

# The Medical Humanitarian Face of Israel

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In February 2013 seven wounded Syrian civilians approached the Syrian–Israeli border asking for medical help. Although the two countries have been in a state of war for more than seventy years, and according to international law countries can close their borders against their sworn enemy, Israel decided to provide humanitarian aid to the Syrian people in their time of need. These seven individuals were treated by the military battalion staff and evacuated to Ziv Medical Center, the northernmost hospital in Israel, in the town of Safed [1]. Later, a military field hospital was constructed at the border in order to better help the Syrian ill and wounded. The Oath of the Medical Corps of the Israeli Defense Forces – “To extend a helping hand to the wounded and to the sick whether common or distinguished, friend or foe” – became a reality.

## THE HUMANITARIAN AID ALGORITHM

Following this first wave of wounded civilians and the decision to provide them with medical care, a humanitarian aid project was established with the mission to save Syrian lives [2]. We learned from this first wave that severely wounded casualties would not survive the 70 klm journey from the border to the nearest hospital (Ziv Medical Center). For this reason and others, we reached the decision to set up a military field hospital to overcome the long evacuation time, especially for critical cases. The project consisted of three components:

### • Component 1 – On the border

Syrian wounded individuals who reached the border were triaged and treated by battalion aid station teams (a general physician, or paramedic and three medics). Treatment capabilities were according to the tenets of Pre-Hospital Trauma Life Support (PHTLS) and Advanced Trauma Life Support (ATLS): namely, airway management, hemodynamic status control, and life-saving procedures. At this point, a decision regarding further treatment was made by a military physi-

cian and, if necessary, the wounded were referred to the field hospital (component 2) or a civilian hospital (component 3) depending on the circumstances (the patient’s condition, the security situation near the border, and weather conditions). If deemed not necessary, these individuals returned to Syria after treatment of their minor injuries. Emergency cases were referred to the field hospital; cases that could not be treated in the field hospital, such as head trauma, were evacuated directly from the border to the civilian hospital [2].

### • Component 2 – The military field hospital

The military field hospital was constructed on the Syrian–Israeli border [Figure 1]. Due to the close proximity of the Syrian border and the war zone, a decision was made to assign to this facility a small staff of about twenty medical professionals. These included physicians (surgeons, anesthesiologists, orthopedic surgeons), nurses, X-ray and laboratory technicians, a pharmacist, and logistics personnel [3]. In view of the emergency situation and with the aim of saving lives, the field hospital included an operating theater and an intensive care unit. The major principle of the field hospital was to treat emergency patients who are unlikely to survive the evacuation to civilian hospitals due to constraints of time, weather and military threat near the border. Activities within the field hospital included initial evaluation and triage of patients, life-saving procedures, damage control surgery, and postoperative care [3]. Syrians who required the capabilities of a civilian hospital were evacuated from the field

Figure 1. The Military Field Hospital



hospital to one of four hospitals in the area. However, the field hospital personnel were not always present and had to be called from their place of employment when wounded Syrians arrived at the border. With patients hospitalized in this border facility, the field hospital functioned until the patients were released back to Syria or were evacuated to the civilian hospitals. During this period the field hospital was available to other wounded Syrians who reached the border. If they reached the border when the staff was not on site, they would be evacuated directly to the civilian hospitals. After about a year, the field hospital was dismantled, based on the knowledge that most Syrians arrived at the border hours and days after the injury had occurred and would not survive the evacuation to the civilian hospitals.

• **Component 3 – Other medical centers in northern Israel**

The four medical centers located in northern Israel that served this project are the Western Galilee Medical Center in Nahariya, Ziv Medical Center in Safed, Padeh Medical Center in Poriya, and Rambam Medical Center in Haifa. Two years after this project began, we realized that some patients do not require hospitalization and can be treated by the ambulatory services. Wounded Syrian civilians would cross the border early in the morning and travel in Israeli buses to civilian hospitals for a full day of diagnostics and medical treatments. Also provided were social support and other necessities such as medications, food, clothes, and games and toys for the children.

**MORE THAN FIVE YEARS OF HUMANITARIAN AID**

In August 2018, the Assad regime took back control of southern Syria, and this humanitarian aid project that had been functioning for more than five years ended. During that time 4163 Syrian civilians – wounded or ill – were treated in Israel, in the field hospital or in the four abovementioned civilian hospitals. These Syrians, males and females of different ages, arrived at the border presenting various medical problems. Among them were 20 pregnant women who were evacuated to Ziv Medical Center and returned to Syria with their babies.

