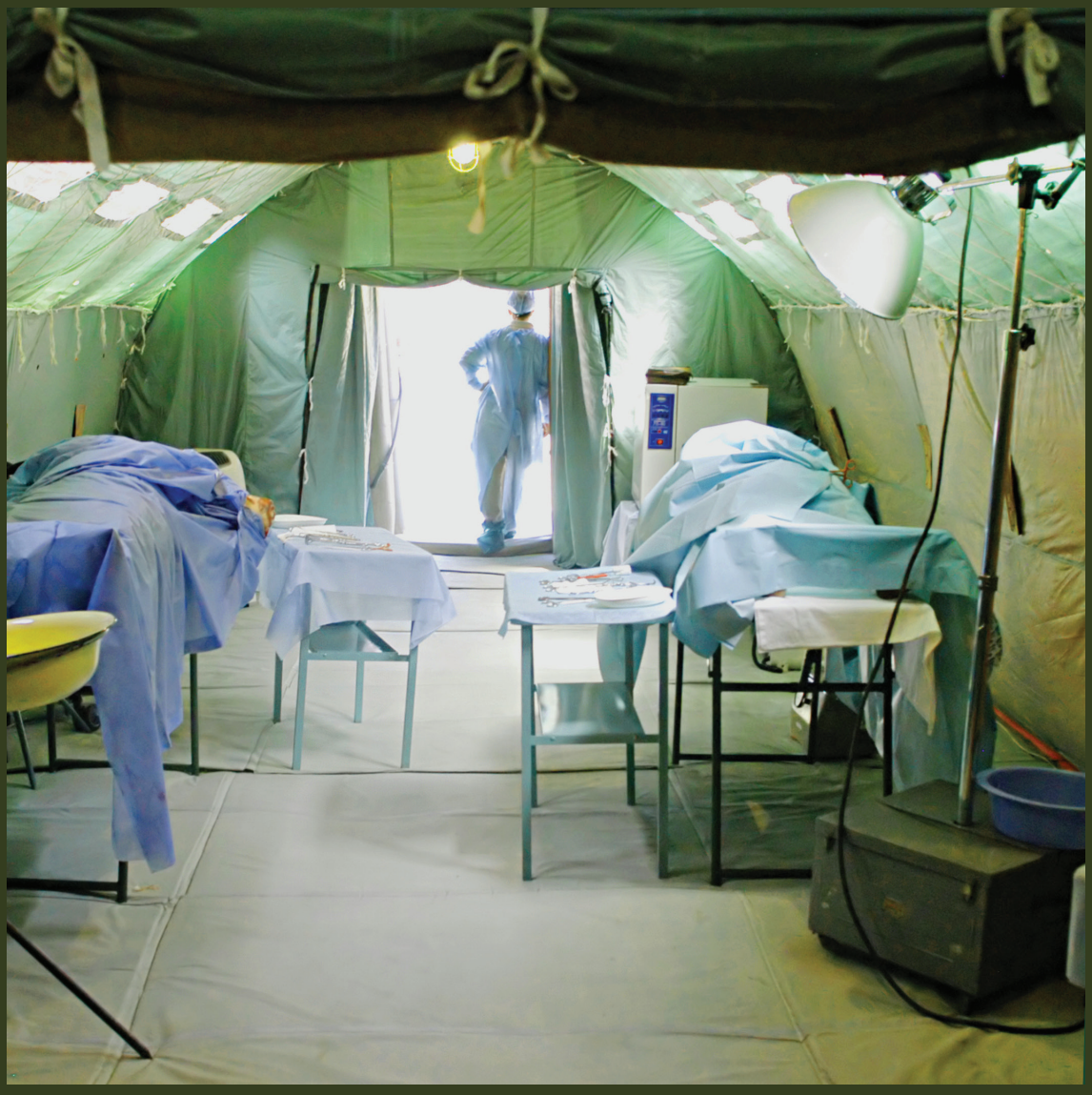
# VOICES

PERSONAL STORIES FROM THE PAGES OF NIB

## Healthcare Under Fire: Stories From Healthcare Workers During Armed Conflict



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To the authors for sharing their stories with us.

# Introduction
# Healthcare Under Fire: Stories from Healthcare Workers During Armed Conflict

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**Abstract.** This symposium includes twelve narratives from individuals or groups who have worked to help the sick and injured receive healthcare during armed conflict. Four commentaries on these narratives are also included, authored by experts and scholars in the fields of bioethics, human rights, sexual violence in armed conflict, the forced displacement of civilians, and policy development for resource constrained healthcare. The goal of this symposium is to call attention to the the difficulties and ethical dilemmas of providing healthcare during violent armed conflict.

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**Key Words.** Medical Ethics, Narratives, Moral Distress, Policy Making, Human Rights, Bioethics, Delivery of Health Care, Armed Conflicts

## Introduction

War and violent conflict dominate the headlines. As a new war erupts, it takes center stage, pushing last week's war lower on the radar, then last year's war fades completely into the shadows. But for many people, the violence and conflict continue and they must learn to live under fire. Even when the shooting stops, they continue to live with the consequences. Those who stay include people who do what they can to care for the wounded, the sick, and the dying. Some are healthcare professionals whose lives are turned upside down by the arrival of war, and they remain to learn how to care under fire. Some are volunteers who seek to do what they can to help others. Some come with the military to care for their own people and then see the unmet needs of many others living in the conflict zone. They struggle with what they are supposed to do when their professional calling pulls them one way and their

military calling another (Gross, 2021). Others seek to use their skills in research or their connections to try to help the hurting through data or policies or just common sense.

Caught in the middle of the world's conflicts are civilians and those who seek to care for their health. In 2022, the number of highly violent conflicts (i.e., wars) increased, with the majority occurring in sub-Saharan Africa (Heidelberg Institute for International Conflict Research, 2023). The number of violent conflicts also increased. The military may bring healthcare professionals to help their wounded, but wars generate more civilian injuries and deaths. In 2021, civilians comprised 89 percent of those in populated areas harmed by explosive weapons (Humanitarian Action, 2022). This does not address the harms arising from loss of homes, incomes and essential services. Millions of people are displaced by violent conflicts each year, adding to the growing numbers of refugees and internally displaced people in the world. Who cares for their health, and their injuries when their temporary homes become targets of violence? As violence continues, humanitarian workers face additional challenges as they try to bring aid within constraints or outright blockages imposed by the warring parties.

As if these challenges were not enough, healthcare workers in recent years have gone from being seen under the Geneva Conventions as protected non-combatants to being treated as legitimate targets of violence (Physicians for Human Rights, 2023). For example, a WHO database for 2023 documented, up until December 8, 1159 attacks on healthcare workers and health facilities in 19 countries and territories, resulting in 690 deaths and 1135 injuries, most of them civilian healthcare workers (World Health Organization, 2023). A red cross on your helmet, vehicle or building is now seen by some as a target to aim weapons at. Some of this can be traced to the rise of nonstate actors who never signed up to the Geneva Conventions or International Humanitarian Law (Gallardo, Burkle, Ragazzoni, & Corte, 2016). But some state militaries also believe in destroying healthcare facilities and killing healthcare workers (Dzhus & Golovach, 2023).

In the midst of all this, healthcare workers try to do what they can to care for the health of those living under fire. They face many challenges and difficulties, including harrowing ethical dilemmas. Yet bioethics as a discipline has paid little attention to the ethical challenges faced by healthcare workers in conflict settings (ten Have, 2023). We wanted to hear from these doctors, nurses and others about their experiences. This symposium sought to hear their stories and bring attention to the courageous men and women who serve in these difficult circumstances. We wanted to give them a place to have their voices heard as they describe how they have faced their challenges and ethical dilemmas.

## The Call for Stories

The call for stories sought narratives from healthcare workers who have provided care during violent armed conflict. The call arose because of recent developments in several conflict zones where healthcare workers, hospitals and ambulances have become the targets of violent attacks in spite of the protections provided by the Geneva Conventions. We were interested in hearing from a variety of healthcare workers who have provided care in the midst of armed conflict either as civilians or members of miliary healthcare services. We wanted to hear about the difficulties and dangers of practicing during armed conflict or being deliberately targeted as part of an armed struggle. We were particularly interested in learning about the stresses and distinct ethical issues and dilemmas that providing healthcare under fire generated. We took a broad view of 'armed conflict,' and were interested in receiving personal stories ranging from a wide variety of settings, ranging from open warfare to chronic armed conflict. We welcomed stories from physicians, nurses, paramedics, clinic administrators, humanitarians, volunteers, healthcare researchers and others.

Authors were asked to consider the following questions, knowing one story would not address all of them:

- Does a particular patient encounter still weigh heavily on your heart or mind? Explain why.

- What were the most pressing dangers you felt during this time? How did you balance the needs of the sick and injured with your own personal safety and security?
- Why did you not leave? If you decided to leave at any point, how did you come to that decision? How did leaving impact you?
- How did you manage scarce resources during the conflict?
- How did caring for those with on-going illnesses and chronic diseases compare to treating conflict-related injuries?
- Did you have struggles with maintaining neutrality with those you helped? If so, how?
- What ethical dilemmas did you face during the conflict?
- What positive or surprising things have come from working during the conflict?

The editors of *Narrative Inquiry in Bioethics* published the call for stories in the *NIB* newsletter and on the *NIB* website. Additionally, the call was posted on several social media platforms, including LinkedIn, Facebook, and X. It was distributed through the American Society for Bioethics (ASBH); the Medical College of Wisconsin (MCW); the Ohio State University College of Nursing, Center for Bioethics, and College of Medicine; the University of Zurich Center for Military Medical Ethics; the American University of Beirut and the Arab Bioethics Group listservs; Humanitarian Healthcare Ethics (Canada); the Westminster Centre for Research in Veterans (UK); the Veterans Employee Resource Group (US); European Masters in Disaster Medicine (Italy); and Médecins Sans Frontières and other NGOs. The call was also shared through numerous private social media groups and with colleagues and experts in disaster medicine, disaster ethics, clinical ethics, law and policy, military science, and patient advocacy.

## The Narratives

The twelve stories included in this issue reflect a variety of experiences during violent conflict. We received many stories in response to our call and were able to include three additional stories in the online supplement that accompanies this issue. The twelve stories in this symposium come from authors who are bioethicists, physicians, pathologists, oncologists, emergency medical technicians or healthcare researchers. Their backgrounds include civilian and military medicine, humanitarian health organisations and academia. They write about conflicts they experienced in Israel, Palestine, Ukraine, Myanmar, Sudan, Afghanistan, and Iraq. Some write as they listen for the next missile to land near them, while others reflect on conflicts they experienced decades earlier.

All stories recount with vivid detail the situations they experienced and the emotions they felt and that have remained with them. The authors ask many deep and searching questions. Is it not enough that they must dodge the bombs and bullets, but they must also grapple with their existential questions and doubts? They talk about sleepless nights and worries about their families. They come across as much more worried about their families and their patients and colleagues than themselves. Why they stayed was summarized well by one author: "*If not me, then who will help people?*" Those who did eventually move to safety continue to be concerned about those they left behind, and struggle with guilt over leaving.

We all owe a debt of gratitude to these authors who have taken the time to share these deep and personal stories with the world. Some have done so at personal risk. Writing their stories also can be a painful exercise in itself, opening wounds that may or may not have had time to heal. The motivation to do so was put succinctly by one of the authors who stated that these stories "should warn the world that these events are occurring and urge that they should not happen again." We could not agree more.

## The Commentaries

This symposium also includes four expert commentaries on the narratives. The commentary authors— Kim Thuy Seelinger, Michael Gross, Esime Agbloyor, and Melissa McRae & Maria Guevara—provide unique perspectives informed and enriched by their expertise in bioethics, military ethics, conflict-related law, military medicine and humanitarian medicine.

Kim Thuy Seelinger, is a Research Associate Professor at the Brown School of Social Work and a Visiting Professor at the School of Law at Washington University in St. Louis, where she also directs the Center for Human Rights, Gender and Migration (Institute for Public Health). Professor Seelinger is an expert on gender-based violence in armed conflict and forced displacement. She has conducted several interdisciplinary studies focused on protection and accountability in Central America, the Mediterranean, and Africa. She also provides technical assistance in war crimes cases around the world and has drafted global guidance on survivor-centered approaches in humanitarian crisis work. Her commentary focuses on five recurrent themes, including the obligation to provide care without discrimination, specific impacts on and considerations related to children, the personal transformation of medical providers, the mental health toll they suffer, and reflections on their proximity to or distance from the conflict.

Michael L. Gross is Professor of Political Science and former Head of the School of Political Science at The University of Haifa, Israel, specializing in military ethics and military medical ethics and related questions of national security. His articles have appeared in numerous prominent journals. His books include *Ethics and Activism* (Cambridge, 1997), *Bioethics and Armed Conflict* (MIT, 2006), *Moral Dilemmas of Modern War* (Cambridge, 2010); *The Ethics of Insurgency* (Cambridge, 2015), *Military Medical Ethics in Contemporary Armed Conflict* (Oxford, 2021) and two edited volumes, *Military Medical Ethics for the 21st Century* (Routledge, 2013), *Soft War* (Cambridge, 2017) and, most recently, *Military Medical Ethics in Contemporary Armed Conflict* (Oxford, 2021). His commentary grapples with differences between medical ethics and military ethics, and uses the stories to explore the complex distinctions between medical impartiality and neutrality in wartime healthcare. He also explores the moral injury and day-to-day struggles noted in the stories.

Esime Agbloyor is a Ghanaian-trained physician and during her practice in Ghana, she worked at a military hospital and is familiar with the challenges her colleagues faced while serving on UN peacekeeping missions in conflict zones. Beyond this, Esime also holds a master's in Bioethics and is currently a Clinical Ethics Fellow at the Ohio State University Wexner Medical Center. Her training as both a physician and bioethicist allow her to appreciate and synthesize the ethical dilemmas that confront healthcare workers in war-torn zones. Her commentary identifies some of the common themes across this issue's stories: duty to others or self, allocating scarce resources, doing research during war, and dealing with the lingering scars of war.

Melissa McRae is an Australian physician, dual specialised in Emergency Medicine and Public Health. She has worked in the humanitarian sphere for over 15 years in a range of roles including clinical care, medical operational strategy development, implementation and evaluation, research, management, and leadership and most recently specialised in medical ethics. Melissa has experience working for government, non-government, and humanitarian organisations in low-, middle- and high-income countries across Australia, Africa, Asia, the Middle East, Europe, and the Caribbean. Within the humanitarian sphere she has worked predominately with the Red Cross and Médecins Sans Frontières (MSF), most recently as Medical Director for MSF (Operational Centre Amsterdam). Melissa currently works for the MSF Research Unit on Humanitarian Stakes and Practices.

Maria Guevara is the current MSF International Medical Secretary. She is a multilingual medical humanitarian specialist and medical doctor, trained in pulmonary, critical care and tropical medicine, and a strong background in complex humanitarian settings, global health policy, and advocacy. She has over 19 years of humanitarian experience and over 10 years management practice through her work with Médecins Sans Frontières/Doctors Without Borders. Her extensive humanitarian field work has spanned across countries in Africa, Americas, and Asia in both emergency and stable settings as well as being the organisation's Regional Representative in Asia from 2012 to 2017 and the Senior Coordinator on Attacks on Healthcare for MSF from 2017-2018, leading reflections on the protection of the medical mission. Her special interests and passions

are Global Health, Response in Emergencies, Health Security and Planetary Health. The commentary by Drs. McRae and Guevara explores approaches to ethical dilemmas involving medical impartiality, or conflicting loyalties or moral distress, as revealed in these stories. They add further details on the variety of ways healthcare delivery can be attacked during conflict.

The way all of the commentaries identify different themes and issues in the stories points to the many complex ethical issues faced by healthcare workers under fire. This also shows the urgent need for support and other resources to help these brave souls face the hellish environments they find themselves in.

## Conclusion

The challenges and ethical dilemmas faced by healthcare workers in conflict zones are many. Some material is available to help military healthcare professionals with issues in miliary medical ethics (Gross, 2021). Slim (2015) has provided an excellent introduction to ethics in humanitarian and war situations. However, very little is available to shed light on how civilian healthcare workers plunged into the depths of violent conflict are to manoeuvre the challenges and ethical dilemmas they face (Fares, 2023).

We hope that the stories provided here will remind our readers of the 'ordinary' men and women taking care of others' healthcare needs during war and violent conflict. Of course, they are not 'ordinary' people at all. They are highly courageous people who respond to the call to serve others. Their stories take us beneath the fleeting headlines that flash across our screens to remind us of our kindred flesh and blood who cry and fear and tremble as they help others while wondering if the next bomb will land on them. Their humanity in response to the cruelty behind those who pull the triggers should be praised widely and loudly.

But what can a collection of stories accomplish? The introduction to a volume of fictional short stories about conflict put it well. Stories serve an important role "of mediating history, interpreting a brutal and brutalizing reality, and keeping hope and dignity alive" (Engelbert, 1988, p. xxix). We hope that these stories will function in these ways.

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## Personal Narratives

### An Unsettling Affair

Zohar Lederman

Adults should not bury babies. Whenever that happens, you know something in the world has gone awry.

Similarly to most Israeli Jews, I had to enlist in the military when I was 18. As part of my basic military training, I had to guard a certain settlement in the West Bank for two weeks. The drill was what we call "4–8": four hours of guarding, eight hours of rest. I was supposed to stand on my feet throughout my shift without eating, reading, or doing anything that might distract my attention. *The terrorists are coming*, we were told, and *they are bloodthirsty*. *You can save lives!* Well, not that of the terrorist, obviously.

I did very little guarding during those two weeks. I was too busy coping with depression and loneliness, although I am only now aware of the latter. Desperately struggling to keep my head above water, I did what I could to survive. I read books, lots of books. I remember reading Nietzsche's Zarathustra's parable of one's development in the desert. You start off as a lion, then a camel, and finally a child. If I could bestow only one piece of advice to my younger self, it would be to pack lightly, as even the camel's back can only take so much. My laziness paid off. Nothing happened during that time. My older brother was kind enough to drive for an hour and bring me and my comrades the best candy Israel has to offer, and Coke. So I snacked, drank, and read.

Two years later, I was called to the very same settlement as an emergency medical technician, just about to commence medical school. I was accompanied by my brother, who was then in paramedic school. We were in the midst of a family dinner in one of the too-many Jewish holidays. A terrorist attack occurred—a terrorist penetrated a house while everyone was asleep and shot everything that moved, including a male baby. Being only a couple of months old, his body occupied less than a quarter of the ambulance gurney. The upper part was bare; the lower part was wrapped in a diaper. There was no blood, no obvious visible signs of trauma on his body, except for a small hole in his right arm, just under the bicipital muscle, right where the brachial artery is.

Talking about the ethics of futile care seems out of sync in such moments, even if I were aware then of the debate. When a baby is dying, you do everything to save him. Two fingers on the chest, 15 chest compressions, 2 breaths. That is what we had to do then, and that is what we did. Needless to say, the pale body did not respond. My brother and I drove the small body to the morgue. I could do nothing but stare at it throughout the 50-minute drive. There is something wrong in a world where this kind of thing happens. I promised the baby that I would fix it.

I have not fixed it. But I have been trying.

I am now an emergency medicine physician and a bioethicist. I have not been involved in other terrorist attacks since then, but I have seen my share. Some deaths feel natural and even due; others feel cruel, untimely, and unjust. The latter takes away a tiny bit of your soul and makes you question your role in the world. By being the best physician I can be, I hope to prevent future cruel, unjust, and untimely deaths, one person at a time. But there is only so much a physician can do.

Similarly to others working in bioethics, my research spans several topics, from clinical to public health ethics. A few topics, however, are particularly close to my heart, and the Israeli occupation is one of them. The untimely death of the baby drives this passion.

I could not save that baby. No one could. But as a physician and a privileged academic I can choose to channel my efforts to make them count towards preventing other cruel, untimely, and unjust deaths. Through effective scholarship that focuses on the Israeli occupation and health conditions of Palestinians in the Occupied Palestinian Territory, I seek to give voice to those who often go unheard. In this specific instance, that voice belonged to a Jewish Israeli baby, whereas in most other instances, it is the voice of Palestinians.

Academia sometimes makes us forget the real reasons we do what we do. We become embroiled in the 'publish or perish' game and focus on publishing for the mere sake of publishing and of professional promotion. Rejections sadden us, making us doubt our aptitude as writers and thinkers. Grant

application and administrative work weigh us down. It seems that almost all of us have considered abandoning academic life at some point, following perhaps some job interview that went sour.

For me, it is exactly during these instances that the image of the pale baby, covered by the ambulance's orange blanket, reminds me why I do what I do. Humanity's past, present, and future are packed with unjust and untimely deaths, and all individuals have a responsibility to remember, attend to, and prevent them, respectively. The responsibility of healthcare workers and academics to do so is even greater. Naturally, the Israeli occupation is personally closer to my heart, but wherever unjust deaths occur, there healthcare workers and academics should be.

Healthcare workers then have several roles during armed conflicts. First, they ought to provide care whenever care is due and as long as their safety is assured. Second, they ought to bear witness and speak truth to power. Through professional and popular outlets, they should warn the world that these events are occurring and urge that they should not happen again.

