taken at the hospital. Of those, 650 were patients and 450 were hospital workers. Many hostages were women and children.

The rebels mined the first floor. Hostages were reportedly divided: men to the basement and elderly women and children placed in the first-floor corridors. Russian Special Forces soldiers surrounded the hospital. Two doctors were sent out with their demands: 1. Stop the war in Chechnya. 2. Pull out federal troops. 3. Start direct negotiations with Chechen separatist leadership.

On Day 4, an attempted rescue operation was launched. Russian troops successfully captured part of the first floor, freeing some hostages and killing some Chechens. However, the Chechens were able to regain control by using hostages as human shields. After several hours of fighting, 30 hostages were killed by crossfire and grenade fragments. Negotiators offered a flight out of Russia; it was refused. Later that day, a second assault using tear gas was launched but failed.

On Day 5, Prime Minister Chernomyrdin and Basayev came to an agreement: Russia was forced to capitulate to the terrorists' demands and allow the terrorists and hostages to have free passage to Chechnya.

On Day 6, hostages and rebels left, with a hostage shackled to each rebel. They took a convoluted route and changed directions several times. At the village of Zandak near the Chechen border, the hostages were released and the terrorists vanished into the forest.

As a result, the Russian government and people were shaken. The Russian leadership was humbled and seen as inept. President Boris Yeltsin was condemned. The security and interior ministers resigned. A law was passed banning accepting terrorist demands during a hostage situation. Also, an X-ray machine and Cesium-137 were stolen and later used to threaten a dirty bomb attack.

Six months after Budennovsk, on Jan. 9, 1996, a group of 300 to 400 terrorists, led by Salman Raduyev, attacked the Kizlyar Air Force Base in Dagestan. There they were able to destroy several helicopters and seize the weapons depot. From there, they moved to the Kizlyar city hospital. There were only 100 hostages initially, so the terrorists gathered 3,600 hostages from the surrounding area over the next three hours.

After inside, the terrorists barricaded themselves inside the first floor and wired the second floor with explosives. The terrorists were on the first floor and the hostages were kept on the third, fourth and fifth floors. Three uniformed police officers were executed and a counter-attack with an ar-

mored personnel carrier was repulsed on the first day.

The terrorists learned important lessons from their attack on Budennovsk and applied them to Kizlyar. They were forced into a siege after a poorly coordinated counter-attack on the bus convoy near the village of Pervomaiskoye. The ensuing battle destroyed the town and the terrorists were able to elude the Russian forces and escape to Chechnya. The treaty to end the First Chechen War was signed three months later.

We see that attacks on hospitals have had a significant effect on the countries they target, from a psychological standpoint but also a political one. The bigger the attack and the larger the number of hostages, the larger the effect on the populace and the more media coverage is gained by the terrorists.

SECURITY GAPS

Most attacks targeting hospitals have been suicide bombings, with the second-most common scenario being armed assault.[4] Hospitals are soft targets with multiple entrances, visitors are seldom identified and their baggage is seldom screened or searched. Many hospitals do not have a significant armed security presence and the large size of the buildings and long, straight hallways give the advantage to would-be hostage-takers.

Further complicating matters, there has also been an upsurge in female suicide bombers. Hospitals have a large number of female employees who could be exploited by radical Islamists and, as stated earlier, physicians are not immune from radicalization.

CHEM/BIO CONCERNS

Hospitals contain radioactive and biological materials that can be weaponized, and the security of those materials is often inadequate. Sadly, hospital administrations need to look at their facilities through the eyes of potential terrorists when planning security. They need to examine external threats but also be aware that threats could be from the inside. Unfortunately, most hospitals do not see potential terrorism as a significant problem worthy of expending valuable resources.

Hospitals have a legal responsibility to provide a safe and secure environment for staff, patients and their families. Do hospitals have a liability risk in the age of terrorism? Is an attack a foreseeable event? Does your hospital have a plan? In the event of a localized terrorist attack, does your hospital have a plan to secure the Emergency Department from suicide bombers? Is there a plan for ambulances and vehicles to be searched before they are allowed to approach the hospital itself?

Would a plan to have trained and armed hospital staff already in place be an advantage? Could it possibly deter or disrupt the plans of hostage-takers and allow staff and patients to escape?

Imagine the devastation in your community were a Boston Marathon-type bombing be followed by a suicide bomb attack on the emergency room as casualties begin to arrive. Just like Boston, it can never happen in your city … until it does.

ENDNOTES

(1) *Giduck, John.* When Terror Returns. *Archangel Group Ltd., 2011.* **(2)** *Denis Fischbacher-Smith and Moira Fischbacher-Smith. "The Vulnerability of Public Spaces: Challenges for UK hospitals under the 'new' terrorist threat,"* Public Management Review, *15:3, 330-343. 2013.* **(3)** *Ganor, B. and Wernli, MH. "Terror Attacks against Hospitals: Case Studies,"* International Institute for Counter-Terrorism Working Papers Series, *October 2013.* **(4)** *Pounds, Keith. dcclothesline.com/2014/07/21/terrorists-will-strike-us-hospitals.*

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