**THE UNIQUENESS OF THIS PROJECT**

Although Israel has vast experience providing medical support around the world, this humanitarian aid project was unique for the following reasons:

- *Enemy population.* Israel's long experience in providing medical humanitarian aid was primarily to countries hit by natural disasters. These operations were never in an enemy country or war zone. The present mission began by providing medical support to Syrians at the active Israeli-Syrian border where artillery firing and intrusion from the Syrian side put the lives of Israeli soldiers and medical personnel at risk in the attempt to save Syrian lives. On several occasions,

due to bombardment from Syria the field hospital's staff had to run to the shelters, taking the Syrian wounded with them [4]. In the civilian hospitals, Syrian patients were hospitalized in the same wards as Israeli citizens, often in adjacent beds. Clearly, this was a highly unusual situation, with the citizens of two warring countries sharing a hospital room. On the other hand, we had to consider the feelings of the Syrian patients, how difficult it was for them to ask the enemy country for help. Initially, we observed that they were terrified and talked very little. To help alleviate their distress we assigned Arabic-speaking social workers to assist them as needed. Providing medical care in such uncommon circumstances demanded an awareness of challenges that were new for us. For example, when Syrians were released back to their country. We learned that they were extremely worried that it might be known in Syria that they had sought medical help in Israel, their sworn enemy. They told us how dangerous this was and that it could result in their execution. Cognizant of this risk and concerned about their safety, we were rigorous not to reveal their identity. We provided them with discharge letters written in Arabic and took special care to remove all Israeli identifying markers, such as Hebrew lettering on imaging scans, equipment, e.g., wheelchairs, or other items.

- *Standard of care.* Humanitarian aid is usually provided at the site of the disaster and in temporary facilities, limiting the ability to provide medical support while addressing other needs. Thus, the standard of treatment is aimed primarily at saving lives and less on improving quality of life. For the abovementioned reasons, humanitarian aid as defined by the World Health Organization aims to save life and is applied for a short time, mostly following a disaster [5]. In our unique humanitarian context, medical support was provided both at temporarily facilities (the field hospital) and in the permanent structure of a civilian hospital, using the same facilities (structure, manpower, etc.) as for Israeli citizens. Although we could have allocated separate locations and manpower to treat the Syrian patients in the civilian hospitals, we decided that there is only one standard of care for all patients – regardless of their native country or nationality. We could have opted to treat the Syrian patients at the field hospital, a temporarily structure, according to the WHO humanitarian standards – which is lower than Israeli standards and whose costs are far less. However, we decided that all Syrian civilians, whether at the field hospital or civilian hospitals, would receive the identical treatment as Israeli citizens, according to the severity of their condition. We aimed not just to save their lives but to improve their quality of life as well. An example demonstrating the differences in treatment standards is the semi-amputated limb. In the saving-life

standard (humanitarian standard of the WHO) a damaged limb would be totally amputated and the patient's life saved. In the "quality of life" standard, not only will the patient's life be saved but the limb as well. This decision to save the entire limb involves high costs, namely, operating theater, lengthy hospitalization, rehabilitation, and other services that are not required for leg amputation.

- Legal considerations.* We treated the Syrian patients at both the field hospital and the civilian hospitals according to the Israeli Patient's Rights Law that was legislated in 1996 and regularized patients' rights in Israel. Similar to Israeli patients in Israeli hospitals, Syrian patients were asked to sign an informed consent for treatment in the various facilities as well as an additional designated informed consent form for surgery if required. These forms were translated into Arabic, and all communication with the patients was facilitated by interpreters who explained the diagnosis, differential diagnoses, investigational diagnostic programs and alternatives, the treatment options and the expected prognosis [6]. In some cases, the patient did not agree to a suggested treatment, or to others that we suggested, and they were discharged. The Israeli Patient's Rights Law states that in an emergency situation, when the approval of the patient is not available (namely, he or she is unconscious), three physicians have to sign the approval for treatment. The same was done with Syrian patients in such cases. If not an emergency situation, the patient's agreement is mandatory and if not, court approval is required. For children (Syrians or Israelis), if the parents were not available and it was not an emergency situation, we needed the court's permission before providing treatment.
- Prioritizing: Israeli vs. Syrian.* Most of the Syrian wounded would arrive at civilian hospitals during the night when the hospital functions primarily for emergencies, with less staff and capability than during the day. In some cases, Syrians entered the hospital at the same time that Israeli patients, particularly victims of road accidents, arrived at the emergency department. In such a situation, the question of priority for treatment arose: who should be treated first, the Israeli or the Syrian? This unique challenge [7] emerged from the fact that Syrians were being treated in the same facilities as the Israelis (apart from the field hospital). Usually in a disaster area, medical services are provided in temporary facilities that are built for this purpose, where medical support is provided solely for people affected by the disaster and not for others. In our case, the Syrians were treated in civilian hospitals and thus the dilemma arose regarding priorities. When separate facilities are allocated to a humanitarian operation (as generally done in a disaster area) this dilemma does not exist. This 'competition'