Everything I do, both as an academic and as a physician, I do for him.

## How We Keep Caring While Walking Through Our Pain

Ola Ziara & Rachel Coghlan

**Author Dedication.** To my dear brother Omar Ziara, a bright doctor, entrepreneur, and community advocate who was killed in an Israeli bombing in November 2023.

May your soul rest in peace and may your memory remain alive in our hearts. May your unborn child grow up to become the wonderful man that you were.

Forever loved by all.

Palestinian-American poet, Suheir Hammad, writes:

> *Occupation means that every day you die, and the world watches in silence. As if your death was nothing, as if you were a stone falling in the earth, water falling over water.*
>
> *And if you face all of this death and indifference and keep your humanity, and your love and your dignity and you refuse to surrender to their terror, then you know something of the courage that is Palestine.*

I am a doctor from the Gaza Strip in Palestine. I live through acute war and protracted occupation. I work under missiles and through scant resources. I experience risks and dangers and face abominable choices made from nightmares. I know heartbreaking death.

As doctors here, we fear, suffer, cry, and grieve alongside our patients and their families. This is my story of how we continue to care.

**********

### Summer 2014 A Fifty-Two-Day War: How To Stay And How To Keep Them Safe

The huge bombardment strikes close to the hospital, scattering glass and rubble. It brings an abrupt end to my rare, quiet pause for coffee. *Are the babies hit?* We sprint to the Neonatal Intensive Care Unit, our full attention only on those infants, hastily checking every crib. My thoughts are frenzied. *What if the next missile strikes us? Will I be able to rescue them? Will I have time to carry their tiny bodies outside through wreckage and fire? How will I choose who to save, and who to leave behind? Could I choose? Will I even be able to think lucidly, act logically for those babies if the fire consumes us?* We stay.

Somewhere, a house razed to the ground, a mother and her children dead. This time, our babies are safe.

**********

### Summer 2014 A Fifty-Two-Day War: How To Cast Off Danger And How To Find Consolation

A missile shatters our neighbour's roof. I am about to leave home for my evening shift. I check on my shaking mum; she is okay, not hurt at least. I ring the senior doctor. *I am sorry. I am coming. I will be a little late.* Two further missiles hit, wiping out the next-door building completely. *No, do not send an ambulance for me. It is too dangerous. I will come*

*alone.* Trembling through the dust and darkness, I leave on foot to reach those babies. I must compose myself. We are needed there to bring calm, to keep caring.

And we gamble our lives to seek distraction and comfort for ourselves. We find solace through unbearable pain in our caring.

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## Winter, Spring, Autumn, Summer, Any Day: How To Question Purpose And How To Feel Helpless

It is an ordinary night shift in 'quiet' times. Tonight, all the beds are occupied. All the ventilators are taken, forcing life into small, sick faces. At dawn, the phone call comes. A new baby struggling to breathe is on his way. I call around. No more beds to take him here or anywhere. No more ventilators—here or anywhere. *Bring him here. We will care for him.*

He is in a very bad way. He needs immediate life-saving care. We take turns manually ventilating him, working to the hissing rhythm of the Ambu Bag[1]—inflating, deflating, inflating. Our arms ache. We keep pumping the bag. *Do not stop.* The moment when the morning shift arrives is our moment of salvage. We can go home. We have made it through the night without medicines, machines, disposables, or enough manpower, our arms throbbing. We have kept him alive.

But he is so fragile, the system is fragile, we are fragile. Dare I even ask—*is it worth it? Is it worth a baby surviving the misery of this overstretched healthcare system, this unrelenting crisis?* We keep them alive in a place that can barely offer them the basics. *Is my job even worth it?*

The effort of caring in crisis bounces back at me and slaps my skin. I struggle to forget the babies' faces, their small bodies lying in intensive care. I struggle to forget my feeling of absolute helplessness. I cannot offer care even to myself.

[1] *An Ambu bag is a proprietary name for a hand-held device used to provide ventilation to patients who are not breathing or not breathing adequately.*

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## Winter, Spring, Autumn, Summer, Any Day: How To Be Successful And How To Bear Guilt

It is a few years later. I have made my way out of direct hospital care to work in the offices of humanitarian health organisations. I use my experiences as a doctor to guide medical care in other important ways. I have replaced intensive care and Ambu bags with sitting at a desk and going to management meetings. I can direct health policies and priorities. I am successful in this place. I am achieving good things. I can offer vital support from here. *Can I?*

There is a constant inner wrestle. *Should I really be here? Or should I be back in the hospital, serving those precious babies, staying, taking away their pain?*

My hospital colleagues work hard, battle to care, lack decent salaries, pay no attention to caring for themselves. Nobody else does either. *Shouldn't I be there supporting them, fighting for them?* There are intense feelings of guilt that dwell within.

**********

## Spring 2021, Spring 2023, The 'Shorter' Wars: How To Feel Worthless And How To Seek Distraction

I keep working in the offices of humanitarian organisations during deadly attacks. The shorter wars. My hospital colleagues leave home and go to work exactly as they always do, as I used to do. They risk travelling through bombardment, venturing into target sites for military attacks to get to the places meant to cure and care. Fearing they will not see their families again, they compose their faces. As they always do, as I used to do.

I am safer at home now. My conscience weighs heavily again. *I should be in the hospital with them, facing their challenges through attacks. Does this make me worthless in war?*

I cannot be distracted now by tending to babies. I sit at my computer. I do not sleep. The night times are the worst. I drown myself in work tasks. I try

from afar to mobilise medical teams to respond. There is little satisfaction in this if I cannot be there with them, helping, serving, accompanying.

I decide to bake a cake.

**********

### Winter, Spring, Autumn, Summer, Any Day: How We Keep Caring

Living here and working here as a doctor brings physical and mental burdens. The crushing exhaustion, the personal risks, the harrowing choices, the helplessness, the guilt, the unworthiness, the terror of seeing death and becoming dead. We all need a break. We all need a holiday. We all need to go outside. *Where can we even go? Who is looking after us?*

But the burden and the dread are always swallowed by the deepest urge to care. Because it is within us. Because we do not want to see their families grieve. Because their families *are* us. Because we love. Because that is what we have to do. What alternative do we have?

We must keep caring while walking through our pain.

### Autumn 2023 Now: How Can We Keep Caring?

This was all before. The now has changed everything.

I have doctor friends who have died under bombs whilst holding their children or their mothers. I have doctor friends forced to choose between remaining with patients and evacuating their families. Those who stay work to save lives, triage injuries and write the names of babies on the torsos of tiny lifeless bodies, over, and over. Without supplies, sleep, food or water, without their homes left standing, with nothing left but their grace and their humanity.

As doctors in Gaza now, we weep an unbearable grief. We no longer know if we can keep caring.

## Adjusting Laboratory Practices to the Challenges of Wartime

Oksana Sulaieva, Anna Shcherbakova & Oleksandr Dudin

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After 500 days of the unjust war initiated by the Russians, we look back to reflect on the challenges our medical laboratory faced during these early days. On the morning of February 24th, we were awakened by the dreadful roar of sirens, the sound of which filled us with adrenaline and anxiety. Although our team had considered the risks of Russian military aggression and thus updated our emergency plan at the beginning of 2022, the first day of the war revealed that nobody was truly ready for the bombing, air alarms, tanks on the streets of towns and cities, violence and murders of civilians. That morning the city's transportation system collapsed, and the flow of cars cluttered all the roads as people were trying to leave the city and escape the upcoming atrocities and death. Serious and disquieted people hurried along the streets—some people rushed to shelters, and others went to the military registration and enlistment offices to fight against Russian aggressors for the life, independence, and sovereignty of Ukraine.

We hurried to work, committed to performing our duties. Our medical laboratory serves more than 750 hospitals in Ukraine. Despite fear and uncertainty, we walked to the lab, taking our children and alarm case[1] with documents and essential things. Months later, people asked us why we went to the laboratory instead of leaving the city or even the country. At that moment, our professional duties

[1] *An alarm case is a portable kit containing items that are important or would help a person survive during an escape or evacuation.*

were an anchor linking us to each other against fear and panic. Our responsibility to provide patients and physicians with the results of blood testing, pathology, and molecular reports outweighed our fears of the war. We had to complete the testing of all the samples delivered to the laboratory to provide our customers—who include children, pregnant women, diabetic and cancer patients—with data essential for identifying accurate diagnoses and effective treatments. So we spent the first days of the war in the laboratory. At the same time, we had obligations and responsibilities to our staff as well. We had to consider how to manage our employees' protection along with continuous laboratory services provided under endless air alarms and bombings. Many healthcare facilities in eastern regions and around Kyiv were affected by missiles or completely destroyed. Of our sixty laboratory offices around Ukraine, ten were damaged or abandoned due to occupation. Several of our fleet cars were also damaged and riddled with bullets. Many employees in the regional offices in Melitopol, Kherson, Mariupol, Chernihiv, and in suburbs of Kyiv such as Bucha and Irpin lost their homes as a result of massive military operations or occupation. Dozens of our employees joined the Ukrainian armed forces to defend civilians and fight against aggressors. Many others became volunteers, involved in blood donation, medical care for the wounded, cooking, and serving the troops. And still, we had to continue our work and protect our staff at the same time. We also helped each other by sharing our goods, medication, homes, cars, warmth, and support. Some pathologists stayed at the workplace for several days moving between pathology stations, microscopes and shelters, and sleeping on the floor but continuing to work.

Our main challenge was the regular terroristic attacks on healthcare facilities situated far away from the front line, which in fact, violated international humanitarian law regarding respect for human rights during armed conflicts. During the first weeks of the war, the magnitude of military aggression, massive bombing, and air attacks undermined the healthcare system and endangered laboratory staff and patients. We prioritized protective measures. Some of our laboratory staff and facilities were evacuated from Kyiv to Lviv in western Ukraine. The partial relocation of our laboratory to Lviv was also driven by the displacement of several million Ukrainians to the western part of the country.

We were able to arrange relatively safe accommodations for our laboratory employees and their families in Lviv. Under strikes and alarms, our team gathered the essential laboratory equipment, freezers, laboratory furniture, computers, reagents and consumables needed for our work. On March 10th, we drove to Lviv in -10° Celsius temperatures, with two trucks and dozens of cars to establish our new laboratory facilities. Within a few days, our lab started operating in Lviv. It was essential to get back up and running quickly so we could support the most vulnerable groups of the population, including cancer patients who needed proper histopathology and molecular diagnostics. Establishing the new laboratory in Lviv eased the difficulties we had been experiencing with logistics and consumables delivery, which had been challenging in the eastern, southern and northern parts of the country. Fortunately, after the de-occupation of the Northern part of Ukraine and Kyiv suburbs in April 2022, we re-established our main laboratory facilities in Kyiv and maintained a reserve laboratory in Lviv. Since May 2022, the two laboratories in Kyiv and Lviv have been operating and this provides backup opportunities for continuous laboratory services and staff.

The next challenge we faced was the recurring missile and drone attacks on the energy infrastructure of Ukraine. On the day when the European Parliament recognized Russia as a terrorist state, Russia confirmed this status through the massive shelling of Kyiv and many other cities in Ukraine, targeting civilian infrastructure. Many innocent people were injured, and some died. However, the most detrimental effect was on the power and water supply. Most Ukrainians will never forget October–November 2022 as a period of regular power outages due to the strikes and drone attacks affecting the energy system of Ukraine. On November 23rd, detrimental strikes caused a blackout, creating full darkness and no power for the whole

city. The strikes on infrastructure were dangerous for millions of people, as living without light, water, and heat in winter brought about illness and disease and, consequently, the need for medical care that was hard to deliver under the circumstances. Our laboratories faced even more pronounced harm from disruptions in access to electricity and water. Both energy and water are required for proper sanitization as most laboratory equipment needs water of high purity and deionization to eliminate various biosafety hazards. Servers and maintenance of the laboratory informational system also require a stable energy supply. Finally, there was a need for illumination at numerous workspaces and accompanying technical areas.

As laboratory medicine is essential for precise diagnosis and monitoring of patients' treatment, physicians working and treating Ukrainians had a continuous need for blood and tissue testing. The uninterrupted work of our laboratory became possible thanks to the selfless contribution of the laboratory staff in coping with new threats and the efficient emergency plan developed before the war and revised regularly during wartime. Before the war, our laboratory was equipped with backup power, and a groundwater well provided an autonomous water supply. Generators kicked on to keep equipment working for many hours and even days. Thousands of laboratory tubes and histological cassettes were processed by the electricity produced by the autonomous energy sources. Thanks to the tremendous efforts of the technical staff whose daily maintenance, care, and refueling of the generator with diesel allowed us to keep providing energy for hundreds of laboratory staff members working for millions of patients under the most trying conditions. During this time, the laboratory became a shelter for staff members, their families, and patients. Laboratory offices provided visitors with hot water, tea or coffee, and access to electricity to charge cell phones and other gadgets. This brought us closer to each other and our customers, especially patients from vulnerable groups.

The experience of the ongoing war has provided us with numerous and sometimes painful lessons. What defined the resilience of the laboratory was a motivated staff, high flexibility, and transformation in the leadership. It was difficult to prepare to face violence and death, however, our mutual affection and care helped us deal with uncertainty and risks. Every staff member focused on their professional duties to meet patients' needs. In addition to emergency issues, crisis management, and preparedness to operate in different settings, we also realized the role of psychological support and links with the community. During the last year and a half, we arranged training for our staff on tactical medicine, emergency care, and posttraumatic syndrome. Together with patient organizations and physician associations, we arranged regular webinars for cancer patients to provide them with essential information about their disease and interpretation of laboratory data. Importantly, many international organizations, partners, and laboratories from the Czech Republic, Germany, Denmark, Croatia, Turkey, the USA, and other countries supported Ukrainians and our laboratory since the early days of the war. This spiritual support, and the consultations, equipment, and consumables have been priceless for our staff and patients. In addition, our laboratory applied for and received several grants to provide Ukrainian cancer patients with free-of-charge services for histopathological and molecular testing. These grants enabled Ukrainian cancer patients to get precise diagnostics and defined genetic alterations for further targeted treatment in Ukraine or abroad.

Lastly, our laboratory provided free-of-charge laboratory testing for servicemen of the armed forces of Ukraine and started social action to help people with mental health problems. On June 27, 2023, Post Traumatic Stress Disorder (PTSD) Awareness Day, we arranged a conference on PTSD and Post Traumatic Growth (PTG) to promote knowledge about PTSD among general practice physicians and military doctors. The conference gathered more than 300 physicians, psychologists, psychotherapists, psychiatrists, volunteers, social workers, and international experts in the field of mental health. It allowed the attendees to share knowledge and best practices and build a strong professional community in Ukraine committed to helping people with mental health challenges under

continuous war-related psychological traumas and uncertainty.

We thank all our laboratory staff for their selfless work despite these many challenges and threats. Under such extraordinary conditions, we have been able to keep up with the demand for our services, performing all necessary testing to give patients and physicians timely and precise laboratory diagnostics.

*Slava Ukraini!*

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## Why We Stay

Vladyslava Kachkovska, Iryna Dudchenko, Anna Kovchun & Lyudmyla Prystupa

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We are a group of physicians and professors in the Department of internal medicine at Sumy State University in Ukraine, located 20 miles from the border with Russia. We have been working together for ten years and, against the background of the war, have become more than colleagues, more than a hematologist, an allergist, a pulmonologist and a rheumatologist. We are now one organism that works for the benefit of patients, coordinating humanitarian supplies, teaching medical students, and at the same time worrying incredibly about our children, but trying to maintain our psychological homeostasis.

Over the past year and a half, we have learned many things. Dividing everything that surrounds us into primary and secondary concerns, we learn how to live without electricity during the winter and how to preserve the water supply. We realize material possessions are not important, as at any moment you may lose everything. After covering the basic needs of our families, we do not try to save money, but rather the opposite: we spend all the rest on drugs and supplies for those who are in need now. Of all that we have learned, one thing we have not learned is indifference, which is not possible during this time of constant loss of acquaintances, colleagues, and friends. We find balance only in our constant work. We have patients with medically complex conditions, and we prioritize them and their needs.

Our multidisciplinary teamwork before the war brought us great pleasure: interesting clinical cases and successful work with our patients, frequent training abroad, scientific research, and work with medical students and residents.

On February 24, 2022, our priorities changed. In addition, each of us faced a dilemma: whether to take our children to a safe place or stay. Balancing our emotional experiences and work is challenging, but mutual support, daily communication, and a heavy workload help us maintain a sense of normalcy. Still, we are sure this "normal" is adapted to our conditions and will not apply in peacetime. Moreover, since the beginning of the war, we have experienced dissonance between our established moral and bioethical principles, our virtues, and the main goal of medicine—preserving human life and dignity—with the surrounding events caused by the war. Daily deaths of Ukrainian civilians and soldiers, innocent children, domestic animals, abuse, rape of women, children, and older adults, demonstrative torture, the humiliation of human dignity, and criminal behavior of the enemy have altered our worldview. We are challenged by the central ethical and Christian dilemma, which our generation is unlikely to cope with—to accept everything we are going through and forgive.

During the last year, we have noticed that the occupation, life in the border area, and daily shelling affect our patients, dividing them into two main groups. The first group includes patients with complex psychological issues who are looking for a physical explanation for their symptoms. This group in particular overloads the healthcare system. Since few mental health specialists are

available for consultations, other physicians often have to act as psychologists to reassure these patients. The second group of patients are those who do not seek medical help because they believe that their health problems are simply caused by the constant stress of war and thus they are indifferent to their health and ignore symptoms such as weakness, weight loss, chronic pain, or enlarged lymph nodes.

Every day we work with patients whose lives have been negatively affected by war. Each has stories about the loss of loved ones, the loss of homes, or constant emotional stress related to relatives who are currently fighting in the armed forces. These stories cannot leave us indifferent. We live this experience together with our patients, in reality and not in the abstract, and we feel their emotions. To do otherwise would be impossible in our realities. In addition to qualified medical care, we take on the duties of psychologists because sometimes, this is the only thing our patients truly need. Here we share the cases of Patient M and Patient K, whose cases are linked by tragic events, late referral to a doctor, and oncological diagnoses.

## Patient M

Patient M is a 60-year-old woman who is the guardian of two grandchildren. She was forced to stay in Sumy during the Russian occupation in the early days of the war and then was temporarily evacuated abroad. Before the war, her daughter died of kidney cancer, and Russian troops killed her grandchildren's father during the occupation. Patient M has a chronic oncohematological disease that requires inpatient chemotherapy every month. Under any circumstances, as doctors, we get close to patients during such long and intensive treatment and worry as if for a relative. War brings you even closer and makes you feel other people's grief more deeply, especially when you realize that the prescribed course of therapy gives only a partial response, and you know this response will be lost over time, and the disease will progress. At her visits, patient M's grandchildren stand before us. They will be left alone without a guardian if she cannot care for them.

Even before the war, obtaining expensive drugs to treat oncohematological diseases was challenging in Ukraine. War has made these challenges even more acute. We try to adhere to international treatment protocols, but there is no insurance, and no medicine. Economic issues for patients and healthcare institutions have been exacerbated by war. Most of our patients' homes have been destroyed and their relatives are dead. It is impossible to use modern drugs and biological therapy.

## Patient K

Patient K, who is 71 years old, is also the guardian of two grandchildren. His son, a soldier, died during the war, and his wife, unable to bear the loss, went to the front as a tanker. He came to us for help because he began to tire quickly and felt exhausted, saying: "Doctor, I am now responsible for the lives of two grandchildren, do whatever you want, but I need to recover." The patient has a malignant neoplasm. Before the war, this could have been treated effectively and free of charge, particularly within the framework of international clinical trials. However, the invasion of the Russian Federation into Ukraine led to the immediate termination of new clinical research in Ukraine. Without access to clinical trials, expensive drugs must be independently purchased—or we must use the drugs we have available, that we know have limited effectiveness. As physicians, when treating patients under these circumstances, it is impossible for us not to plunge headfirst, using all our "free time" in search of the best option for the patient or searching for alternative ways of obtaining treatment for a certain patient. Such heroic efforts are now relatively routine.

A lack of medical resources and expensive modern drugs characterize each of these cases. We began treating Patient M and Patient K before the war and have managed to successfully control their chronic diseases despite the challenges of war.

## Managing Scarce Resources

We manage the situation of scarce resources with the help of our contacts at international medical societies, and colleagues and friends from Europe and the US. Here, we must note that international medical communities and doctors from around

the world—our friends—show incredible care and humanity. In addition to words of support, they help us with medical equipment and medicines. This is an incredible fact about this war: people who are far away and not exposed to any physical effects of war continue to share our pain and help our patients even one and a half years after the Russian invasion.

