When Humanitarianism Trumps Politics

Elon Glassberg MD MHA[1]*, Tarif Bader MD MHA[1]*, Roy Nadler MD[1], Avi Benov MD MHA[1], Salman Zarka MD MPH MA[1,2] and Yitshak Kreiss MD MHA MPA[1,3]

[1]Surgeon General's Headquarters, Israel Defense Force, Ramat Gan, Israel
[2]School of Public Health, University of Haifa, Haifa, Israel
[3]Department of Military Medicine, The Hebrew University, Jerusalem, Israel

KEY WORDS: ethical dilemmas, field hospital, Syrian civil war
IMAJ 2015; 17: 339–340

Humanitarian medical missions often raise ethical dilemmas and pose challenges at both the organizational and the personal level. These dilemmas are even more prominent when such missions involve areas of conflict that place the medical staff under threat [1-4]. The most challenging scenario for medical humanitarian assistance is probably when it takes place amid two nations in a state of war.

As of December 2013, the civil war in Syria claimed the lives of over 115,000 and left hundreds of thousands severely injured [5]. The local health infrastructure has been decimated, leaving the sick and wounded without medical assistance. In despair, and not without trepidation, some Syrian victims of this civil war chose to seek medical assistance in Israel, a country that borders it to the south and with which it is officially at war.

A special medical humanitarian operation had to be designed by Israel to overcome the political, cultural, security and emotional barriers involved. This extraordinary mission comprises three levels of care and an evacuation system. Israeli Defense Force Medical Corps (IDF-MC) teams perform triage and initial medical care at the border itself, sometimes under fire. A designated nearby field hospital, deployed especially for this mission, serves as the second level, and the civilian medical centers in northern Israel provide advanced medical care.

Over 1000 Syrian citizens, many of them children, have already been treated. We describe here our approach to reconciling the ethical conflicts that arose when our military forces attempted to address a humanitarian crisis arising from a civil war in a country with which we are also at war.

Our first decision as medical care providers was to adopt a strategy of treating everybody unreservedly and free of any and all political considerations. This meant adjusting the first-response medical team's mode of operation along the Syrian border from routine deployment to one capable of providing medical care to civilian casualties of a war on the other side of the border [5,6]. Providing medical care for men, women and children who suffered combat-related injuries and addressing the needs of chronically ill men and women of all ages who could not receive medical care within Syria required the IDF-MC to allocate medical resources in an unprecedented manner to allow such an undertaking. Supplementary medical teams, including specially recruited reservists, were deployed in the region in order to provide primary medical care to the increasing volume of sick and wounded patients who approached the border. Another important modification was the deployment of a dedicated medical facility on the border itself for carrying out life-saving interventions, including damage control resuscitation and surgery. Specialists were assigned to staff the facility and provide onsite medical care according to international standards for patients whose injuries were too severe for immediate evacuation to civilian hospitals in the region.

Syrian casualties reach the border with injuries that had been sustained between several minutes to several days earlier. Some arrive after receiving basic, often improvised, initial medical care within Syria. Some cross the border bearing written medical notes from Syrian health providers. Others arrive with only wound dressings or new surgical incisions and sutures indicating recent care. By the end of 2014, 1473 casualties had crossed the Israeli Syrian border. The majority of patients were young adults; 9% of patients were under the age of 18 years.

The benefits of an unorthodox approach of deploying forward triage officers and senior physicians of relevant specialties quickly became apparent. Arabic-speaking personnel needed to be recruited in order to obtain essential medical information from the patients. Dedicated translators and Arabic-speaking social workers accompany the Syrian casualties throughout their hospitalization and assist in addressing their basic needs. Their presence is especially critical in obtaining informed consent for carrying out medical and surgical procedures.

Providing care across a hostile border poses safety considerations to both the patients and care providers who sometimes must treat casualties under mortar and machine gun fire. Military medical teams are trained and expected to provide medical care under fire to fellow combatants while

*The first two authors contributed equally to this report

risking their own lives: the motivation for such exposure is far from obvious when caring for civilian casualties from a foreign and hostile country.

The threat to the personal safety of the Syrian casualties upon their return home also needed to be taken into account because of the risk of their being identified as having received care from Israelis. Towards this end, hospital discharge letters are written in Arabic and special care is taken to remove all Israeli identifying markers, including Hebrew lettering on imaging studies, to allow for continuity of care. Several months' supply of medications and dressings are provided upon discharge so that local health providers and family members can continue with tasks such as changing wound dressings. Some patients have already returned to the Israeli border at a later date to complete necessary medical follow-up, which is currently unavailable within Syria. A few remain hospitalized for extended periods for the same reason.

The burden placed on regional civilian hospitals in northern Israel by the increasing numbers of Syrian patients continues to pose a substantial national challenge. This is especially true for specialty capabilities, such as neurosurgical and pediatric intensive care beds, where resources are already scarce. The utilization of already limited national resources for the benefit of citizens of a declared enemy country affects morale and raises questions of professional ethics. Our strategy, as approved by the Israeli government, was to provide the best care possible.

Above all, trust between physicians and patients that could be difficult to achieve even under the best of circumstances is especially elusive when dealing with opposite sides of a hostile border such as the heavily fortified, mined Israeli Syrian border. The increasing numbers of Syrian casualties choosing to reach the Israeli border seeking assistance, as well as the patients returning to receive follow-up medical care is testimony that trust can be established and maintained between the Syrian patients and the Israeli medical care providers.

As long as the civil war in Syria continues to rage on and cause injuries, Israeli medical teams will continue to administer care to those in need, guided by the IDF-MC mandate to provide the best medical care possible and to do so unconditionally. We would like to believe in a better future – when humanitarianism trumps hostility between two warring nations.

Acknowledgments

We are grateful to Esther Eshkol, MA, for editorial assistance and to Professor Mark Lowenthal and Dr. Avi Shina for their valuable comments on the manuscript.

Correspondence

Dr. E. Glassberg

Israel Defense Forces Medical Corps, Surgeon General's Headquarters, Military POB 02149, Israel

Phone: (972-3) 737-9284

email: idf_trauma@idf.gov.il

References

1. Merin O, Ash N, Levy G, Schwaber MJ, Kreiss Y. The Israeli field hospital in Haiti – ethical dilemmas in early disaster response. *N Engl J Med* 1 2010; 362 (11): e38.
2. Amital H, Alkan ML, Adler J, Kriess I, Levi Y. Israeli Defense Forces Medical Corps humanitarian mission for Kosovo's refugees. *Prehosp Disaster Med* 2003; 18 (4): 301-5.
3. Kevlihan R. Providing health services during a civil war: the experience of a garrison town in South Sudan. Disasters 2013; 37 (4): 579-603.
4. Ahmed F. Humanitarian aid. The sideline or frontline: where should the UK medical profession stand in times of armed conflict overseas? *BMJ* 2014; 348: g83.
5. WHO. Donor update, The Syrian Arab Republic. Last accessed December 2013.
6. Stone-Brown K. Syria: a healthcare system on the brink of collapse. *BMJ* 2013; 347: f7375.