between citizens and the humanitarian patients raised an ethical dilemma on the value of human life versus the basic right of Israeli citizens to the available health services [8]. Our decision was quite clear and our staff were instructed to triage according to the policy that the more urgent cases should be operated first, irrespective of nationality. This policy was not universally accepted by all Israeli patients, with some complaining that their treatment was delayed as a result. They demanded priority as citizens of Israel, citing the Talmud, "Your town's poor people are first."

**CONCLUSIONS**

A unique Israeli project that was operational during the last six years and provided medical and other help to Syrian ill and wounded, the same standard of care that Israeli citizens received and in the same facilities, exemplifies humanitarian medical care. Unlike the humanitarian standards of the WHO, the Syrians were treated in adequately equipped and highly professional medical facilities [3].

Over the last few years we have had to deal with many challenging situations that the western clinical world has yet to face. The diverse questions discussed earlier brought us to the clear understanding that under these unusual conditions we must be consistent yet flexible and not sacrifice ethical integrity because of the objective difficulty of this project.

Three seminal issues require the attention of the humanitarian community dealing with humanitarian aid: the standard of care, ethical principles, and legal complexities [8]. We believe that the complexity of this project requires additional study, and in view of the new geopolitical situation a thorough understanding of the Israeli experience is necessary.

I would like to end this article with a personal note. For the last six years I have met and spoken – in Arabic – with Syrians who crossed the border. At the border and in the field hospital, I saw the fear in their eyes. Later, at Ziv Medical Center, I saw how those fears changed to hope. They used to be our sworn enemy and perhaps still are, but we healed their wounds and lifted their spirits. During these years, they left Israel and returned to Syria, but they became our extended family and we theirs [Figure 2]. With this unique project, I have come to realize that the field hospital personnel, my

**Figure 2.** Celebrating a Syrian teenager's birthday at Ziv Medical Center



medical staff, and I were fortunate to have had the opportunity to provide medical support to these people in their time of need, and to show the Israel that we know but they had not known.

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**Capsule**

**SP3 is key to Smac mimetic efficacy**

Finding drugs that selectively target tumor cells and spare healthy tissue is challenging. Smac is a mitochondrial protein that is released into the cytosol during apoptosis. Smac mimetic compounds block anti-apoptotic machinery and induce production of the cytokine tumor necrosis factor- $\alpha$ . Smac mimetics have emerged as promising cancer therapies. **Beug** et al. found that the transcription factor SP3

critically mediates the effects of Smac mimetics and is more abundantly expressed in tumors than in normal tissues from the same patients. Thus, SP3 may provide a biomarker for patients that will best respond to and tolerate these drugs.

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**Capsule**

**Dietary modulation of T cell immunity**

Commensal intestinal bacteria respond to dietary changes by modifying gene expression, leading to shifts in the amounts of bacterial antigens encountered by the intestinal immune system. **Wegorzewska** et al. developed a mouse model system to investigate whether CD4+ T cell recognition of antigens of the gut symbiont *Bacteroides thetaiotaomicron* is subject to dietary modulation. T cell receptor-transgenic T cells that recognized a bacterial outer-membrane vesicle protein differentiated into

both regulatory and effector T cells, and colitis emerged after selective depletion of the regulatory T cells. Dietary glucose strongly repressed the T cell-detected antigen. Thus, dietary modifications that reduce bacterial expression of immunodominant antigens targeted by T cells could ameliorate some forms of human inflammatory bowel disease.

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**Capsule**

**Teasing apart tonsillitis**

Although exposure to group A *Streptococcus* is prevalent, only some children develop recurrent tonsillitis, which can lead to tonsillectomy. To discern why some children are susceptible and others resistant, **Dan** et al. examined tonsil samples from two cohorts. Children with a history of recurrent tonsillitis had tonsils with smaller germinal centers and had reduced antibacterial antibodies compared with children with non-recurrent tonsillitis.

Moreover, the T follicular helper cells from those subjects could be cytotoxic toward B cells. Class II human leukocyte antigen analysis also identified protective and risk alleles. Thus, altered adaptive immune responses to group A *Streptococcus* may differentiate those at risk of recurrent infection.

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