The concept of justice influences individual and collective behavior and our ideas about what is "ethical." Accordingly, in the case of providing medical assistance, it should also be decisive in providing all necessary resources per local protocols and standards for providing medical care. We adhere to the idea of distributive justice, which refers to the fair, equitable, and appropriate distribution of healthcare resources determined by justified norms that structure the terms of social cooperation. Triage is used in extreme conditions to assist according to clear principles. Accordingly, under the conditions of limited funding, providing long-term care to chronic patients and expensive treatment, for example, to cancer patients, is questionable. In addition to a lack of funds and medicines we also experience another problem—that of insufficient medical personnel, which creates difficulties for the healthcare system and society as a whole. Many of our colleagues have gone abroad, so we face the problem of a lack of medical personnel, but on the other hand, we have medical students and residents who are eager to join us in caring for patients. Similar to the early days of the COVID-19 pandemic, students and residents have volunteered to take on more than their usual tasks.

### Continuity of Care

While we treat those patients who have stayed in Ukraine, we also maintain contact with our patients who are abroad, some since the beginning of the war. Firstly, because of the waiting time for specialists in other countries and the need for quick advice on correcting treatment; secondly, they need our psychological support, sometimes help for their relatives who have stayed here, and the last one is no less an important reason. During many years of communication, they, like us, have become emotionally attached to each other, and we feel responsibility for their lives. All of them undoubtedly dream of returning to Ukraine. But for many, because of their health conditions and the limited availability of medicines in Ukraine, they are forced to live and work in European countries so that they can access vital treatment.

We shared the stories of two patients, but there are many such situations; now, we face them every day. Daily shelling and news about dead civilians and children create emotional stress and force us to fight stress and help our patients in this fight every day. Can we, in this situation, feeling our patients' need for help, leave our native country and these heroic people? We have but one answer to this question—we remain here, despite the daily emotions of upheaval. We believe in victory and our armed forces. We believe in the development of medicine and our patients, who also made their choice and stayed in their native land.

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## A Semi-Personal Story from a Ukrainian NGO Professional (or a Semi-Professional Story from a Ukrainian Person) Living through the War

Yuliya Nogovitsyna

I live in Kyiv with my husband and two daughters. On 24 February 2022, my husband woke me up at 5 am tapping me on the shoulder and saying, "Yulia, wake up. There are bombings outside. The war started".

That day was our younger daughter's birthday. She turned six. We had planned a birthday party for her with friends, cake, candles and birthday gifts. Instead, we had to move both daughters to the bathroom where there are no windows so that broken glass did not hurt them if a missile hit.

I am the Program Director at Tabletochki Charity Foundation, Ukraine's largest childhood cancer NGO (https://tabletochki.org/en/). For 11 years before the war, we have been fostering childhood cancer care in Ukraine—through our direct assistance to families, support of pediatric oncology units, professional development of medical personnel, and advocacy.

The Russian invasion of Ukraine in February 2022 dramatically changed the healthcare system landscape in Ukraine. The physical threat, treatment disruption, exposure of immunosuppressed patients to improper conditions in bomb shelters and cellars, interruption in supplies, infrastructure damage, logistics failure, and funding constraints have been among the most manifested immediate and deferred implications of the war for the healthcare system in Ukraine.

That said, the biggest professional challenge was uncertainty and inability to plan. You have nothing to rely on in developing at least a short-term strategy. This may sound speculative and unimportant—who bothers about uncertainty when there is a physical threat to your life? But this is a wrong perception—uncertainty paralyzes and disables long before a bullet or missile reaches you.

War also brings the collapse of relationships, partnerships, and coalitions. It depletes and limits resources, whether human, financial, or emotional. Scarce resources make hospitals, healthcare professionals, and NGOs compete for patients, donors, and financing. The war and the external threat unite only for a short period of emergency response. Once the situation transitions to a protracted conflict, people and institutions start fighting for their own survival.

My family stayed in Ukraine but moved to Lviv, a city in Western Ukraine, which turned into an evacuation hub for children with cancer. More than 1,000 children with cancer were evacuated and referred for treatment abroad through the SAFER Ukraine collaborative initiative by St. Jude Global, Tabletochki, West-Ukrainian Specialized Children's Medical Center (WUSCMC), and other international and local partners.

During the first months of the war, we worked hand-in-hand day and night to bring critically ill children to safety and treatment. We sent evacuation convoys from Lviv to Poland twice a week, the largest one with 71 families, included four buses and 11 ambulances. We slept 4-5 hours per day. Within two weeks, my hands and legs were trembling from constant tension, concentration, and tiredness.

And even this extremely fast-responding and effective evacuation may be questioned. We have been facing an ethical dilemma—whether the safety needs of the existing patients prevail over the needs of future patients in diagnostics and treatment in Ukraine. We discussed more than once whether we should stop evacuation and referral of children to European hospitals to sustain the Ukrainian childhood cancer care system and prevent it from degradation. It is very uncomfortable to confront such questions. Could our heroic efforts to evacuate as many Ukrainian children with cancer as possible turn into an evil for future patients to come? By evacuating patients, we left pediatric oncology units empty, without work for Ukrainian pediatric oncologists, and the usual pathways for diagnostics and treatment were disrupted. A healthcare system without patients is like a cardiovascular system without blood.

My family returned to Kyiv in August 2022 for our daughters to continue their schooling. There were (and still are) only five to seven kids in a class; other children left Ukraine or switched to online studies. My husband and I decided that our children will attend school offline—despite the regular missile attacks. This is a private school; we pay for it. In such a way, we want to support local businesses. Sending our kids to school every day (it takes 1.5 hours one way) and paying for their studies is a personal act of patriotism.

We lived through a very challenging autumn and winter with regular blackouts, cold meals, stuck elevators, melted fridges, and uncharged smartphones and laptops. Sometimes we had no water or heat. We have learnt how terrifying and ghostly a three-million-person city looks when submerged

in full darkness—with no traffic lights, glaring signboards, or luminous windows.

I recollect that in November, I had a meeting with representatives from a large international charity foundation who were considering giving us a grant. The day before that meeting, Kyiv was subject to the most severe missile attack, and there was neither power, nor water, nor heating at my home. In the midst of our meeting—when I was being told that we had to introduce a more sophisticated bidding procedure and have bidders send their offers in sealed envelopes—I burst out crying. Their procedure mandates were so irrelevant! In my mind, I was seeking a solution to how my family would defecate and urinate in our apartment on the 13th floor with no power and water if the situation persisted.[1] At that moment, I hated all international donors for being so absolutely out of touch with what Ukrainians were going through. Only the looming prospect of getting USD $342,000 for our assistance programs kept me at that meeting.

I am writing this piece at the end of May 2023. Almost every night in May, we had a missile and drone attack. It is a very bizarre feeling—in the daytime, the city looks perfectly peaceful, merry, sunlit, and busy: with kids, ice cream, scooters, blooming lilacs, and chestnut trees. At night, "the city falls asleep and the mafia gets up". We are living two parallel lives—sunlit peaceful days and then the horror of nights full of air strike alarms, explosions, and flashes of downed missiles in the dark sky. Some people spend nights in the metro stations, sheltering their kids there. Others sleep in corridors or bathrooms where there are no windows. I opt to stay in bed and let my kids sleep. I do not want them to be traumatized—they still go to school, have picnics, and dream of roller skating with their friends over the weekend. They do not wake up at night or experience sleepless nights. I know that the cost of my attempts to preserve their childhood may be very high, but I persist.

Why did we not leave the country? Finding a true answer in the entangled mix of rational and irrational considerations is difficult. First of all, I wanted to stay in Ukraine because while I am here, I can speak on behalf of Ukraine. I can be a witness. Second, I did not want to split the family—my husband is of draft age and cannot leave the country. Third, if everybody flees, who will our army fight for? I think that many families who left Ukraine will never come back. And this hurts me. We need young, ambitious, educated, open-minded, and creative people to rebuild the country. Our mission is not only to win the war but to make Ukraine better.

[1] *Incidentally, I found a solution to my challenge and will share it with you—this is a valuable piece of knowledge—not like that bull sheet about bidding procedures. You must buy plastic garbage bags and pet litter. And here you are!*

## When Ethics Survives Where People Do Not: A Story From Darfur

Ghaiath Hussein

I was not new to Darfur. I had been here before, although I wore a different hat as I literally walked under the burning April sun along the wide, dusty, unpaved streets of Nyala, South Darfur, to "headquarters." It was to be another interesting, but normal, peaceful, and safe day as I led the Sudanese household survey in South Darfur, then the largest of all Darfur states. That was in 2006, a few years after I joined the Federal Ministry of Health. My office overlooked the Nile, but getting out of the capital city of Khartoum was always the best part of working there. I had the opportunity to meet real people in their real places, where they are home and at ease.

Overall, the data collection team's work went according to plan. Most of the randomly selected villages were visited as planned or replaced according to protocol. But this morning was anything but normal. A few days earlier, while visiting a village in a nearby town, Kass, my team was able to make a single phone call to us, the leadership

team, composed of two colleagues from Darfur and myself, indicating the team had no reception—the nearest signal was an hour's drive away. The team leader assured me that they had started collecting data and promised to call every day or every other day. They were a team of six young men and women (I called them boys and girls because they were so young and innocent) between the ages of 20 and 25, all from Darfur. Two of them were in love and participated in the survey collection to save the per diem for their wedding.

The time I was expecting their call came, but the call did not come. Then another day, then another, then another.

One of the management team was in charge of the security update, and that morning he asked me in a shaky voice if we could have a private meeting as soon as I entered the room. He informed me that the village where my team was located had been attacked by the Janjaweed, the notorious militia known for its ruthless, brutal attacks that leave nothing behind, but men killed indiscriminately, houses and children on fire, and women raped. I recalled my experience in Darfur the year before when I mechanically asked a woman if she had lost a family member in the last six months and what the cause of death was. She burst into tears. I tried to calm her down. Finally, she told me that her few-month-old baby had been burned alive in front of her own eyes. Before I could even imagine the fate of the boys and girls on the team, a call came in. It was not from the team, but from a crying mother who asked me to "bring her daughter back." She told me she did not want her daughter killed or raped. I cannot remember what I said because I was in shock and did not want anyone to see this, especially the other teams. The last thing I needed was to see the panic for which I was not trained to manage.

I had no time to waste. I had no exit or contingency plan in the 224-page survey guide that explained how to collect the data, how to ask the questions, how to sort and safely store the paper questionnaires, how to enter the data. It seemed to provide extensive guidance on everything except for the only instruction I needed at the time—How to keep my teams safe under fire. I took the first flight to the survey's national headquarters in Khartoum seeking help. I was promised to be put in contact with the intelligence and army in the region through the government agency responsible for organizing humanitarian work in the country. In fact, none of them were in the attacked village. My colleagues on the management team seemed more hardened to the conflict than I was. For me it was something I followed on the news, but for them it was a part of life. They tried to reassure me by suggesting that the team knew all the risks of travel and that they could have been attacked anywhere anyway.

The irony is that I gave up clinical practice in favour of public health because I could not face the death of my patients. Now I had to deal with the possible deaths of the children I sent to the middle of hell and those whose names, and whose children's names, ages, addresses, and the causes of recent deaths in their families and more were collected in completed questionnaires. I never imagined that what I thought was the least harmful data collection tool could become a death list if it fell into the wrong hands. Attempting to save the questionnaires would not just save the survey and the numbers—it would possibly save real people before they became just another statistic in mortality studies.

I flew back to Nyala, called all the contact lists I had at the time, and then visited their offices. All the major UN agencies and the international NGOs, the South Darfur State Minister based in Khartoum, and even the country's intelligence agency were on the list. I asked for help with two things. I wanted to know what happened to the team and how to save them. The first request was met with appeasement, the second with hope for the best. Eventually, every organization had its limits and mandates. None of them had the mandate to save trapped data collectors in a village that was thought to be safe when random and randomly selected. Under fire, embarrassingly little is certain and what can be done is even less.

Those were the hardest five days in the field. The task at hand was not only about finding my missing children but about keeping the survey running by the other teams who had to travel outside Nyala. I could see the fear in their eyes and feel it in their

words. They had to make the hard choice between risking their lives and the payment they received that was at least four-fold what they would get from their governmental jobs.

Finally, a call came. It was the one I was waiting for. The team leader told me in a tired voice, made even worse by the terrible signal that made his voice sound as if it were coming from a cave, that they managed to escape the village. They were all physically safe and he spared me the uncomfortable task of asking about the survey data by adding, 'And we have the filled questionnaires with us.' I cannot recall any comparable moment of relief. I called all the worried mothers and when the team arrived a day later, I joined them at each of their houses. No words could describe the feelings, the tears of joy, and the gaze of blame when the mothers saw their children safe.

I gave them a break before asking them if they wanted to continue with the survey. I had to have an eye on the progress, the decaying budget spent on the daily payments, per diems, rentals, etc. and handle the growing feelings of concern. The headquarters in Khartoum was generous enough to send me an extra budget and a week's extension. Seems like a happy end, right?

I am not sure if a completed survey and well-paid yet traumatized young men and women counts as one. I had to move on and fly back to Khartoum, according to the plan for data entry and data analysis. The final reports had all the numbers the United Nations and the government needed. Very few people knew what the stories behind each of these numbers were. Even fewer people cared to know what the story is. We went to do a well-paid job and we did. When I returned to my office in Khartoum, one of my welcoming colleagues tried to tease me by saying, "Welcome the Lord of War!" with a smile on his face hinting at the generous payment I received. I smiled back and said, "You are right. I feel like one, but I bet you Nicholas Cage was paid much more." I was referring to the movie that starred him with the same name.

What made me feel less of a 'Lord of War' was a promise I gave to the people I left behind to make sure their stories remain alive and not hidden between the lines of the graphs in the report of the next survey. Almost all the assignments I submitted for the courses in my master's in bioethics at the University of Toronto were about Darfur and the people of Darfur. My PhD in bioethics at the University of Birmingham was about them and dedicated to them. And here I am sharing this story with you in the hope that when you come across the next report from a survey conducted during an armed conflict, you will see the people; you will hear the people; you will feel the people—not only those surveyed but also the surveyors. We are all part of a story worth telling.

## Burma's Healthcare Under Fire: My Experience as an Exiled Medical Professional

P. P. Kyaw

I used to work as a medical doctor in a less developed state than many big cities in Burma[1] that experienced prolonged civil wars and current similar atrocities decades before the urban areas of the country experienced them. Before everything started, I was responsible for the medical management of the most vulnerable communities and had been struggling with pandemic-related medical activities. Those were the happiest years of my life. I was with one of the best international organizations, where every effort I made was directly delivered to the patients with no unnecessary paperwork. The system was efficient, my colleagues were supportive, and I had a good work-life balance. I supported my family and whoever needed temporary financial support, played music weekly, met good friends who I hung out with every weekend, and

[1] *The junta forcefully changed the country's name from Burma to Myanmar in 1989. The author prefers to use the less formal, more familiar name 'Burma'.*

found hobbies like gardening and crocheting. I was content and happy. I even postponed my plans to get registered as a doctor in the Western world.

Before moving to this beautiful ethnic state in 2019, I previously worked as a government medical doctor in Yangon, the capital. As much as I loved working in those civilian hospitals, I could not support myself with a monthly pay of $100-$150 USD. It was a hard decision to leave the service because it meant I could not pursue the medical specialty that I had always longed for and had to leave like-minded supportive colleagues. In Myanmar, unless you are a civil servant, you cannot pursue further clinical specialties. However, after leaving the government's service to work in humanitarian medical assistance in hard-to-reach areas of Burma, I learned that life is still beautiful outside my comfort zone, until February 2021 when the coup began. Democratically elected members of the country's ruling party were overthrown by the military, which then bestowed power in a military junta.

I expected the election prior to the coup in November 2020 to be an uphill battle for Burma, but nothing more. I was still in denial when I first heard the news from one of the town's NGO staff. The person had to travel on a motorbike to inform everyone that the junta had staged the coup. No telephone or internet was working at that time. My colleagues and I cried in our office, saying, "We are so young, and the future is still ahead. I don't think this is going to last long. Maybe it will be over in a few days or, at most, a few weeks." Once the peaceful protests started nationwide, my friends and I provided medical cover for the protesters, initially for minor medical problems such as low sugar, low blood pressure, injuries from accidental minor slips and falls, etc. Never in my life had I imagined that I would be taking care of bullet wounds and people injured by live rounds. While learning about gunshot wounds in forensic medicine, I thought, "Oh, this is not going to be very useful because Burma is not America, and I am not going there." Then suddenly, it became too real and more useful than I would've liked it to be.

I always think back to one especially bloody day when many people in the town were shot with live rounds. We assisted many patients. Usually, we would go around with the protest groups until they were over in the late afternoon. The protesters were always peaceful. There were no riots, no harmful acts, or vandalism. Only when the protesters were cruelly dispersed with tear gas, high-pressure pumps, rubber bullets, and live rounds (to the head) did they decide to defend themselves while still making their voices heard. The only defenses people had to counteract the live rounds were things like metal covers, firecrackers, and slingshots.

One afternoon in March 2021, my team and I took an early break for lunch—unaware that some people would lose their lives that afternoon. We followed the local protests through Facebook Live while having lunch and started to hear firecracker sounds. A few seconds later, we knew they were neither firecrackers nor rubber bullets. They were *real* bullets killing *real* humans in front of our eyes. We saw two people shot in the head, and people started to run all over the place. We stood up from the lunch table and started to call and alert facilities that could help the injured, hoping we could still save some. The junta's soldiers started killing people a bit later in our town. After hearing about other towns' experiences, we prepared and alerted our friends and colleagues. Still, when the attack came, we were shocked just the same.

Since February 2021, I have helped start a network among medical personnel, CDMers[2], and medical professionals outside of civil service. I had good connections and points of contact all over Burma. When we saw the first patients in our areas with shots to the arms and legs, we still could not believe that the junta used real bullets. The denial was gone only when we saw the bullets in situ. As the day went on, the bloodier it became.

There was a child who was not even 15 yet. He had a bullet wound to his face. Luckily his mouth was intact. He was not crying and not saying a word. Because his wound was not as severe as the

[2] *We call people involved in the Civil Disobedience Movement (CDM) "CDMers" or "CDM professionals."*

man whose wound we had been treating, he sat quietly. I asked if he was okay, and he only replied with nods and headshakes. But what I remembered were his vacant eyes. The gaze was fixed and blank. I can still recall his face even after two years now.

Another lady came in whose arm was only hanging by the skin and almost cut off—another bullet injury. What surprised me was that she told the medical personnel to attend to those who got shot in the head and return to her later because she could handle her wound. She kept telling us that hers was not serious (it was!) and that she could wait. I was inspired and amazed by her empathy even under life threats. She did not know that the other people who got shot in the head were killed on the spot, and there was no helping them anymore.

We could not use the medical facilities properly because of all the patients who had serious injuries. In some areas, the junta raided healthcare facilities to pick up the injured and take them away. No one knows what happened after that. Therefore, we always had to treat the injuries covertly and not let many people know what we were doing. It was like an underground, covert medical operation. We always had to cover our faces whenever we went out. Every day we went out, we had to write our blood type and emergency contact number on our forearms so that if we got shot and needed blood, any nearby person could help.

One time, during the medical cover, my friend and I were stuck between a big crowd and the approaching junta's troops. We tried to hide inside an empty small vendor shop. I remember someone picking us up by the hands and yelling at us to run because it was a dead end, and they would round us up very soon. Luckily, we escaped, but some of the people that day did not. Because we were still employed back then, the medical supplies we provided came from donations. Many friends contributed weekly. It was enough for our local activities back then.

Tear gas, rubber bullets, explosions, sounds of fighter jets, suspicious motorbikes during night curfew, calls, and messages 24/7; the sounds had become an ugly lullaby. I dared not leave my phone unattended for a minute. It was with me whenever I had meals, showers, or even went to the toilet. Because I was networking and coordinating underground teams, I was scared that if I missed one message, I would be unable to save a life. I could not sleep. Even if I did, I woke up after some hours fearing that someone must be outside looking at me because they knew my activities or had intercepted my messages and calls. I made plans with my housemates to confiscate my gadgets and things once they came for me. I was paranoid about my safety and what would happen to my family and friends once they caught me. But I never stopped doing what I had to and wanted to do.

We heard how the junta soldiers interrogated the captured protesters and people whom they suspected. There was a lot of pain, emotionally and physically, for those unfortunate people who had been detained—harassment; physically, verbally, and sexually inflicted by the junta's soldiers. There were no laws, no international watch, no one to defend, and no hope at all. I started to meditate to be well prepared when the time came. I was focused on doing my best for the democratic movement as a healthcare worker, and not harming my loved ones by giving out any information if I were detained. I believed both could be achieved if I could meditate. It would give me the calmness I needed and increase my threshold for pain if I were severely tortured, like some of my friends were.

When my closest friends were detained, I realized that I had two options: go to a liberated area or leave the country while I still had the chance. I discussed it with my friends and colleagues and chose the latter. Even though no one was sure who was on the watch list and who was not, some took the risk and got away. Fortunately, I became one of them and am now physically safe. Since leaving the country, I have lived with the guilt of leaving my friends and family behind. My family feels safer without me, but the thought of not going to the liberated areas, knowing I could do a lot on the ground, burdened me with guilt. Even if I do not stop doing things for the democratic movement online, seeing patients remotely, or networking and coordinating remotely, it will never be enough. That is why, even after two years, I am still working remotely for the people of Burma, hoping that one day we will have the peace we deserve.

Along the journey, I have learned many invaluable things, obtained many like-minded and

genuine friends, and got to know many inspiring and selfless people. I had to leave a job and the income it provided for two years, then I lost many friends who failed to side with justice and witnessed many people lose their lives. There are a lot of people I have never met face-to-face, but we love and care for each other like blood-related brothers and sisters, just by having the same goal. Many medical professionals in Burma are doing online or on-the-ground medical work without getting paid. All we want is true democracy, the right to health, and for our people to live peacefully. We have been through a lot and learned a lot. Yes, we are exhausted and broken, but we will end this together to bring a beautiful new day for the people of Burma.

> "One friend here and one friend there
> Life-now differs, then memories shared
> Soon will be a day with no despair
> Just hugs and tears to be laid bare"

This is my original poem for my friends who are behind bars. Many of them are waiting for ruthless and meaningless sentences. I hope we get enough international attention just in time so my friends will come out alive soon. For the medical students whose lives have been lost; the doctors who were killed during their medical assistance; the nurses who were sexually assaulted and killed afterward; my brother and sister-like friends who are now in the interrogation centers and in prisons for giving their help to the people—one day, I will see them again.

## When a Conflict Collapses on a Child: An (Aborted) Medical Evacuation of a Hazara Toddler During the Kabul Airport Blast and the Taliban Takeover

Ayesha Ahmad

I work in the capacity of an academic researching conflict in Afghanistan. My commitment is rooted in the firm terrain of friendships that merged into sisterhood of the Afghan terrain spaning decades of war but which is also the home of poetics and legacies that refuse to be clouded by the traumas of the land.

As a medical ethicist situated in global health, I perceive the inadequate focus on recognising the mental health needs born from living in war as a moral injustice and a form of silencing the suffering. This injustice should be held by the geopolitical hands that play the chords of conflict.

However, such research is all too often concluded before it can develop as *too* dangerous, or *too* risky, or even as unethical because potential participants are perceived (often, unjustifiably so) to be *too* vulnerable.

Another peril of research is the boundary drawn between a particular experience of the research objective and the life experience of the research participant. Connecting as a researcher and in a personal capacity, I fell into a chasm unseen in the context from where I work in London, United Kingdom.

I remember the evening before Kabul city fell to the forced control of the Taliban. My friends reminisced during a nightfall reflection on the battles where the city walls had barricaded its inhabitants from centuries of invaders trying to access the valley of a city surrounded by mountains. Kabul city is a haven for war. Its geographic location makes it desirable to conquer, but part of its desirability is because of how the mountains envelop where the languages, ethnicities, religions, and stories of the Silk Road have settled and rested. Once conquered, the city protects you. And Kabulis felt safe. And to that end, on that fateful night, we ended our conversation in the confidence of hope; that Kabul city would not fall, and with the heart of the country still intact, Afghanistan would be saved.

The dawn arrived and so did the approach of the Taliban to the city gates. There were frantic and rapid whispers that transformed into screams. And then the moment came, the Taliban were within the city walls.

The juxtaposition between the regular London traffic heaving and breathing, and the frantic, panicked sounds of horns and vehicles fleeing in Kabul that I heard through WhatsApp audios in the background to friends narrating their journey home, was as stark as the peace and war they both echoed.

Soon the stories started speaking, pleading, paining, pressuring—stories seeking survival. In the dawn, instead of the sun breaking the sky, I broke the morning to a friend during a telephone conversation who had just awoken and had not yet received the news. I told my friend that the Taliban were in Kabul city. The reaction was grief, just like the grief I had heard in their voice a few months prior when their beloved father had passed away and entered the grave before they had breathed the new dawn. In the dusk, instead of the moon shining upon the city, women, families, and children were sheltering from the darkness of the grave closing amid their breathing bodies.

Then, the blast came. In the energy of the quest for safety, people, walking like pilgrims, surrounded Kabul airport, queuing like worshippers. Prayers died. Hell rose. The waiting crowd was fired upon. The air did not offer breath; instead, a final moment of the sound of war that had blighted lives.

In the crowd was a family who I dedicate this article to. I write the story of the father, the mother, the daughter, and the son of that day. The family was Hazara, a disputed and discriminated ethnic minority in Afghanistan, of a legacy traced to the invasion of Genghis Khan, the founder of the Mongol Empire. Theirs is a story of travellers and a soil of stories; a particularly profound story because the parents had specialised in geology and were experts of the stones of their long heritage. Yet, still, they could not trace their belonging, and their two-year-old son, on his father's shoulders, was a target. Shrapnel desecrated his skull and spine. The love and trust held in his arms as they were wrapped around his father's shoulders became confetti among the carnage of blood and bones. Weapons do that. They destroy the visceral even when the spirit is stoic.

The child was blasted from his father's shoulders. A two-year-old child entangled in a conflict that did not belong to him. How are we to respond to the ethics of this? His injuries were severe: shrapnel penetrated his spine and brain. His personhood was violated by perpetrators of humanity. His healthcare needs were vast: he needed a neurosurgeon. He needed specialist equipment. He needed a hospital. He needed transportation. He needed safety. He needed protection.

After emergency spinal surgery in a hospital run by a non-governmental organisation, he was dangerously discharged after one night because of the demand for children requiring emergency care. Children of conflict. Children born in conflict. Children conflicted between life and death. Children are the suffrages of conflict. Where are they? Children are not treated in hospitals. Children are in graves, being grieved for in homes where they should be playing, thriving, and living. This is war.

I remember where I was standing in my apartment. A friend requested help for medical intervention for a two-year-old child symbolising the fragmentation of Persepolis. Who would repair this sorrowful land?

I contacted a physician—a paediatric intensivist, and a medical ethicist—in London. Within ten minutes, a request was administered to the hospital executives for an emergency medical evacuation. Within twelve hours, two world-leading paediatric neurosurgeons were on call to receive the child to the major specialist children's hospital. The hospital offered its hospitality—the kind of hospitality that is perverse. The hospitality to treat; to treat a child of conflict. Such hospitality should be shunned—should be condemned. No child should need to be treated for a wound of war.

Here, the hospital was waiting. Waiting to admit the child, to welcome him. But the country that guarded the borders of the hospital did not offer such hospitality.

For days that progressed into weeks, the child waited. The complex web of emails and exchanges between the Foreign Office and my colleagues and I, acutely aware of the breadth of living that was being lost, exhaled to nothingness, of a child laying bereft, partially paralysed, traumatised in hiding from persecution because of the blood that he was deemed to possess from his heritage and battles long dead. Hopes were annihilated with his future.

The impossibility of the child, I will name him as Azad, was prescribed because of the words of war, written but not entombed. The story of Azad's life

was imprisoned because of politics and persecution before he had the pen to voice his verses.

To illustrate the ethical challenges created by my own positionality in the United Kingdom, and not those directly stemming from the new regime that is now Afghanistan's government, I recall this example. One evening, in the immediate aftermath and daze of the takeover and the blast, Azad's father walked to the hospital where his son had briefly been treated to obtain his medical records so he could provide evidence of the injuries to a government over five thousand miles away, which had played a role in the events that had happened. During this journey, Azad's father was stopped, interrogated, and beaten for wearing a t-shirt. His appearance as a westernised Hazara stripped him of worthiness to be received with humanity. This is the reality. The British government required a father to make a journey through Taliban-governed streets, a father who had an ethnic identity that was targeted to obtain evidence and proof that his child was a casualty of an act of terrorism orchestrated and fired from a philosophy that neither father nor child could conceptualise.

When the father reached the hospital, the request for the child's medical records was denied—unless a bribe was paid for the attending doctor to be included in the medical evacuation visa request. I received the doctor's desperation but had to close off from it. I silenced his suffering. I had to choose. If I included a medical doctor on a medical evacuation request, would this weaken its success? I could not risk that when a child's life was in jeopardy. Sometime after, I discovered that the doctor who made this request was also the hospital director. He has since been replaced by a Talib with no medical education, and his whereabouts are unknown.

I had to focus on the one cry I heard and had a chance to respond to. To break out from the corner, I was forced into a required negotiation. I was undertaking precarious conversations via different forms of communication and executing quick and decisive pathways to reach a satisfactory conclusion that was incredibly time sensitive. The child was in physical and psychological pain, being cared for by his parents who were having to shift locations daily in a collapsed city to avoid detection. The family had already endured targeted persecution, including a mock execution under the previous government, which had claimed to offer some protection towards minority groups. However, in these initial days after the takeover, the danger was wide open. There was no impunity, shelter, rescue, or expectation of what horror to imagine.

Trying to mediate healthcare under conflict was full of expectations. I was located where the conjectural doors were. They needed to be unlocked, opened, even if forced, so the family could enter and bring their child to safety. At one point, I was instructed to guide the family overland to the Iranian border, a somewhat day-long journey across stark and unforgiving terrain and through checkpoints, to cross under disguise in an opening being permitted for religious pilgrims. I was then supposed to facilitate the family's passageway through Iran into Iraq, again under disguise as part of a moving caravan of religious pilgrims. From there, they would be met by a non-governmental organisation operation who would fly the family in a military plane to a processing camp for refugees in Albania with no further destination in place for Azad to receive healthcare. Should I relay this option to the family even in the face of its futility, or should I deny the family their agency and refuse? Was I making a decision about the child's fate? I stayed silent.

With a few dedicated colleagues, I continued to pressure the British government while considering whether I should draw on the connections of an Afghan colleague based in the United Kingdom with a medical background. I was cautious about approaching my colleague. The cultures of conflict travel. I couldn't be sure about any discriminatory views my colleague might have towards Hazaras. One phone call or one wrong move from me could lead to the family's execution.

The formal route of a government-supported medical evacuation to specialist surgeons collapsed. It did not reach a sudden death; rather, the leash to hope retreated and ebbed away silently as if the leaders with the key to power were ashamed. Their indifference was pitiful.

The family escaped to another neighbouring country, where I met them some months later. The child would only cry. Cries were his only sounds. Or silence. Silence of a story that was beyond any words he would form.

The father was bereft. At the moment of the blast, the child was sitting in the sky on his father's shoulders. The legacy of trauma took away the child's trust in his father's embrace, the arms that had tried to lift him to another country, another life, another world.

Now, the family is in exile in their third country in two years. Another language. Another culture. Another government.

A child in conflict is never disentangled from war. Azad's birth and near-death were imprisoned in the cradle of a conflict-ridden land. Will Azad return and live through the meaning of his name—freedom—in his lifetime, or will he, like his parents, forever be a war child?

My final reflection is towards healthcare. My gaze now sees that healing is an ethical endeavour. The philosophy of medicine clashed with the confrontation of conflict, and for Azad, attacked and violated by indiscriminate armed actors, his story of suffering was written by the governments who failed to free him.

## The Vagaries and Vicissitudes of War

Richard W Sams II

I remember standing in the kitchen of our home on Camp Pendleton—a United States Marine Corps base in Southern California—listening to National Public Radio (NPR) and doing dishes in the fall of 2002. President Bush announced to the world that he was considering a pre-emptive invasion of Iraq on the pretext of Saddam Hussein harboring weapons of mass destruction (WMD). Three months later, as a Navy Family Physician, I deployed with a surgical company in support of Operation Iraqi Freedom. Reflecting on the situation with a like-minded close friend, I was not sure—would this be a just war? A necessary war? In my mind, it did not rise to the level of conscientious objection, yet the rightness of invading another country with all the anticipated death and destruction was not clear.

En route to Kuwait, we laid over in Spain. While fixed to a TV in a holding area, I watched the Secretary of State make a case to the United Nations (UN) and the world that removing Hussein from power would protect us from mobile anthrax labs that could kill tens of thousands. I thought to myself, *Either he is absolutely right, and we are protecting our country and the rest of the free world, or he is terribly mistaken and we are embarking on a disaster.*

As we trained, prepared, and waited in our tents to invade, we listened to the news on "Voice of America" with a hand crank radio. Thousands of citizens from nations around the world protested. Pope John Paul II, a man well acquainted with the tragedy of war, even spoke out about the planned invasion. "War is not inevitable. It is always a defeat for humanity." He admonished our leaders that war needed to be the very last option. As a man of faith, I was troubled by his resolute, thoughtful opposition to the crusade I was embarking on. As the day of the invasion approached, scud missiles flew over our camp and we scurried into bunkers, day and night, with our gas masks donned to protect us from possible WMD attacks. In March, with the announcement of a "shock and awe" missile attack on Hussein's palace, the invasion commenced.

Within a day of flying by helicopter into enemy territory to set up a surgical company, the fog of war set in. A series of mass casualties streamed in from nearby Nasiriya. We received dozens of injured enemy combatants and American soldiers. Most troubling were the civilians. An entire extended family fleeing for their lives stumbled into an Iraqi minefield meant for us: a mother dead, the men with shrapnel wounds, and an aunt lost both of her legs. Then there was the little boy. By doctrine, our leaders reassured us we would not care for children. Yet, out of instinct, the field corpsmen scooped up all injured, including children, and

brought them to us. The five-year-old's legs were blown to bits. We had no pediatric supplies. The anesthesiologist heroically intubated the child's tiny airway with a urinary catheter and placed an adult IV. The surgeons corrected the wounds the best they could. Hours later, in futility, we performed chest compressions on his tiny mangled body.

A day later, the worst sandstorm in a decade struck the area. We struggled to keep the patient-filled tents erect. A Marine appeared on the scene out of the darkness (you could not see beyond your nose in the storm) exclaiming we were going to condition one—lock and load our weapons due to an imminent threat. As healthcare professionals, Geneva Conventions dictated we were to use weapons only in self-defense. We chambered our 9-millimeter pistols to defend our patients and ourselves while Marines formed a defensive perimeter. I thought to myself, *Great I'm gonna be shot up and die during a freaking sandstorm in Iraq*. Hours later, we were told to stand down. The threat was not from approaching enemy combatants but from shepherds running from the crossfire. I had a small nervous breakdown, sleep deprived and under duress. One of my physician comrades forced me to get a night's rest. Then I was back at it, caring for the wounded.

As the flow of casualties drug on over the ensuing weeks, a glimmer of hope justifying our actions arrived: an injured Kuwaiti interpreter who volunteered for the war effort. He shared with me that he volunteered because he was inspired by the liberation of Kuwait from the hand of Saddam in 1991 by U.S. forces. He envisioned a free, democratic Iraq that could thrive with the "sweet water" of the Tigris and Euphrates. His hopefulness bolstered in me a sense of rightness in what we were doing. His words inspired me to write a letter to the President expressing gratitude for the opportunity to bring freedom to Iraq. I received a personal letter back from the President, thanking me for my service to "advance peace to a troubled world." Advancing peace by waging war. The letter hangs in my office to this day. I'm proud of the sender, but now not so sure of the ideas conveyed.

Iraq fell, and reports that sounded like the liberation of Paris streamed in. The President declared, "Mission accomplished." The positive vibes lasted a mere week. The insurgency erupted. We moved twice, setting up outside of Baghdad, then in the university city of Ad Diwaniyah, living amongst blown out buildings. Just as we were beginning the next phase of operations, opposition to our efforts mounted in the U.S. news, even as we found mass graves and evidence of a terrible dictatorship to the likes of Nazi Germany. I was so troubled by the opposition that I wrote an op-ed to my local newspaper, "Saddam Hussein was a Weapon of Mass Destruction." I so needed to believe that what we were doing was somehow just.

As our deployment drug on, I grew tired of consuming MREs[1], urinating in trenches, the foul smell of feces in burn pits, and the dehydrating restless nights in the sweltering heat. I was depressed that I would likely miss the birth of my bride's and my fifth child. The initial ambivalence of our efforts turned to hopefulness but now devolved into despair. We cared for epidemics of dysentery, renal stones from dehydration, and a child struck by a Humvee, looking to get an MRE. His father shared with me about his community's exhaustion from decades of war, first with Iran, then amongst themselves, and now with the U.S. He longed for peace.

Providence smiled into my small world, and my company commander told me while standing in his skivvies in the shower tent that I could re-deploy home with a convoy to Kuwait. After a long journey through the desert and a period of waiting in tents again in Kuwait, I took a 72-hour sleepless, convoluted journey home. We were treated like royalty by the lovely flight attendants on chartered commercial flights. We arrived on the parade deck, greeted as heroes, some of the first to return from war. Hours later, at 0530, our baby girl burst into this turbulent world. Sleep deprived again and overcome by a wave of joy interspersed with the ambivalence of what I just took part in, I sobbed uncontrollably on the phone with my mother. Then I was fine. I moved

[1] *Meals, Ready to Eat (MREs) are self-contained, shelf-stable meals for the U.S. Armed Forces.*

ahead, caring for my family, my patients, serving my country, and teaching the next generation of physicians. Before completing my Navy career, I deployed once more, this time to Afghanistan in 2011, another war that ended in futility.

Years later as I reflect back on the Iraq war, I sometimes wonder if we received a divine, "You'll reap what you sow," for the debacle we embarked on in 2003. We did not usher in a new era of freedom in Iraq. Instead, over 4,000 allied troops perished and more than one hundred thousand Iraqis died violent deaths. Waves of suicide bombings continue to rock the country. Political instability checkered with terrorists persists. Thousands more American Veterans were permanently maimed—mentally or physically. As the aphorism declares, war is definitely hell on earth. I am thankful to have served my country even amongst the vagaries and vicissitudes of war, but perhaps Pope Saint John Paul II was right: war is a defeat for humanity. I now cling less to the ideals of political and economic freedom and more to the beatitude: Blessed are the peacemakers, for they will be called the children of God.

## Providing Care to a Potential Aggressor: An Ethical Dilemma

Handreen Mohammed Saeed

Following the abrupt fall of almost a third of its territory in 2014 to armed militias, Iraq fell into civil war turmoil. As a direct result of the armed conflicts, hundreds of thousands of Iraqis were displaced or subjected to atrocious human rights violations with physical, sexual, and psychosocial abuse. While the scenes on the TV provided only a glimpse of what was happening on the ground, the true stories circulating about people's suffering left me personally in absolute shock. Among those who suffered the most from the offences were marginalized religious and ethnic minority groups, who were viewed and treated as infidels by the aggressor militants. Those marginalized communities not only endured displacement due to the armed conflicts but they were also mass-exterminated, sexually abused, and underwent massive destruction of their towns and villages.

In 2016, I was working for Ministry of Health as a primary care physician in a small town in Iraqi Kurdistan, which hosted tens of thousands of internally displaced people (IDPs) from one of those marginalized minority communities. I had the opportunity to hear their tragic stories firsthand as they fled for their lives in 2014. Working in those communities as a primary care physician allowed me to truly understand their feelings and emotions and reflect on their experiences while providing healthcare services. This experience sparked an interest in humanitarian work, in which I could be close to areas of need and involved in providing physical health first-aid and also psychological and social first-aid; all crucial in addressing the future health consequences experienced by people going through humanitarian crises. In the same year, 2016, I joined an international medical organization and started working in remote and low-resource settings in northern Iraq as a humanitarian physician. Our projects included a variety of primary care, psychosocial, and urgent care services targeting refugees, IDPs, and vulnerable host communities in areas near conflict zones. The projects were designed and implemented with the hope that the most vulnerable populations have access to our services.

In October 2016, the Iraqi authorities launched a massive military operation known as the "Battle of Mosul" to regain control of Mosul, the second-largest city in Iraq. As an emergency medical humanitarian organization, we had to be near the battlefield and respond to the unfolding humanitarian crisis on a daily basis. As the official security forces backed by the international alliance started to advance, tens of thousands of people, including some militants and their families, fled Mosul and headed towards areas controlled by the Kurdistan Regional Government's forces in the north, where our organization was operational. Some of them sought refuge in one of our medical facilities in northern Iraq, which was operated by local staff,

including members from some of the minority communities that had suffered the most from the militants' aggression in 2014. The patients entering our facilities were mainly older adults, women, and children, but we were also visited by a small group of potential militants who were either injured, malnourished, or just seeking help and refuge. As a neutral, impartial, independent, humanitarian organization compliant with medical ethics, we were committed to providing healthcare services to anybody in need without discrimination or judgment.

As we responded to the humanitarian crisis unfolding before our eyes, some of our staff members came forward and raised valid questions about the ethics of treating patients potentially involved in serious human rights violations. With tears in her eyes, one nurse approached me and stated, "Seeing these people reminds me of all the girls and women who went missing from my village and are now being sold as sex slaves in Syria". The staff expressed serious concerns about their ability to provide care to patients who may have been involved in mass killing, torture, and the destruction of their own towns, as well as sexual abuse against their family members, friends, and people in their communities. Due to the psychological and physical trauma caused by the militants' conquest, the staff was reluctant to provide medical care to these patients, as seeing and hearing them brought back memories of the atrocities that occurred a couple of years ago. As a local staff member myself, who was initially merely looking at the medical side of care for patients coming into our medical facilities, I was immediately touched by this position. I was reminded of the ultimate human nature of healthcare professionals despite rigorous trainings and education about ethics, neutrality, independence, impartiality, and duty of care taught during medical training.

We faced an ethical dilemma, dealing with those involved in mass casualties entering our clinics and providing medical care during armed conflicts. Some healthcare staff members were directly or indirectly affected by one side or the other of the warring parties. These staff members had no intention of seeking retaliation or revenge. In fact, one of them stated, "My morals and ethical principles, which I gained from my parents and community, require me to help others regardless of who they are". However, encountering aggressor militants or their family members at the hospital triggered memories of the atrocities they and their communities had endured, leading to internal emotional and mental crises. One staff member expressed concern, saying, "What if they take over our facilities and repeat what they did in 2014?".

Consequently, the staff were worried about fulfilling their roles and duties as healthcare professionals first and as employees of the organization second. As someone who had listened to tens or maybe hundreds of true tragic stories from patients of their communities, I could empathize with their emotions, understand their feelings, and as the medical manager in the organization, I appreciated their honesty and candid communication during those difficult times.

Given the ethical dilemma we faced during a sensitive time of rising humanitarian crisis and heightened emotions, the fundamental principles of healthcare services rooted in medical ethics and the obligation to provide impartial and neutral treatment to all patients without discrimination or judgement, as per the Hippocratic Oath, were clearly at stake. While this situation provided us all in the humanitarian agency with an opportunity to reflect as human beings first and as humanitarian workers second, we were determined to tackle the ethical dilemma sensitively while upholding the principles of medical ethics. These principles required us to provide care without discrimination to anybody seeking medical assistance in our facilities. Therefore, we held several meetings with staff members. The primary objective of these group meetings was to reorient staff members about medical ethics and their roles as healthcare professionals and to truly listen to their stories, thoughts, and feelings as we embarked on the emotionally charged and sensitive mission of providing care to our patients. We reviewed our organization's code of conduct and discussed medical ethics as professionals, exploring our perspectives on similar situations. One of the agency's international workers remarked, "This is

a very unique and unprecedented situation that I have not encountered previously".

Finding a balance between emotional reactions and medical ethics was challenging at the beginning. However, as we deeply reflected on our duties and responsibilities as healthcare providers, we began to realize that medical facilities are not courtrooms, and we should never assume the roles of judges or law enforcement agents. While we were all deeply affected by listening to our coworkers' stories, feelings, and emotions, we agreed that the duty of care, a fundamental principle guiding our work as healthcare professionals, needed to be our overarching guide in this situation. We understood that those who committed crimes or violated human rights deserved to be prosecuted by law once outside the medical facility. This situation served as a reminder to me personally that we, as healthcare workers, are human beings after all, with our own emotions and feelings. These aspects can be affected and have an impact on our work. We are not simply robotic creatures expected to work and serve neutrally one hundred percent of the time; however, we need to have flexibility, courage, and willingness to reflect on our daily interactions with our patients and coworkers to expand our understanding of the emotions and feelings of all involved in order to create an understanding and resilient way of thinking at our workplaces.

## One Surgeon's Experience During Armed Conflict in Ukraine

Artem Riga

Shortly before the war, I completed my postgraduate studies for my PhD degree and became a young teacher at a medical university, gaining academic experience. And I carried out my surgical clinical practice on duty in the 2nd level district hospital for the civilian people in the city, which is located not far from Kharkov. My story begins at 5 a.m. on February 24, 2022. A terrible and awful morning found me on duty in this hospital near Kharkov—the sounds of explosions, shock waves, and the smell of burning—all at the same time. My thoughts turned into a swarm of bees. *This is a war.*

There had been anxiety in society for several days before, that Russia would attack Ukraine. Now, within a short time after the explosions, adults and children with numerous injuries and wounds began to enter the hospital. There were many. How to help so many wounded at the same time? It was a challenge. What will happen next? The hospital was dramatically unprepared to receive such a large number of victims. It turned out that there was an acute shortage of medical personnel, medical materials, and painkillers. It was difficult for me to sort the patients according to the severity of their injuries, since I was the only surgeon on duty. In the first hours of the beginning of the aggression, the management of the hospital was paralyzed. I could not leave the victims alone and leave my post. I felt that my strength was slowly leaving me but I stayed to provide medical care to people. I was stunned by the children's injuries and their damaged faces. There was fear and alertness that the shelling of the hospital would begin. I was in fear for my life. At the same time, there was fear for my patients and loved ones. *Oh! What about my relatives?* I called my relatives, and told them about everything I was seeing. I asked them to leave Kharkov for a safe place. I still remember the words I said to them: "I see hell."

From the first day of the war, the logistics of vertical hospital management were disrupted. The main principles of medical care—availability, accessibility, acceptability, and quality—were violated. The city became a front line and was under occupation for several months. Transportation of patients to a hospital of the 3rd level of care was impossible, as all roads and highways were shelled. Most of the medical personnel became refugees, a certain part of the medical personnel did not have the opportunity to get to the workplace. A few colleagues who remained in the hospital and I began to organize horizontally. It was important to me that I was not alone. Still, I had to rely only on my

own strength and sometimes the help of colleagues. Starting in February and for the next two to three months after, we worked independently without staff rotation and with meager medical support. I had to stay on duty for a long time, and knew I would most likely have to live in the hospital. Two months after the end of the occupation, the shelling of the city intensified. In the conditions of constant shelling and threats to life, medical assistance to people who remained living in the city and the countryside was provided only in stationary conditions. A lot of the population left, and the rest hid in shelters. The city was a ghost town. There were no lights on the streets; no people, no cars, no signs of life. My personal transport was damaged in one of the shelling attacks and I had to get to the hospital on foot or by bicycle. During the fighting, it was dangerous to move around the city and get to the hospital, because there was always a threat to life. At the same time, I was always certain that the colleague whom I had to replace on duty would not leave the post if I suddenly did not arrive—I myself had to arrange shelter when I was outside the hospital. For patients, the basement of the hospital was used as a refuge. Surgical interventions were carried out in operating rooms, where sandbags were placed on the windowsills. Only after some time were we able to carry out surgical operations, albeit in body armor. The supply of food for patients was sufficient, but still it had to be rationed. Why? Because neither I nor my colleagues knew what would happen the next moment in time—what would happen tomorrow.

The conflict has changed my life and my personality completely. The war also changed the focus of my professional activity. The vector of my medical skills has shifted to the treatment of various injuries. For the first time I encountered operations that I had not previously performed. It was always stressful and required great responsibility. Still, the sense of duty to save the injured prevailed over my fears. On those difficult days, it was necessary to bandage with a smaller amount of medical material, dilute (make a lower concentration) antiseptics in order to save money, and even use integrative medicine (various herbs and decoctions) in the absence of medicines. In peacetime, doctors don't do this for ethical reasons and out of concern for patient safety. Under conditions of a shortage of medical staff, it was necessary to assign dentists, residents, and other employees to work as assistants in surgery. I had to work as a doctor of other specialties. I performed the functions of a pediatrician, since I had to treat cases of pneumonia and intestinal infections in children. I assisted obstetricians in performing cesarean sections. Lastly, I had to devote a lot of time to training the victims of the conflict. The postoperative period of patients with injuries associated with the military conflict was fundamentally different from the postoperative period of patients with traditional surgical pathology. In conditions of an acute shortage of medical personnel, I had to teach patients how to care for and dress wounds, and how to administer intramuscular injections to themselves and to their comrades. I asked them to look after and help each other. It was a miracle! Before my eyes, people turned into paramedics. I have never seen such a transformation and mutual assistance! We weren't ready for all this.

*If not me, then who will help people?* I overcame fear and the decision to leave the workplace. As a surgeon in a front-line city, I had to take on the responsibility of making decisions before more complex surgical interventions, sometimes for the first time. After two months of acute shortage in medical practice, thanks to the solidarity and courage of volunteers and strong international support, the supply of medicines and equipment began.

I still remember all the patients, both civilian and military, whom I treated during all these 500 days of the war. Everyone is remembered! Each patient led to a wide range of emotions, but always different. In my practice, there were also "scars on the heart". Most of all, I was shocked by two cases and one event. These two cases had unfavorable outcomes. A young man suffering from a head injury, who had no upper or lower limbs, died. And another patient, who came under fire and had multiple severe injuries, died on my operating table during a surgical intervention. And yet, during this difficult time, there were a lot of positives. For all the time of the military conflict, with the tension in society,

and a heightened psychological state, there have never been problems or conflict situations (even the slightest psychological stress) with patients. I supported patients with all my spiritual strength and always tried to joke. In response, I always saw a smile! It was life through death. I was sometimes distressed due to disagreements with the management of the hospital, but never with the patients!

Another event that left a deep emotional imprint on my mind and a sense of extreme danger to my life was the rocket attack on the hospital while I was on duty. The enemy fired three rockets at the hospital. One rocket landed very close to the oxygen station and could have caused a large fire. Another missile damaged the integrity of the hospital and injured patients and medical personnel. The operating room and other premises were destroyed. My colleagues and I were able to bring down to the shelter only patients who were able to move independently. I was helpless when, under the threat of life, I did not have time to evacuate the sick, who were in serious condition and not mobile during this shelling. While in the shelter, I was very worried about their integrity and life. After the end of the shelling of the hospital, my colleagues and I immediately went up to them. Oh Lord! All severely immobile patients were alive, but were covered in glass, cement dust, and shards of broken glass. It is hard to imagine the experiences of these helpless people! We immediately treated their wounds and began to support them psychologically. I did my best on this difficult day using my own strength. Only the eyes of the sick . . .

What was missing for me as a specialist? I missed telemedicine. I sometimes needed advice from senior experienced colleagues. In the absence of telemedicine, I consulted with my surgery teacher, who was in another region, by phone.

The spectrum of my emotions and experiences is multifaceted. It is so wide and different that it can be described by a cocktail of emotions: fear, confusion, helplessness, and a sense of death. You will now die and be gone. There was endless insomnia; moments when I turned to God for prayers. There were moments when I took alcohol with friends. What helped to keep your own internal resource was that you managed to be absorbed by the process, namely, repairing your own transport, knowledge of military operations, faith in victory, being in nature! Forces gradually added experience in the field of military surgery. The internal resource is replenished by the fact that the patients I encountered during my surgical practice during the military conflict still thank me and express warm words, both at a chance meeting and on the phone.

Still, I have read the news about the course of the war several times a day. And the sad news keeps me chronically stressed. I still worry about myself and my family, because there is no safe place in Ukraine.

Despite the fact that I live with a sense of faith and hope in the victory of our people, I still do not know what will happen to me and my family tomorrow, as rocket attacks on the city continue. I have learned to live with a sense of the present, the uncertainty of the future, and the inability to return to our old life. I am happy to share my story and experiences—events that have cut into my life, because I think that my story can add self-confidence to other people in a military conflict and humanitarian crisis.

## The Limits of Our Obligations

Ryan C. Maves

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In 2012, I was a commander in the United States Navy, deployed to the NATO Role 3 Multinational Medical Unit in Kandahar Airfield (KAF), Afghanistan. The KAF Role 3 began as a tent hospital under Canadian command, built along the flight line at Ahmad Shah Baba International Airport as

part of an expanding NATO base. By the time of my arrival, it was a small but capable brick-and-mortar building under U.S. Navy command, with four operating rooms, two CT scanners, and a busy intensive care unit (ICU).

Not long before my deployment, the KAF Role 3 was described as one of the busiest trauma hospitals in the world. Casualties arrived every day, usually by helicopter. Blast injuries from improvised explosive devices (IEDs) were common, ranging in severity from concussions in passengers in armored vehicles, to multiple amputations from blast injuries with concomitant thoracic, abdominal, and pelvic trauma. KAF had a daytime population of over 30,000 in 2012, and our hospital was effectively the referral center for the region, so patients with non-surgical diagnoses were similarly common: myocardial infarctions, seizures, pulmonary emboli, and endemic infections, to name a few.

As an infectious disease (I.D.) specialist, I functioned mainly as a hospitalist, managing patients postoperatively, but I also provided any consultative support when needed. During mass casualty events, the intensivists and I would act as backups in the trauma bay, freeing up the surgeons for the most acutely injured patients. It turned out that an I.D. doctor's skillset lent itself well to acute trauma evaluations; we are well known for having an eye for fine details, combined with low-grade paranoia. These traits served me well during what I came to describe as "my involuntary trauma fellowship."

Our patients could be divided into five key groups: Afghan National Security Forces (ANSF, including the army and national police), non-Afghan coalition military (mostly U.S. and other NATO members), Afghan civilians, NATO civilian contract staff, and the Taliban. Our approach to each of these groups was different. For all patient groups, we would provide the same emergency care, including acute resuscitation and immediate life-saving surgery. It was after this emergency care period that our management plans diverged.

For coalition forces, our next priority after acute resuscitation and stabilization was to assess whether a patient could remain in theater. Stable patients with relatively minor injuries could often undergo rehabilitation at KAF; many personnel could subsequently return to combat duty with their units. More seriously-injured patients would be transported out of Afghanistan within 24-48 hours (if not faster). Usually, this would involve stops at Bagram Airfield near Kabul and then Landstuhl Regional Medical Center in Germany before reaching a military hospital in their home countries. There were few limits on whom could be transported. Dedicated critical care air transport teams (CCATT) included intensivists, respiratory therapists, and critical care nurses, who could manage the most unstable patients on board what was effectively a flying ICU. The "lung team" in Landstuhl could fly to KAF to start patients with severe respiratory failure on extracorporeal membrane oxygenation (ECMO) and then fly them out on maximal support.

NATO civilian contractors would receive comparable care, although the exact details of how they would be transported out of theater would depend on their home countries and the nature of their contract. We cared for one civilian contractor with newly-diagnosed HIV infection whom we were able to stabilize on the ventilator, get him extubated, start on initial antiretroviral therapy, and transport him home with a referral to his local HIV care program.

Afghan soldiers were part of the coalition, but there was no distant home country where we could transport them. They were home. After their resuscitations and surgeries, we would arrange transfer to the Kandahar Regional Military Hospital (KRMH), the local ANSF facility. KRMH was a good hospital with a talented and hard-working staff, but they were limited by shortages, equipment, and medications. An embedded NATO medical training team worked at KRMH to provide support as well, which streamlined the transfer process. We would send patients to KRMH with the medications we thought they would need, such as antibiotics, but we knew they were limited in their ICU beds, functioning ventilators, and other key resources.

Afghan civilians were also home, but our options for them were even more limited. Once they had undergone their initial procedures, we would send

them to Mirwais Hospital, a large facility in Kandahar City funded by the International Committee of the Red Cross/Red Crescent (ICRC). Mirwais's staff were idealistic and brave, but their needs also exceeded the ICRC's ability to provide. Medication and supply shortages could be even more acute than at KRMH. Procedures that would be routine in the U.S. could be out of reach. Infections were common and often fatal. We also tried to send patients with supplies and recommendations for follow-up care, but we had no real ability to confirm this ourselves, and this is setting aside the obvious language barrier. Our recommendations could also be unrealistic: a rural villager would have difficulty obtaining a colostomy takedown in six months even if there were not an active shooting war going on.

Detainees were our other patient group. The Taliban were classified as "enemy prisoners of war" (EPWs). (Not all our detainees turned out to be EPWs; sometimes, they were noncombatants who were subsequently "declassified" and released.) EPWs were a special category: they needed to be well enough to go into detention, dress themselves, feed themselves, and go to the toilet. Detention facilities had limited medical capabilities, and they certainly were not in the business of managing a bad fracture or a tracheostomy. This occasionally meant that a good portion of our hospital's census consisted of Taliban under constant armed guard.

This system arose for a reason. Even if the KAF Role 3 was the best-resourced trauma hospital in the region, it was a finite place with a finite mission: to care for ill and injured coalition forces. We had around 50 beds total between the ICU and the ward. Our crew was predominantly from the U.S. Navy, augmented by colleagues from Australia and Belgium. We had one fellowship-trained trauma surgeon and one trauma orthopedist; everyone else was a non-trauma specialist, beyond the additional training that all military medical personnel receive. No one got to practice in their specialty alone; everyone had to be a jack-of-all-trades. Our vascular surgeon did emergency salpingectomies on women with ectopic pregnancies. Our pediatric intensivist cared for adults; our adult intensivists cared for children. I was the only I.D. specialist within hundreds of miles, and I was also the *de facto* cardiologist, hastily retrained by a friend in treadmill testing and acute coronary syndrome management at the beginning of deployment. If our small hospital assumed the care of every ill and injured civilian in the region, we would not be able to complete our primary mission. We could not be the community hospital for Kandahar.

I was the hospital's director of medical services, responsible for the ward, clinic, and rehabilitation services. During my deployment, I was contacted by a New York Times reporter doing an article on medical care in Afghanistan. With my commanding officer's approval, I answered some general questions about the work we did. When the article came out, it was brutal, filled with horrific stories of Afghans who received care at NATO facilities and then died of complications after transfer to Mirwais or other humanitarian facilities. The director of one Italian NGO was particularly scathing in the article: "They don't take responsibility for the patients . . . they start a job, and they give all the complications to somebody else" (Mogelson, *New York Times Magazine*, 18 May 2012). This particular NGO refused to accept any patient who had received surgery at a NATO facility, with one of its leaders saying, "It's better to let (a patient) die than to suffer while going from one hospital to another."

The article stung. We did care about those patients whom we sent to Mirwais and KRMH. We wanted to give them the best possible chance at recovery. We tried to send them along with enough information for their new caregivers to manage them, with enough supplies to make it work. Perhaps we would have had more success if we had a way to build professional connections with our counterparts at Mirwais, but security concerns made that nearly impossible. "Green-on-blue" attacks were common in 2012, when individual ANSF personnel would attack coalition personnel, and Mirwais Hospital had been attacked by militants more than once. Transitions of care, when a patient is transferred from the care of one team to another, are risky times even when they occur within a single hospital in the U.S. The risk is magnified when that transition occurs between two hospitals in an

active war zone who speak different languages with widely divergent capabilities. The article did sting, but there was truth to it. We were failing these patients, or at least some of them.

Over 16,000 civilian trauma victims received care at U.S. military hospitals during the wars in Afghanistan and Iraq. Over 90% of them survived their initial hospitalizations, although an unknown (to me, anyways) number succumbed to injury and infection later. All of our patients received the same standard of care at the time of presentation; it was the follow-up that diverged. I had no solution for this at the time, and I do not have a good one now. When you look at the spectrum of resources utilized across our patient groups (i.e., airborne ECMO for NATO forces versus ground transfer to an ICRC hospital for an Afghan villager), it troubled me that the wounded civilians seemed to come up last.

So what are the limits of our obligations in war? NATO policy stated that our obligation was for emergency care only; we were not equipped to manage these patients for the long term. We did the best we could with the tools we had and hopefully gave them better odds than a local hospital. In other conflicts, NGOs might have been able to fill the void, but many of these groups prize their neutrality and are understandably reluctant to coordinate with the U.S. military. The deliberate targeting of medical facilities in war has also made their work increasingly hazardous, both for local caregivers or NGOs. While undoubtedly courageous people, I do question the morality of the NGO that refused to care for any patient we had touched before. I will not defend the wisdom of our discharge policies, but punishing these patients for our failures is also hard for me to defend.

Before I went home, I updated our turnover guide for the new rotation who would be assuming responsibility for the Role 3. Writing about detainees, I said: "Try not to jump to too many conclusions about these guys and be 100% positive that you are providing the same level of care to them as you would to any other patient. We are not cops, we are not judges, and we are not prison guards. Be always mindful of safety and security, but don't do anything that will bring discredit on the Navy or that you will regret." Looking back, I hope this was good advice. I also hope that I remembered to take my own advice.



## A Liberating Breath

Elizabeth Dotsenko

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The war in Ukraine started not in 2022, but in 2014. Some of my relatives have been living under occupation for the past nine years. After a year of occupation, parts of Ukrainian society stopped paying attention.

But on February 24th 2022, that changed. The whole country was awakened by missile attacks in almost every region. Kyiv, the capital, was heavily shelled by air strikes, and from the North, South, and Eastern borders, Russian troops entered our territory with long convoys of military vehicles. In one moment, we all woke up in a country at war.

I have experience working in conflict zones. In 2017, I worked in Iraq in Internally Displaced Persons (IDP) camps for one year. On the 25th of February, 2022, my colleagues and founders of STEP-IN, the NGO with whom I used to work in Iraq, initiated a Zoom call. We decided immediately to start work in Ukraine—without any funding. Although my only previous work experience was being a doctor, I ended up taking on managerial responsibilities and established a Ukrainian branch of STEP-IN. I was also mother of a 1.5-year-old girl in a country of war. To say it was challenging is an understatement.

In the first week of the full-scale invasion, STEP-IN opened a crisis intervention point on the

Ukrainian-Slovak border crossing, where people could get psychological help and warm meals. We provided shelter and a place to sleep for those waiting in overcrowded border points.

As soon as we received our first grant, we started a mobile medical team in the Western part of Ukraine, where thousands of IDPs were relocated. They were living in schools, huge sports halls without any privacy, kindergartens, churches, and at the end, any building that could provide shelter from winter weather.

My colleague and I assessed the region and settled on ten permanent, consistent locations for biweekly visits. Aside from my role as coordinator, I also worked as a doctor for the first few weeks because we struggled to recruit any Ukrainian doctors. However, within a month, we had a full team with a psychotherapist and medical doctor. The team traveled through the Trascarpathian region in Western Ukraine and provided free consultations with physicians and psychotherapists as well as medicines, hygiene kits, and social services.

After the de-occupation of northern Ukraine, the tension and hopelessness seem to have decreased. People started smiling on the streets. I feel like I can finally breathe and live. At the beginning of the war, my husband and I, with our young daughter, fled from Kyiv and were not sure we would ever be able to return. After the de-occupation, life started to feel more stable. During one of STEP-IN's assessment trips, my husband and I visited our home. In such a situation, very small things unexpectedly become very valuable to me. I was so happy to see pictures on the wall, a ceramic bowl I brought from Iraq and our child's favorite toys.

The project in the Transcarpathian region had been ongoing for a few months, and in October 2022, I went to work there for a week as a physician to cover for someone else. We were searching for a new candidate and didn't want our beneficiaries to remain without medical help, especially in the peak flu season.

There is a day that I remember vividly in all its details. I remember the smell in the room and how the light from the window lay on my patient's face. It was Tuesday, and each Tuesday, we went to the Protestant church guesthouse, where around sixty IDPs were hosted. The church was one of my favorite places to work because the administration was very supportive and caring toward IDPs. Unfortunately, that was not the case everywhere. From the moment I arrived at a location, it was apparent how the IDPs were treated. Their eyes were the best indicator. In some locations, people were hopeless. But at this church, we were able to provide the IDPs with free hot meals, acceptance and support, and probably most importantly, a job on the church farm. People greatly appreciated these niceties, as they felt more in control of their lives.

When we arrived there on Tuesday, we had all our equipment with us and set up a reception area in the corridor. The psychotherapist worked in one of the rooms of the facility. The other medical doctors and I usually used a laundry room as all the other rooms were occupied by inhabitants. There would often be a big family in one room. One big hall was divided up by improvised partitions, and in each constructed section lived a family.

In the laundry room, two washing machines were working non-stop, as it was the only way people could clean their clothes, and often, they had only two spare sets. Therefore, to stop washing machines for a working day would cause a lot of discomfort for the residents. I put the washing machines on pause only during lung or heart auscultation. The ironing board served as a makeshift working table, as the other tables were needed in the kitchen or for kids' activities.

My next patient entered the room. It was a lady in her fifties with shiny, smiling eyes. I will call her Lady S. In a very calm way, she told me that she had some thyroid issues. She was not sure what the condition was, but back in January, before the full-scale invasion, she had all necessary tests and examinations and was planning for thyroid surgery in February. But then the Russians invaded the Kharkiv region, and she fled without medical papers. And now, she was having difficulties swallowing and breathing. The discomfort had become unbearable. All I could offer her was a physical examination, which was not enough. I referred her to the local family doctor, who could refer her for

further tests and examinations for free, as she could not afford to pay for the tests herself.

While I was upset by my limitations to help her, our conversation was interrupted by her phone ringing. She gazed at the screen, and her face showed hope, fear, and surprise all at the same moment. She very modestly apologized and said that it was her daughter calling. She immediately started to cry. She asked maybe five times "How are you?" And I heard how her daughter replied to her multiple times, "Mom, I'm alive! I'm alive!"

After the call she breathed in deeply and exhaled all the tension and stress. It looked like she recalled how to breathe—like she allowed herself to breathe and live again.

It was a short and very emotional talk. After putting down the phone, she explained that she hadn't heard from her daughter in three months. Her daughter was 17 years old and remained in the city that was occupied by Russians who had destroyed communication facilities, jammed the connections, and tracked those who were calling the territories controlled by Ukraine. For three months, her mother didn't know what was going on with her daughter. I didn't dare ask how it happened that her daughter stayed there and did not escape with her mother and other siblings to western Ukraine. What I know is that she was there with her father, who stayed to protect their properties from the Russian soldiers, as they are infamous for depredation.

Later on, I learned that Lady S has seven kids altogether. The four youngest were with her—the youngest was only three years old. I was astonished by the thought that she lived not knowing what was happening with her 17-year-old daughter for three months. During the de-occupation, there was heavy fighting, and their apartment was destroyed. She felt very ambivalent, as there was much relief that Russians were pushed from their city, but at the same time, during the de-occupation, many facilities were destroyed. The area was mined by Russian forces before they left and heavily shelled by their artillery. Soon after the de-occupation, the woman's daughter was able to flee; prior to that, the Russians didn't allow people to cross checkpoints towards our territories, but only to move abroad to Russia.

Our psychotherapist continued to work with Lady S and we closely supported further medical check-ups. We even had a team discussion with our coordinator to determine if we were crossing a boundary—providing more humanitarian help to Lady S at the expense of being able to allocate ample time and resources to other IDPs. We agreed that hers was an exceptional case. Our team, but especially the psychotherapist, supported Lady S even during her doctor visits and testing. Without support in a completely unknown hospital and new region, which was stressful, Lady S was inclined to ignore her symptoms and hesitant to proceed with examinations.

We also had ethical concerns about referring this patient for surgery. If Lady S followed the usual referral path, she would endure weeks of visits and trips to multiple hospitals and laboratories in the city, which was 40 kilometers from the guesthouse where she lived. Due to health conditions, it was very difficult for her to find a job, so she saved her money for the needs of her kids and put herself last. Even a bus ticket to the city was out of her financial capacity.

Meanwhile, our NGO had a parallel project, where we supported hospitals with brand new expensive equipment. We provided such help to a few regional hospitals in the Transcarpathian region, therefore I knew the hospital director and had interacted with them in the past.

I was concerned about whether asking them for direct support for our patient without adhering to the bureaucracy of the referral policies was fraudulent or corrupt. According to our policies, that situation could be classified as so. I took some time to analyse the situation and consult with others. The ethics of the situation were ambiguous—if we helped one patient to shortcut the patient route system, should we be prepared to help all our patients in the same way? Nevertheless, I decided to ask the director for help and support for Lady S. We agreed, that she would arrive on the scheduled day for tests, and the hospital would take care of her during all the next stages of care. At the time, I was in the other region, therefore all those agreements were done by phone. In the end, Lady S was

hospitalized and received all the necessary treatment and surgery.

The time of her surgery was around the invasion anniversary. It was a difficult time for everyone. Some patients reported that they felt an irrational urge to flee even from the safer western Ukraine. Lady S also had a mentally difficult period, but she wanted to return to her home in the Kharkiv region, some 50 kilometers from the Russian border and much closer to the frontline. Once she disappeared from the region, the hospital administration was searching for her and called us. The psychotherapist and I didn't know how to approach this situation. On the one hand, we had more of a history with her and knew more personal information about her. On the other hand, not being part of the hospital administration, it was not our responsibility to search for her. Even though, at one time we crossed our usual scope of the help we provide, should we do it one more time? We had a long conversation with the psychotherapist and discussed all possible options. We even discussed the prospect that she returned to a heavily shelled home because she was tired of being an IDP. We decided to provide our private numbers for her relatives, so in case lady S wanted to reach out, she could and knew we were open to hearing from her despite her relocation back to the Kharkiv region. We were very happy to hear that all went well. She came back to the guesthouse for a few days. She is one of the patients with whom I became fairly close. Even though I didn't visit the field for a while as I was doing other work, very often, our psychotherapist reported back to me about how Lady S was doing.

Some eyes of the patients I remember more than others, and some kid's paintings remain with me always. Sometimes I wonder if it is just because I feel more compassion for some people than for others. I sincerely hope that each of the people we work with has at least one person in the world to share their worries and thoughts with even if they are far away because only our relations with other people make us humans.

## Soldiers of the Invisible Front: How Ukrainian Therapists Are Fighting for the Mental Health of the Nation Under Fire

Irina Deyneka & Eva Regel

### Irina Deyneka

When the Russian army attacked my country, I became a volunteer for a hotline offering psychological support to those in crisis; refugees, those who were under the shelling, those who were hiding in bomb shelters, and who were directly in the zone of fighting. People were lost and disoriented by constant bombing, by the fact that their country was under attack. Once, I had a woman who lived in Mariupol on one of these calls. I was living then in another city, Odessa, but was experiencing the same horrors of war that my client was—the shelling, uncertainty, and despair. We were processing my client's feelings of grief and anxiety when I heard the sirens on her end. I offered to stop our session so she could seek shelter. She told me she would not have time to find shelter and wanted to continue our meeting. And so, we continued . . . But soon, Odessa's sirens broke the silence, and it was my turn to decide what to do; should I continue our session or try to find a bomb shelter for myself? I decided to stay because I thought that was the right thing to do morally, professionally, and personally.

I eventually left Odessa, but only after a bomb destroyed a house next to mine, and I saw a family, my neighbors, perish in the destruction. I am now a member of one of Slovakia's Non-Governmental Organizations (NGOs) and work in a mobile brigade providing medical and psychological support to refugees. I can remember every one of my clients. Children, adults . . . I can remember their stories, their traumas, their memories of the horrors of war and devastation. Sometimes I meet with them only once, and they move on to another refugee center or are on their way to a Western part of Ukraine, trying to escape the war. And frequently, I do not know how many sessions I will be able to have with clients. Sometimes it is only one time, and sometimes

we can meet for many months. Initially, I thought, *What can I do in one therapy session?* Now, I know that I can do a lot. I can provide people who survived the most inhuman conditions and witnessed death and destruction around them with a space and time to talk through and process their experiences. I am their support, and they lean on me as they try to make sense of what has happened to them and their country. I always tell my clients that my goal as a psychotherapist is to help them withstand, survive, and hold on while still being able to continue to function in a country at war. All I can do is treat each of the therapy sessions as our last one and try to provide as many strategies and skills as possible to cope with anxiety and depression, to be able to function, and to live in the present.

Every session is about installing hope, moving slowly forward, and away from traumatic events. One of my clients, a 14-year-old boy, was diagnosed with a neurological condition, involuntary facial muscle spasm, or tics. He was barely talking when I first saw him, and I decided to use art therapy as a trauma-processing tool during one of the therapy sessions. He was drawing an explosion, fire, and destruction of his neighbor's house. He blacked out the horrors of his experience to preserve his strength. Yet, he began slowly remembering his experiences, re-creating the story of his trauma, and making memories. I was fortunate to work with him for many months, carefully and thoughtfully helping him re-create the sorry of his trauma, helping to become its witness. Ultimately, it was great to see that he could control his memories and his emotional stress; he felt empowered and in control.

## Eva Regel

This is the story of Irina Deyneka, one of many Ukrainian psychotherapists working in Ukraine, providing mental health support to a nation ravaged by war. I met Irina through my work as clinical director of the mental health support program of the NGO, Health Tech Without Borders. Almost instantly in February 2022 when Russia invaded Ukraine, many Ukrainians were separated from their families and loved ones. So many Ukrainian people lost everything, including property, family photos, and savings. Their children were separated from friends, school support, and social networks. So many lost their plans for life, their hopes, and expectations of what their lives will be. In many ways, they were separated from who they were, their identity, their future. The anxiety of the unknown, the depression, the grief, and the need to protect their children and elderly parents and to survive, became the "new normal" for the Ukrainian people. Ukrainian psychotherapists are fighting for the future of Ukraine under the most challenging conditions of ongoing armed conflict and constant re-traumatization. Every Ukrainian is affected by war; every Ukrainian is experiencing direct and secondary trauma. The psychotherapist's goal right now is to help the people of Ukraine not only to withstand the ongoing trauma of war but still be able to function, still be able to do their daily activities, care for their children and elderly parents, and care for themselves. And for Ukrainian psychotherapists, it is not simply a professional goal or professional obligation. It is a humanistic desire to help others in need; it is simply the right thing to do.

Despite that, moral distress and burnout rate are high among Ukrainian psychotherapists. Mental health clinicians (psychotherapists, psychologists, social workers) working in the zones of armed conflict face many issues that challenge their sense of identity. Many therapists are refugees experiencing the same feelings of uncertainty, fear, anxiety, and worry about their loved ones and their family. Adhering to professional and moral ethos during armed conflicts like the one in Ukraine can be challenging and demands a significant reorientation of personal and professional identity. The responsibility to provide each of their clients with as much support and emotional resources, without the ability for a referral or a treatment plan, is very difficult for those whose professional identity is about helping others, non-abandonment, restoration of mental health, and support their clients through the most challenging times of their lives. Furthermore, there is still much prejudice toward psychotherapy; many Ukrainian people worry about being stigmatized or called "crazy" if they see a psychotherapist. This

attitude towards mental health changes, but the process is slow.

Day in and day out, Ukrainian mental health clinicians witness the trauma of war, hear the stories filled with grief and desperation, and see the emotional aftermath and devastation the war has on people of all ages. The mental health clinicians work in environments that are not typical for therapy sessions; in hallways, in cramped offices with other therapists separated only by a thin fabric curtain to give some appearance of privacy. Despite all that, they continue to create space for hope and a future for those who felt they lost both. The Ukrainian mental health clinicians are soldiers fighting one of the most critical battles of our times, and they will win.

## Stories of Families with Chronically Ill Pediatric Patients during the War in Ukraine

Vita Voloshchuk

February 24th was a day that has left a mark in the memory and on the lives of every Ukrainian person. My husband and I work together in a hospital. He had gone into work early to conduct a kidney transplant that had been scheduled for that day. Suddenly, whilst on my way to work that morning, I heard a strange sound—it was an air-raid siren. Before that, I had never heard such a sound. I went through all the possible options of what it could be. Of course, watching the morning news had never been a habit either. The next thing that astonished me was that the taxi I had ordered was taking an unnaturally long time to turn up. When I got into the taxi, I noticed that the taxi driver was really upset and silent for half of the journey. He then said, "A war has begun . . ."

"War? So? The war has been going on since 2014."

"You don't understand," he said. "Russia is launching missile attacks all over the territory of Ukraine; Russian troops are coming from the east and north of Ukraine. They want to capture the capital of Ukraine." (Kyiv).

Arriving at the hospital, I saw confused faces everywhere. The morning meeting began with a discussion of how we were to act in any possible situation that may occur. We were to discharge patients from the hospital, as many as possible. The arrangement of a bomb shelter began (although I didn't even think that such a thing existed in our hospital), along with the strengthening of the hospital's windows, and the increase of supplies such as medicine and food. Of course, the boy who expected a kidney transplant did not receive it because no one knew what to expect at any second or where a hostile Russian missile might hit, as Russian missiles hit not only military objects but residential buildings, hospitals, and memorials as well.

Children who had to continue therapy remained in the hospital. As soon as we heard the sound of an air-raid siren, we had to go down into the bomb shelter. This happened 5-10 times per day. Families with palliative and chronically ill children began to call and ask for advice on how to proceed in such a situation. As many children were on artificial respiration devices, others needed oxygen therapy, and sputum of mucus from the upper respiratory tract. All this required uninterrupted power supplies and appropriate equipment. Later that day, a doctor from Poland called me and asked if our pediatric patients needed help, saying it would be better if they were moved to Poland, where they would be safer and have the correct equipment. We started organizing evacuations for chronically ill and palliative patients.

Seven days after the war began, parents from other regions, where the situation was more dangerous, began calling, asking for help evacuating. The hospital began to work intensively round the clock. Some patients moved in, and others were evacuated abroad. Some did not want to go. They continued treatment in the hospital, which turned into a hub for patients who had come from more dangerous, occupied territories; patients who were forced to leave their motherland to continue treatment.

Since the beginning of the war, I have been responsible for transferring palliative patients and other patients with gastrointestinal diseases abroad.

After the massive invasion, everything changed in our country. It is important to say that during the war, Lviv is safer than any other Ukrainian city, still air-raid sirens often go off, and everyone needs to run immediately to shelters for their safety. Palliative patients need special care. It is very difficult to run with patients several times per day during an air-raid siren or live with these children for a long time (2-3 weeks) in shelters because of the explosions occurring around them.

It is impossible to move some patients to safety because they need appropriate medical equipment or mechanical ventilation is necessary. In shelters, there are crowds, and the high risk of infection for these children is present.

The families of these children are terrified. Some children have an (exacerbation) aggravation of seizures due to explosions. Others have different infections or dehydration. Some of them must go to shelters during treatment in hospitals. Families with palliative children from other Ukrainian regions, where the situation was more dangerous, came to our region. The Russian army has been attacking civilians, their houses, and other places. A lot of people were without electricity, food, or water. Many families with patients began to ask about different ways of evacuating. From the beginning of the war, our hospital has been a clinical hub for these patients and their families. We were willing to hospitalize children from different regions of Ukraine around-the-clock. They were hospitalized in order to stabilize them and after that, they were transferred abroad by forming convoys through the green corridors. Although a lot of families decided to stay in Lviv or other parts of the Lviv region because it is safer.

The evacuation convoys were terrifying. Families were petrified. They cried and asked for help for their children. Some of them said that they don't have a house anymore, their city is destroyed. They didn't know where they were going to live in the future.

The night the first group of palliative and chronically ill children arrived, most were from Kharkiv and Sumy. I examined the children in the reception department and determined who needed treatment. With the proper appointments, they were hospitalized in wards for future treatment. The mothers of the children cried and asked for help for their children. Some said that they did not know if they would see their husbands alive again.

The Russian army shot civilians and shot cars and prevented them from leaving the occupied territories. Examining one child, I saw various notes on the body.

One mother showed us her child's skin—she wrote the child's first and last name on their body. She explained that if the Russian army shot their car while they were coming to our hospital, and if they died and the child lived, maybe some relatives could find them and continue taking care of the child.

In another ward, a grandmother was crying out of happiness. She said, "I am crying because the child can sleep." They had arrived from a city that experienced constant explosions and alerts, and the child had been having convulsions frequently. This was the first time the child had not had convulsions for a while.

A palliative patient with severe cerebral palsy came from Kyiv to our hospital. He and his mother had lived in a shelter for two weeks. The boy, who needed to remove mucus from the tracheostomy several times per day, was without this procedure for two weeks. His mother had to suck the sputum from him several times per day. When they arrived at the hospital, he was in serious condition, as his saturation was at 80%. He stopped breathing and his heart stopped beating—it was a clinical death. We began to resuscitate him in the ward. At the same time, the mother calmly started to unpack their luggage. With what she had seen before their arrival, she had experienced her own trauma.

Two girls with acute liver failure as a result of Wilson's disease were hospitalized in Kyiv for examination and continued treatment. The cases were identical. One girl was 17 years old, and the other was 13. The treatment turned into greater torture as they spent three weeks enduring it in a bomb shelter under constant fire where the treatment they received wasn't adequate. When they finally arrived at our hospital, it was absolutely clear that both children were in serious condition and needed liver transplants immediately. Doctors from abroad

agreed to help them. The children were transported by individual transport abroad. One of the girls told me that she wanted to be a model. I told her that everything would be like that. However, after some time, I found out that she died. Damn war! Maybe she would have lived if treatment decisions had been made in time and not so much time had been wasted.

I never once had the thought of going abroad. I always thought that I could be useful in my country. I would do everything for that. Furthermore, there were thoughts that if everyone leaves the country, who will remain? Without people, there is no country. I don't have children of my own, so it's probably easier for me to think and say that. I am also sympathetic to people who have children who leave because they want to protect them or their children may require treatment that cannot be adequately provided in Ukraine today (e.g., oncological diseases, chronic diseases, etc.). However, I am sure that after treatment, when all is fine, they will want to return to a country without war.

## Commentary

# A Call to Duty; but Duty to Who?—Voices of Healthcare Providers in Conflict Zones

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**Abstract.** Serving as a healthcare worker in a conflict zone is an experience that is characterized by peculiar and unimaginable challenges. This commentary is an exposition on twelve collated stories of healthcare providers currently serving or who have previously served in war. The stories bring to bear the heaviness of emotions such as fear and guilt that the authors grappled with, while concurrently showing that they embody virtues such as altruism, self-sacrifice, courage, and solidarity. In these stories, we see highlighted recurrent ethical themes including the tension between the duty to others and the duty to self, prioritization and allocation of scarce health resources, ethics of research in war, ethics of virtue and the lasting effects of war. This commentary thus explores and heightens our awareness of the interplay between personal morals and the translation of these into ethics of healthcare provision in war. In so doing, the commentary urges us to reflect on ways by which we can engage the discourse pertaining to war and healthcare ethics.

**Keywords.** Disaster Bioethics, Wartime Ethics, Narrative Ethics, Duty of Care, Scarce Health Resource Allocation, Virtue Ethics

## Introduction

Healthcare under fire—nothing exemplifies the title of this symposium more than the words of Riga, Sams, Hussein, and Ahmad, who respectively said, "I see hell"; "war is definitely hell on earth"; "the middle of hell" and "hell rose." "Hell" was one word that was common across the stories. These words paint a picture of hail, fire, and brimstone as experienced by healthcare professionals in war zones; they tell us the stories of healthcare workers from all over the world—Israel, Palestine, Sudan, Ukraine, Myanmar, Afghanistan, and Iraq. While serving in the thick of conflict, the authors faced the most unimaginable challenges, enough to scar most people irreversibly—and scarred they were.

When we hear crackling explosions or sounds, most of us safely assume the resounding crack is from someone lighting off fireworks. But for others, those sounds are ominous; they spell doom because they are the sounds of missiles, weapons of mass destruction, and shattered glass—that is war.

The more I read and re-read the stories, the more I realized that despite the uniqueness of each story, there are many recurring themes. These include the tension between duty to self and duty to others, the questions that arise about prioritization and allocation of scarce health resources, the virtues epitomized by the authors of these stories, and the lasting effects of war on not just the authors but their families and the community at large. The ethics of healthcare practice in war is embedded in the much larger and burgeoning field of 'disaster bioethics', which encompasses both natural disasters and human-initiated ones (O'Mathúna, Gordijn, & Clarke, 2014). In this commentary, I will shed light on the stories in a way that situates and captures them under the faces of morality—their duties and values—subsequently drawing on the authors' lived experiences. Beyond that, I will highlight and analyze ethical themes that apply to wartime ethics and suggest ways to advocate for change.

## Duty to Others Over Duty to Self

To whom do we first owe duty? Ourselves or others? Humans are inherently primed to put ourselves first and pursue the path that best serves our interests. To do otherwise under circumstances such as war, which palpably threaten one's life is to probably act in a manner that philosophers describe as supererogatory, that is, "to act beyond the call of duty" (Heyd, 2019). The foremost tension then that arises when providing healthcare in a war zone lies in the struggle between whether to prioritize self or the other.

This duty to others is encompassed by the words of Kachkovska, Dudchenko, Kovchun & Prystupa, who said, "Can we, in this situation, feeling our patients' need for help, leave our native country and these heroic people? We have but one answer to this question—we remain here . . ." These thoughts are further echoed by Nogovitsyna, who stated, "I wanted to stay in Ukraine because while I am here, I can speak on behalf of Ukraine." For many of these authors, making that decision to remain and serve others in war was made in a heartbeat, without room for doubt. As such, tied to this duty to others is another idea—the spirit of togetherness and unity, depicted by the African philosophical term and humanistic ethic, "ubuntu." Ubuntu can be translated to mean "I am because we are" (Mugumbate & Nyanguru, 2013). Indeed, there is unity in adversity. We see this come to life in the stories. The doctor from Myanmar speaks of the patient whose arm was blown apart by a bullet and barely hanging to her body by a strip of skin. Yet, the patient asked to wait her turn so that the medical team could first attend to those with gunshot wounds to their heads—this is the zenith of the spirit of togetherness and humanity, born out of adversity.

It is worth noting that even while highlighting this "duty to the other", an important question must be answered: In the first place, who is the other? Who is included in that definition, and who is excluded? Does concern for the other include providing care to injured militia and war perpetrators as well? Should care be extended to the enemy? And does this even align with the code of ethics of medical practice in war? According to International Humanitarian Law, "There is an unequivocal duty on all parties to armed conflict to provide impartial care for wounded and sick combatants" (Maurer, 2015). Though this law exists, we must acknowledge the emotional burden and moral distress health workers face in such situations and provide an outlet for them to channel those emotions.

In Saeed's write-up, the weight of the emotions his staff carry is evident as they reminisce the atrocities they and their communities suffered under the same people they were asked to care for. One nurse is documented to have said, "Seeing these people reminds me of all the girls and women who went missing from my village and are now being sold as sex slaves in Syria." I would be mad too. However, through continued discussions and engagement, the team came to agree that in accordance with humanitarian laws, it was still their duty to provide care to all patients regardless of which camp they belonged to. This duty would still hold even if the enemy did not keep their side of the deal. Crimes against humanity have been committed in the name of war—with civilians killed and hospitals attacked. Regardless, Saeed and Maves use very similar language when they articulate, respectively, that "Medical facilities are not courtrooms, and we

should never assume the roles of judges or law enforcement agents" and "We are not cops, we are not judges, and we are not prison guards." In summary, the healthcare worker's role is to heal, not judge—a Herculean task indeed.

In contrast to the natural instinct to save oneself and family first, these stories depict the selflessness and dedication to others that can be hard to fathom. In at least seven out of the twelve stories, we see the authors speak about their deep sense of duty and commitment to the care of others, even though it often meant putting themselves and sometimes their families and staff at risk.

It is hard to visualize the amount of risk these authors took to ensure the well-being of others until we take a step back to reflect on some of their words. One of the authors, an exiled doctor from Myanmar, and whose full name was not shared for safety reasons, describes their role as a physician in a medical team operating covertly to bring care to wounded civilians. In their own words, P.P. Kyaw says, "I was scared that if I missed one message, I would be unable to save a life. I could not sleep . . . but I never stopped doing what I was doing." The author continued in this role until they were able to leave the country for security reasons, and even though they are now safe, they describe feeling guilty about not being on the ground to serve the people of Myanmar. Kyaw's sentiments of guilt are shared by Ola Ziara, whose narrative was written with assistance from colleague Rachel Coghlan. Ziara describes intense guilt over not being physically present in the hospitals to assist her colleagues in Gaza after transitioning to a safer, more administrative role. Such is the burden of guilt some authors carry—guilt fueled by the depth of their sense of duty to their compatriots and fellow humans. And so, even in safety, their thoughts are never far from the communities they served. They remain relentless in pursuing justice for the people. The truth is, whether they stay or leave, there is no winning, which brings to the fore how neither option is a good one.

On the other hand, three stories explicitly commented on the need to ensure one's own safety while administering care or collecting data and the extreme lengths required to ensure the safety of their staff. Ghaiath Hussein, a researcher in Sudan, had sent data collectors out into the field. Hussein put it eloquently when he said the survey guide "Seemed to provide extensive guidance on everything except for the only instruction I needed at the time—How to keep my teams safe under fire." His words emphasise that no matter how much one prepares for war or thinks they are prepared for war, no amount of preparation can ready a person for the atrocities of war, bringing us next to the issue of resource allocation.

## Allocation of Scarce Health Resources

Health resources are not infinite—this is further heightened in war-torn areas. In the face of scarcity of health resources, questions arise about who gets what, when they get it, and whether they get anything at all. Whose lives are worth saving—the one who cries loudest or the one who has more social value? These decisions are veritable moral quandaries, as was Ayesha Ahmad's dilemma. Ahmad had to choose between evacuating an ill child alone or with his doctor, who refused to provide the child's medical records unless he was included in the request for medical evacuation. Though Ahmad was sympathetic to the doctor's desperation to flee, she knew including him in the request would likely lead to the request for a medical evacuation visa being denied. Ahmad could not save both the child and the doctor, so she chose to pursue other avenues to save the child. The child and his family eventually escaped Afghanistan. What happened to the doctor? He was replaced by the Taliban, and, to date, his whereabouts are unknown.

Allocation of resources sparks questions of distributive justice, which involves the fair and equitable distribution of resources, which, especially in war, can be scarce. Questions about resource allocation and whose care should be prioritized should never have to be deliberated at the bedside but are the very questions that healthcare workers in conflict areas grapple with daily. These decisions are difficult, and the available literature does not provide straightforward pathways for how to prioritize treatment and resource allocation among patients (Fares, 2023). If all who need care can't be

saved, how does one live with the outcome and moral burden of one's decisions? No matter what one chooses, the guilt never goes away, and the burden is the healthcare worker's alone to carry.

While a number of the stories focus on the limitation of resources like medicines and equipment, a few others involve the scarcity of human resources. Many experienced and trained healthcare professionals fled the countries where the narratives are set, leaving the remaining few to be stretched beyond their capabilities—often to the point of providing care beyond their scope of practice. According to Riga, Sams, Maves, and Hussein, healthcare workers and researchers became many things to many people. Physicians worked in fields outside their specialties in support of their colleagues or simply because no one else was qualified enough to function in those roles. In wartime, the practice of medicine is no longer a question about the standard of practice, but rather, it is about the best that can be done given the constraints. It is only in war that an adult-sized urinary catheter is used as a replacement for a pediatric-sized endotracheal tube, as was narrated by Sams. In these circumstances, practices deemed unacceptable in modern-day medical practice become tragically acceptable—and even essential. That is the stark reality of healthcare provision during war.

## Ethics of Research in War: A Unique Perspective

This paragraph is distinctly featured because it accentuates the unique perspective of the particular challenges those who carry out research in conflict zones face. In Hussein's description of the landscape of his research in Sudan, we come to appreciate how "mundane and routine" data collection could be harmful for all those involved. Data collectors, often compensated well above what other jobs would pay, may be motivated to obtain data in dangerous circumstances that put them in harm's way. Both the collected data and the collectors themselves may be highly valued. When the data collectors go missing, finding the data can be as important as finding the collectors. Hussein hopes, "When you come across the next report from a survey conducted during an armed conflict, you will see the people; you will hear the people; you will feel the people—not only those surveyed but also the surveyors." For every published report of war we read going forward, may we remember that someone took on unimaginable risk to obtain the data. Let us strive to acknowledge and appreciate the untold and unheard stories of those who walked paths of thorns to fulfil a duty.

From an ethical standpoint, I wonder if, given the opportunity to earn equivalent amounts of money in safer jobs, these same individuals would still opt to serve as data collectors in conflict zones. Do they sign up for these jobs voluntarily, or are they swayed and influenced by the thought of the money they earn? Vulnerability, as applied to research participants in the social sciences, includes "people who may have decision-making capacity but who lack the power and the resources to make truly voluntary choices" (Levine, 2004). If the data collectors are motivated by the money to do this work, are their choices truly voluntary? If not, should we extend the term 'vulnerability,' as used in social science research, to include these data collectors?

I do not have the answers to these many questions. However, I suspect that the influence of the money may have a role to play in people "choosing" to accept such risky jobs, and maybe this should give us some food for thought.

## Lasting Impact—An Indelible Scar

Even after war ends, its devastations and ramifications continue. Its effects are far-reaching and bleed through every aspect of the life of survivors, even decades beyond the initial trauma. In this paragraph, I focus separately on highlighting the downstream effects, not just for health workers, but also for children who are born into, yet to be born into, and who live through war. To these children, war is their normal—only it is not. War can never and should never be normalized. Whether in the form of emotional, psychological, or many other forms of trauma, war leaves scars that are difficult to heal from—if one ever heals from them at all.

The healthcare workers themselves are not spared the trauma, which is why Lederman wrote

that " . . . even the camel's back can only take so much." Each person has their breaking point. As a society, then, each of us must work to provide resources and connect them to children and healthcare workers who have lived through war. Their resilience is admirable. However, while resilience is largely considered to be positive since it is a helpful adaptation to stressful situations, some scholars have critiqued the concept as it tends to focus on the individual's response rather than fixing the source of adversity (Mahdiani & Ungar, 2021). In an ideal world then, these children and healthcare workers would not have to display that level of resilience at all.

## Ethics of Virtue

Virtue is worthy of emulation and is needed to stand one's ground in the face of challenges. According to Aristotle's version of virtue ethics, a virtuous act or moral good is one that will be done by a virtuous agent (Timmons, 2013). Examples of these virtues include courage, altruism, sacrifice, and truthfulness. According to Aristotle's concept of virtue, all these authors express many different forms of virtue. It takes courage to serve in a conflict zone; it takes sacrifice and generosity to give over oneself, one's energy, and skills for the benefit of others; and above all, it takes truthfulness (together with courage) to bear witness to the status quo of healthcare delivery during war. It takes courage to draw international attention to suffering through excellent penmanship. To witness evil and not speak against it is to be complicit in perpetuating the evil. These authors chose to speak up and, by so doing, exude the virtuous traits that Aristotle describes. They are worthy of praise and admiration.

## Conclusion

Providing healthcare in conflict zones is fraught with peculiar ethical dilemmas, including the commitment to caring for others and how to balance that with one's own safety, deciding how to allocate limited health resources, ethics of research in war, ethics of virtue, and the downstream effects of war on both the healthcare workers and children, who remain a very vulnerable population that must be protected.

As we read about the experiences of the authors through this commentary, in the words of Lederman, "We must give voice to those who often go unheard" by remembering to leverage our privilege and positions for the advancement of peace for all humanity.

Perchance, the greatest lesson we can come away with from these stories is that we must not be silent—these stories are about people; people with names, faces, and families; and people who lose their lives in war. They are not just statistics. Beneath the statistics are actual people. The one thing the world ought not to do is to look on passively as people's lives continue to be affected by hellish conditions of unassuaged fire.

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# Commentary
# Healthcare Workers in Conflict: Challenges and Choices

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**Abstract.** *'War is definitely hell on earth'.* All too often, we hope the hell will be short-lived, over in a few days, and yet, as we know from experience, hell can go on and on and on. For healthcare workers who provide care to victims of conflict, the work raises many ethical dilemmas. The stories showcased in this edition of NIB share the experiences of a handful of brave individuals and how they navigated their professional ethical obligations as well as their personal convictions during times of conflict. Adeptly portrayed are various approaches to ethical dilemmas, such as adhering to the ethical imperative of medical impartiality, the limits of professional and personal responsibility, coping with moral distress, and the power of humanity, evident through the collective efforts of strangers to help others. This commentary reflects on the ethical grey zones of being a healthcare provider in conflict, as there is no single right way of fulfilling professional obligations, each context being different. As several stories highlight, whilst stressful, the solidarity and comradery of working in a healthcare team can provide great support, purpose, and motivation.

**Keywords**. Healthcare, Conflict, Attacks, Medical Impartiality, Moral Distress, Ethics

## Introduction

As Richard Sams starkly points out, *"War is definitely hell on earth"*. All too often, we hope the hell will be short-lived, over in a few days, and yet, as the war in Ukraine is demonstrating, hell can go on and on and on. The collection of stories showcased in this edition tells the experience of a handful of brave individuals and how they navigated their professional ethical obligations and their personal convictions during times of conflict. It seems ironic that a profession dedicated to respecting and caring for human life and dignity can be so implicated in acts as destructive as war. At the time of writing, the conflict in Gaza is escalating, bringing loss of life, destruction, suffering, and misery to all affected. Once more, we live in the hope that this conflict will soon come to an end, demonstrating, yet again, the toll it takes on healthcare providers to try and save lives with few resources under a shower of artillery.

In 2022, the number of conflict (battle)-related deaths related to state-based conflicts[1] increased

[1] *A state-based conflict is defined as a contested incompatibility over government or territory, where at least one party*

more than two-fold in one year. This death toll was the highest recorded in any year since 1984 (Obermeier & Rustad, 2023). Two wars in particular contributed to this rise: the resurgence of conflict in Europe via Russia's invasion of Ukraine and the war in Tigray, Ethiopia, overshadowing the ongoing conflict-driven humanitarian crises in regions such as Syria, Afghanistan, South Sudan, and Yemen, where the underlying hostilities remain unresolved. To say the media has a pivotal role in influencing where attention is given would be an understatement.

Evidently what is not captured in these fatality figures are the millions of conflict-affected individuals who survive and who are not counted. It is hard to quantify the true toll on the individuals and communities who suffer the negative health and socioeconomic impacts of either remaining in or fleeing from conflict zones. Both come at a cost. Displacement is an evitable consequence of conflict that significantly reduces access to healthcare, and it remains a grim reality that Médecins Sans Frontières (a.k.a., Doctors Without Borders) (MSF), alongside others, continues to see worsening year upon year. As reported by the Office of the United Nations High Commissioner for Refugees (UNHCR), in the last decade, the number of forcibly displaced people[2] has doubled, with more than 108.4 million people displaced by the end of 2022 (United Nations High Commissioner for Refugees (UNHCR), 2023). This figure is the highest number available on record and includes 62.5 million people internally displaced due to conflict and violence across 65 countries and territories (Global Migration Data Analysis Centre (GMDAC), 2023). More than 90 per cent of forcibly displaced persons worldwide are in low- and middle-income countries. As an independent, non-governmental medical humanitarian organisation, MSF seeks to provide medical assistance to the people reflected by these statistics and who live in unstable contexts, where most of our interventions take place. In 2022, MSF conducted over 83,000 consultations globally related to intentional physical violence (Carnimeo & Sayyad, 2023).

This NIB edition brings personal stories that put faces and names to these bleak statistics. Spanning two decades and six countries, the narratives bring together diverse and inspiring voices to share what it means to be a healthcare provider in the particular types of hell that are conflict zones. The authors adeptly portray their individual approaches to ethical dilemmas, such as adhering to the ethical imperative of medical impartiality, the limits of personal responsibility, coping with moral distress, and the power of humanity, which is evident through the collective efforts of strangers to help others. They delve into issues such as who really pays the price of conflict and describe different ways in which the authors adjust to suddenly being in a conflict area, where basic primary needs must be differentiated from secondary priorities.

In this commentary, we will unpack the key ethical dilemmas and themes that these different stories portray from our perspective as medical humanitarian workers. Whilst the narratives are diverse regarding provider experience, we wish to highlight two connecting threads we detected. Firstly, the majority addressed challenges at the individual patient-provider interface (micro or clinical level). In our experience, tensions can arise for providers when trying to balance the needs of many patients with equal needs and limited resources. They can also encounter challenges at higher levels of the health system (meso and macro) when resources, programming, or advocacy decisions have the potential to de-prioritise the extent of individual care but advance a larger agenda to end the violence and protect many civilians from harm (macro level). The second thread is the experience of caring for civilians injured during conflict 'events', most likely attributed as collateral damage, as far

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*is a state and the use of armed force results in at least 25 battle-related deaths within a calendar year. Ref: Obermeier, Anna Marie & Siri Aas Rustad (2023) Conflict Trends: A Global Overview, 1946–2022. PRIO Paper. Oslo: PRIO.*

[2] *Forcibly displaced people data includes both within countries and across borders, as a result of persecution, conflict, generalized violence, human rights violations or events seriously disturbing public order.*

as we can tell. From the MSF perspective, we will further complement this with a brief reflection on intentional, targeted attacks on healthcare facilities, staff and patients, acts classified as violations of International Humanitarian Law (IHL).

## Medical Impartiality

For healthcare workers, working in conflict introduces a very real test to the professional ethical obligation of medical impartiality. This ethical principle ensures fair access to care for all and prioritises health needs without bias. Healthcare providers must not discriminate based on race, ethnic origin, age, disease or disability, gender, nationality, political affiliation, culture, sexual orientation, social standing, or any other factor (World Medical Association, 2022). Collectively, the authors shed light on their experiences of remaining impartial in fundamentally unjust conflict environments.

The particular test is that conflict brings healthcare providers into proximity with the causes of harm in a way not always experienced in non-conflict settings. It is difficult not to think about who is *'responsible'* when you see such violence firsthand, especially if you determine the acts to be unjustified, disproportionate, and avoidable. Providers often directly witness both the occurrence and the consequence of violent acts, caring for innocent civilians as well as the individuals perpetuating the hell being inflicted. They are patients and cannot be seen as an enemy.

What mental steps should a healthcare provider take to remain impartial? Unsurfaced is the dilemma of your head, knowing at the head level you are ethically obliged to provide care to all patients, yet also, at a heart level, it is human to seek justice. Even though logically, we know healthcare providers are not official instruments of justice and that this task falls to judges and courts. An added dimension is when we must treat injured friends and loved ones, which impacts our ability to be objective and impartial—whilst not considered 'best' ethical practice, this is often the reality. Furthermore, in our experience, this dilemma is not limited to local providers but can equally impact workers specifically sent into conflict zones as part of international response efforts.

Handreen Mohammed Saeed's piece painfully uncovers this turmoil but goes a step further by speaking out loud about this dilemma in real-time, something not often done in our experience for fear of being judged to be 'unfairly' partial. What if, by allowing entry to injured combatants, you introduce a potential aggressor into the facility, bringing potential harm to your colleagues? As explored, the harm is not always physical but may be psychological, triggering memories of recent attacks experienced in their personal lives. The way Saeed provides space for the team to express their feelings and praises their honesty and candid communication is to be commended.

## Dual Ethical Loyalties

Several of the pieces recounting recent experiences in Ukraine evoke thinking on the dual ethical loyalties that exist professionally and personally. The professional obligations of healthcare providers are to help those in need of care, to do no harm, and to act in patients' best interests whilst not being swayed by potential conflicts of interest (World Medical Association, 2022). Sometimes framed as part of a social contract and also a duty of care, these obligations go well beyond those asked of the public at large (Ruderman et al., 2006). Whilst deciding to train as a healthcare provider is a choice, the level of professional obligations associated with that choice is not always consciously accepted or considered in the light of working in conflict. Interestingly, society permits providers to self-regulate the limits of this obligation. We do so with the confidence that providers will always fulfill this obligation to the best of their ability (Ruderman et al., 2006). In conflict settings, this obligation can become very demanding, and new limits need to be decided in moments. The provider's own safety and competence must also be considered in conflict as in communicable disease response, and fulfilling this obligation assumes a level of personal risk.

Equally, all global citizens have a special ethical obligation in their personal lives to support

those who are most proximate, above what we are expected to do for a stranger. This 'kin' obligation is one example where it is often viewed as morally correct to act partially towards our loved ones (McManus, Kleiman-Weiner, & Young, 2020). Conflict response requires a sudden rebalancing of these professional and personal responsibilities, not excluding providers specifically deployed to the conflict whose families are at home, as recounted by Sams. Revised limits often mean not doing what you *'could in peace time'* and introducing a necessity to reprioritise, which can cause moral distress.

This rapid reprioritisation exercise involves deciding what are *now* basic primary needs and which aspects of life that were previously routine must now be pushed aside as secondary concerns. If your loved ones are at risk, do you leave your professional duties to assist them first? Does this balance change if a long-term patient of yours is critically injured? An extended duty of care is often considered *'just'* for patients under chronic care compared to 'new patients', as the longevity of the patient-provider relationship may bring a deep sense of responsibility. These are some of the ethical grey zones met by healthcare providers in conflict, as there is no single right way of fulfilling these obligations. As several stories highlight, whilst stressful, the solidarity and comradery of working in a healthcare team can provide great support, purpose, and motivation.

## Moral Distress

Closely shadowing our own experience as two doctors working with MSF in conflict, tension inevitably rises when you are privileged to possess skills that can help save another life, and yet performing these skills (or not being able to, to full capacity) due to circumstances beyond your control also comes at a personal cost and can contribute to moral distress. This concept is described as an individual toll that comes in the form of a negative emotional response to knowing the morally correct action but being powerless to do it (Kherbache, Mertens, & Denier, 2022).

Moral distress has many triggers. It gained higher exposure during the COVID-19 pandemic but was initially undisclosed in the nursing profession (Jameton, 1993). Being unable to act according to our morals brings endless self-questioning of one's own role in hell; unease of potentially contributing to harm, the feeling of never doing enough; and as reflected on by narrative author Artem Riga, a feeling of immense individual responsibility for others, *"If not me, then who will help people?"*. These can be very lonely and isolating emotional reactions, compounded in peak moments of shelling and bombardment when one starts to question the worth of their role in keeping people alive, and for what? *"Is my job even worth it*?" (*Ola Ziara & Rachel Coghlan)*

As explored by Ghaiath Hussein in his piece on Darfur, whilst often associated with micro-level care, moral distress can also occur through decisions taken to prioritise larger agendas in health programming, advocacy, and policy (meso and macro level). For example, moral distress could develop when stopping violence by influencing the actions of warring parties to respect International Humanitarian Law (IHL). On a macro level, adopting policy changes that may help end a conflict but might not serve individual needs directly could cause moral distress. Hussein weighs the pros and cons of individual sacrifice in order to continue data collection that would call attention to the situation in Darfur and likely bring much-needed support. Such moral decisions are lonely ones that, as Hussein recalls, can haunt you long after the moment.

## Attacks on Healthcare Facilities and Teams

As defined by the World Health Organization (WHO), an attack on healthcare is "any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative and/or preventive health services during emergencies" (World Health Organization, 2023). MSF continues to work to prevent and denounce any act that deliberately aims to interfere with medical action and deny healthcare to the wounded and the sick, despite the challenges of doing so under fire. Violence experienced at field level can be either indiscriminate or targeted; either way, they impose significant challenges and

dilemmas internally and externally. In the MSF experience, and through review of various case studies when our teams have come under fire while delivering medical care, five broad types of attacks or acts of violence emerge (International Committee of the Red Cross (ICRC), 2013; Médecins Sans Frontières, 2014, 2015). The first occurs at the triage point of entry when there is a request for preferential treatment either for oneself or for others to be denied treatment, an ethical challenge not unlike what has been presented in the examples above. The second is linked to unsatisfactory care, which can be due to unrealistic expectations for quality care in dire settings, cultural health-seeking behaviours, or being an avenue of last resort to express a call for justice or reparation. Looting and violence for economic gain or political reasons is a third category that often occurs in unstable and conflict contexts. A fourth is as an extension of war when attacks on medical personnel are part of a wider assault on civilians. Finally, a fifth is related to hospitals serving as protection zones when there is no other safe space to go, which can lead to suspicions from armed groups and make the facility an easy target.

Within each of these broad categories are different scenario settings that pose challenges and dilemmas to the healthcare provider. The burden of ensuring safety and security should not be borne alone by health personnel. Legal and ethical frameworks such as IHL and medical ethics are meant to ensure there is protection. The challenge lies in ensuring states and participants in conflicts respect these frames and enable health workers to carry out their medical duties in safety and security. Addressing such challenges can help mitigate health workers being confronted with ethical dilemmas on issues beyond their control. Preserving the sanctity of medical action is a collective duty that must be fulfilled to ensure that the medical act benefits all who need it.

## Conclusion

This collection of stories contributes to shared knowledge around the experiences of healthcare providers working under fire. We thank the authors for sharing their honest and, often, vulnerable reflections. The narratives tell of events we all wish never occurred that may haunt those involved long after the shelling has stopped. We hope that by highlighting the professional responsibility boundary challenges, ethical dilemmas, and most of all, the relentless self-questioning and feelings of responsibility for others, we provide guidance and support to others working in similar conditions.

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## Commentary

# Twelve Postcards from the Frontlines: Reflections From Healthcare Providers Operating in Armed Conflict

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**Abstract.** Armed conflict can destroy both a healthcare system and the people who comprise it. Where the facilities themselves may take decades to rebuild, this collection of essays is evidence of the remarkable resilience of healthcare providers working in these conflict zones. Twelve narratives are shared by doctors, nurses, and other staff working in current crises in places such as Afghanistan, Darfur, Gaza, Iraq, Myanmar, Syria, and Ukraine. The essays reveal logistical, personal, and ethical challenges of providing fundamental healthcare services under fire, coalescing around five recurrent themes: the obligation to provide care without discrimination, specific impacts on and considerations related to children, the personal transformation of medical providers, the mental health toll they suffer, and reflections on their proximity to or distance from the conflict itself.

**Keywords.** Medical Ethics, Mental Health, Human Rights, Bioethics, Delivery of Health Care, Armed Conflicts, Narratives

Armed conflict can have a devastating effect on a community and its ability to access medical services, be it regular prenatal care or treatment for war-related injuries. In Syria, from March 2011 through February 2022, Physicians for Human Rights (PHR) corroborated 601 attacks on 400 separate healthcare facilities (Physicians for Human Rights, March 2022). During the humanitarian crisis that gripped Tigray in northern Ethiopia in November 2020, only 40 out of 228 healthcare centers were functional by February 2021; 90% of the ambulances could not be located (Gesesew et al., 2021). In Ukraine, attacks have reportedly affected 1257 healthcare facilities since 24 February 2021 (World Health Organization, 2023b). According to the World Health Organization's Surveillance System for Attacks on Healthcare, there were 246 attacks involving healthcare facilities in Gaza from 7 October 2023, to 16 December 2023 (World Health Organization, 2023a).

Armed conflict can destroy not only a healthcare system but the people who comprise it. For example, PHR recorded 948 medical personnel deaths in Syria from 2011 through March 2023

(Physicians for Human Rights, 2023). In Ukraine, 111 healthcare workers and patients were reportedly killed between 24 February 2022 and 31 October 2023 (United Nations, October 2023). In addition to risk of death, medical professionals providing critical services during crisis show up for work every day to face unimaginable resource constraints, critical security challenges, and no clear signs of respite. Some work under the gun, literally, to provide care in hostile environments. Others struggle with painful ethical questions as they make the best decisions possible under near-impossible conditions.

This collection of essays offers profound insight into the multifaceted challenges faced by medical personnel working in armed conflicts around the world. The narratives are provided by doctors, nurses, and other staff working in current crises in places such as Afghanistan, Darfur, Gaza, Iraq, Myanmar, Syria, and Ukraine. Strands of these diverse essays align along five central themes: the obligation to provide care without discrimination, specific impacts on and considerations related to children, the personal transformation of medical providers, the mental health toll they suffer, and reflections on their proximity to or distance from the conflict itself.

## The Obligation to Care Without Discrimination

The ethical obligation to provide medical care without discrimination is a recurrent theme. Saeed emphasizes the commitment of a humanitarian organization to treat all individuals in Iraq, regardless of their affiliations. In this context, he notes the ethical challenge when a nurse struggled to treat patients suspected of committing human rights violations, reminded of friends and neighbors who had been abducted and sold into sexual slavery. Maves' account further complicates this theme, reflecting on the challenges faced by medical personnel serving in Afghanistan when policies limit the scope of care, raising questions about morality and the consequences of disparate intake and discharge policies for different groups of patients.

## Children

The second theme revolves around the profound impact of armed conflicts on children. Several strands emerge. Lederman's emotional account emphasizes the ethical dilemma of trying to save a 2-year-old boy who was blasted from his father's shoulders. "Adults should not bury babies," he writes. Ahmad, Ziara, and Sams deepen the discussion, shedding light on the healthcare needs of children entangled in conflicts, their vulnerability, and the logistical and ethical challenges of providing care, including issues of accessibility and safety.

Some essays note the basic yet sobering reality that childhood in war is inherently interrupted. For example, Novogitsnya's vivid account from Ukraine describes the all-consuming effects of war on parenting and childhood, with families forced to seek refuge in unconventional places to protect their children over and over again. She shares the story of the full-scale invasion starting on her daughter's sixth birthday and the subsequent desperate preservation of normalcy for her children amid the chaos of conflict—one of the tenderest labors a parent can shoulder in wartime. Finally, other essays note children as a driving force behind seeking healthcare for some. Kachkovska's account from Ukraine highlights how grandparents assume caregiving responsibilities for grandchildren after the loss or departure of parents serving on the front lines. The essay underscores the interconnectedness of family dynamics and healthcare-seeking behavior. These ties can be strengthened or disrupted as families struggle to adapt to the shifting realities of armed conflict.

## Changes in Roles, Relationships, and Worldviews

Another theme surfaced by this collection explores the dynamic shifts in the roles, relationships, and worldviews of medical personnel as a consequence of armed conflicts.

Some essays shed light on the challenges of adapting medical practice to the evolving circumstances of war. Sulaieva's account highlights the logistical challenges of transitioning from a

well-equipped laboratory in Ukraine to a more makeshift location with unreliable energy sources. This downgrade threatened to affect the care provided, serving as a poetic reflection of the larger impacts of war. This metaphor is borne out by Kachkovska, who describes how economic challenges, destruction of homes, and interruptions to clinical trials due to conflict significantly impact a team's ability to provide effective and advanced medical care.

Other essays brought into high relief the way war can affect relationships. Novogitsnya's narrative emphasizes the strain on relationships, partnerships, and coalitions during armed conflicts, noting that the scarcity of resources intensifies competition among hospitals, healthcare professionals, and NGOs. This can affect essential, life-saving collaborations during humanitarian emergencies. Ahmad pauses to regard the provider-patient relationship. Her narrative presents the ethical dilemma faced by a healthcare worker when considering how to present a patient's family with information about possible treatment. She describes a sense of inner conflict relaying clinical options rendered largely futile by war, coupled with the obligation to ensure patient agency.

The collection also amply demonstrates healthcare providers' own resilience of practice, with many taking on multiple roles or evolving their own practice. Accounts from Myanmar and Kharkov exemplify the evolution of medical roles in response to escalating conflicts. In both places, healthcare providers were initially involved in treating minor injuries during peaceful protests but find themselves compelled to address gunshot wounds and life-threatening injuries. The necessity to adapt to a changing conflict landscape transforms healthcare providers into first responders, challenging traditional roles and raising ethical considerations. Maves' account from Afghanistan echoes this, noting the multifaceted roles medical professionals take on during conflicts. They become soldiers. They become psychologists. They adapt as needs and environments change.

Other essays go deeper, delving into the profound changes in priorities and mindset transformation of physicians themselves. For example, Kachkovska describes an experience that prompts a reevaluation of material possessions and triggers a focus on immediate needs. It seems a reaction to war, an acknowledgement of how little one can control what lies ahead.

## Providers' Well-being and Mental Health

One clear throughline in this collection is the profound impact of armed conflicts on the mental health of healthcare providers, with several essays exploring the challenges providers face and the coping mechanisms they employ.

Ziara in Palestine describes how exhaustion, personal risks, guilt, and exposure to death take a toll on providers' well-being. Kyaw, the exiled physician from Myanmar, notes how the constant threat of danger and surveillance results in severe psychological distress and paranoia among many healthcare providers. Similarly, Saeed recounts how encounters with militants in Iraq trigger internal emotional and mental crises.

The narratives also highlight diverse coping mechanisms providers employ. Some interventions come at the institutional level. For example, Sulaieva's account highlights efforts in Ukraine to address mental health challenges among medical professionals through a conference on PTSD and Post Traumatic Growth (PTG), which helped to build a support network and exchange best practices. Sulaieva further describes how the laboratory itself became a shelter, fostering mutual support among staff members, their families, and patients. Elsewhere in Ukraine, Riga notes more personal coping strategies. She mentions finding solace and resilience in prayer, moments of camaraderie, and immersion in the healing process. Solidarity also emerges as a crucial factor in coping with mental health challenges.

The collection raises the delicate question of how "confidence in cause" can affect providers' mental health. The narratives by Kyaw from Myanmar and Sams from his time in the US Navy highlight the complex interplay between personal beliefs, moral uncertainty, and the pursuit of a cause. Despite the

emotional and physical toll, healthcare providers draw strength from their commitment to democracy, justice, and the well-being of their people. This resilience, however, can be in tension with moral reflections about the justifiability and consequences of wars their communities are waging.

## Taking Distance

One final theme struck by several essays is the ethical dilemma healthcare providers face regarding staying in conflict zones as opposed to leaving for safety. The authors weigh the impact of their decisions on local health systems and relationships with diaspora communities. Some also reflect on the challenges of maintaining academic distance from the conflicts tearing their homes apart.

First, the narratives highlight the internal struggles healthcare providers face when deciding whether to stay in conflict zones or seek safety elsewhere. In Ahmad's essay, the juxtaposition of everyday life in London with the chaos in Kabul adds depth to the dilemma of distance. In another essay, the commitment to professional duties becomes an anchor against fear, with healthcare providers facing emotional stress and daily upheavals in Ukraine. The decision to stay is often driven by a sense of duty, patriotism, and belief in the eventual victory.

Not surprisingly, the relationship between healthcare providers and diaspora communities is multifaceted. In Ukraine, healthcare providers maintain contact with patients who have left the country, offering not only medical advice but also psychological support. The narratives caution against biases and stereotypes that might migrate with people. In Afghanistan, cultural considerations influence decisions, as healthcare providers weigh the potential biases of colleagues with ties to different ethnic groups.

Ethical questions arise about the impact of decisions on the local health system. In Ukraine, the evacuation of children for medical care abroad raises concerns about potentially undermining the Ukrainian childhood cancer care system. Evacuating patients leaves pediatric oncology units without work, disrupting usual pathways for diagnostics and treatment. The ethical dilemma revolves around balancing immediate patient needs with the long-term health of the local healthcare system.

Finally, certain authors comment reflexively on the ethics of conducting research in humanitarian crises or being part of academia while war rages in their homeland. Ahmad's reflection on the dangers, risks, and perceived vulnerabilities of potential participants emphasizes the challenges researchers face in conducting meaningful and ethical research in volatile contexts. Hussein's experience in Darfur further illustrates how research protocols may not adequately account for emergencies, potentially jeopardizing the safety of research teams. Apart from conducting research amid armed conflict, some essays reflect on the role of an academic. Specifically, how does one square the demands of academia, such as publishing for professional promotion, with the moral imperative to address real-world, often hotly political issues during conflicts? This is indeed a question for our time.

## Conclusion

This collection is a gift. It is a twelve-paged postcard drawn by hand. Where time, quiet, and even electricity are in short supply, these doctors, nurses, and other healthcare providers stopped to type out their long days and long nights. They describe the physical, psychological, and ethical tolls this work can take on themselves and their peers. They share wartime glimpses of their patients, colleagues, and families.

Content aside, the gift was in the making. Perhaps our contributors stayed late at the office to finish drafting and the commute home was darker or more full of checkpoints that night. Perhaps they simply sacrificed a precious hour of sleep to proofread their essay before submitting it and heading back to clinic. It is hard to know. What is clear is that the value of this collection lies not only in its documentation of the harsh realities of providing healthcare in acute conflict but in the intimate and generous act of narration by healthcare providers operating in extraordinarily difficult circumstances.

Their series of essays fosters a deeper understanding of the moral and ethical dimensions of their collective work and the risks they take to do it. The risks they take to write.

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# Commentary
# When Medical Ethics and Military Ethics Collide

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**Abstract.** In 12 narratives, medical workers from Afghanistan, Darfur, Gaza, Iraq, Israel, Myanmar, and Ukraine describe the day-to-day challenges of providing quality medical care in austere conflict zones. Faced with severe shortages of supplies, overwhelmed by sick and injured civilians and soldiers, and subject to constant attacks on medical personnel and facilities, the contributors to this collection confront difficult dilemmas of justice, medical impartiality, neutrality, burnout, and moral injury as they struggle to fulfill their duties as medical professionals, military officers, and conscientious citizens.

**Keywords**. Military Medical Ethics, Ukraine, Middle East, Myanmar, Justice, Medical Neutrality, Impartial Treatment, Prisoners of War, Moral Injury, Medical Rules of Eligibility

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Writing about military medical ethics in two books, *Bioethics and Armed Conflict* and *Military Medical Ethics in Contemporary Armed Conflict*, I asked whether medical ethics in wartime differs from medical ethics in peacetime. Over the years, the World Medical Association (WMA) has said, no. Medical ethics is unaffected by conflict; its principles and tenets remain constant. Despite its confidence, the WMA declaration struck me as unrealistic because war imposes severe circumstances on the practice of medicine that are absent in peacetime. These include the tension between justice and medical neutrality, the personal danger caregivers face as they deliver care under life-threatening conditions, severe scarcity, competing claims among different classes of patients such as combatants, civilians, and detainees, and the justice of the war medical workers support.

## Justice, Neutrality and Impartiality

Ordinarily, the principles of justice in medicine govern the distribution of medical resources according to criteria of medical need and fairness. These criteria aim to assure primary care for all citizens and extended care for those who need it most. War, however, introduces a different notion of justice, namely who is right and who is wrong; who is the defender and who is the aggressor and; who adheres to the law of war and who is a terrorist?

We immediately see shades of this in the NIB authors' stories—several stories recount terrorist attacks and atrocities in Israel, Ukraine, Darfur, Afghanistan, Kurdistan, and Iraq. Many of the authors ask similar questions: Should terrorism affect my work? Should it make a difference in how I treat my patients? Must I remain neutral?

To be sure, the question confuses neutrality with impartiality and, therefore, is not posed correctly. "Impartiality" is a medical precept that requires caregivers to ignore everything but urgent medical needs as they deliver care. "Neutrality" is a political notion averse to any allegiance to one side or the other. Neutral parties, whether states or international medical organizations, like the International Committee of the Red Cross (ICRC) or Doctors without Borders, place themselves above the fray. No one expects neutrality from civilian or military medical personnel when their nations go to war. On the other hand, whether and how to remain impartial are key questions.

These questions arise because war is not morally symmetrical. In contrast to medical ethics, military ethics takes stock of the just and unjust parties, bald aggressors and spirited defenders, and law-compliant combatants and criminal terrorists. These categories are not subjective but are at the center of international law. The United Nations (UN) charter, Article 51, permits any nation to defend itself with military force in the face of an unjustified armed attack that causes significant injury, loss of life, or destruction of property But the right to fight is not unlimited. International humanitarian Law (IHL) protects combatants by outlawing torture and inhuman weapons (e.g., poison gas) (Geneva Convention I, art.12, para. 2; Geneva Convention II, art. 12, para. 2; Geneva Convention IV, art. 32; Customary IHL, Rule 72, Rule 74). IHL safeguards noncombatants (e.g., civilians, prisoners of war, and the wounded) by conferring immunity from direct attacks (e.g., murder, rape, torture and kidnapping). But immunity is not absolute. While protecting civilians from direct attacks, IHL leaves a narrow window to harm civilians collaterally during necessary, self-defensive military operations. Civilians die in war, but their deaths are excusable while defending one's country from aggression or rescuing those endangered by a brutal, authoritarian regime. In the landscape of this volume's stories, Russia's invasion of Ukraine and terrorist attacks by armed groups such as ISIS, Hamas, Janjaweed, and the Taliban are singular examples of aggression and criminality.

In these instances, medical staff may face significant emotional hurdles when asked to treat terrorists or an enemy who commits war crimes. Some caregivers may be reluctant to endanger themselves at the site of an attack; others will find it difficult to ever treat terrorists or criminals or, in the very least, while their victims still require care. In their narrative, Zohar Lederman, a doctor in Israel declares, "*The terrorists are coming*, we were told, *and they are bloodthirsty. You can save lives!* Well, not that of the terrorist, obviously." The italics are his and the tension is clear: he can save lives, but bloodthirsty terrorists may not qualify. Oksana Sulaieva, Anna Shcherbakova & Oleksandr Dudin recognize that Russia is a terrorist state that attacked healthcare facilities; Handreen Mohammed Saeed asks about the ethics of treating patients who may have committed grave human rights violations. The tension is palpable, yet each focuses on patient care. With great fortitude, these healthcare professionals push on not by remaining neutral but by providing care impartially. As these stories attest, medical practitioners will try to ignore or, more precisely, bracket the deeds of their patients despite their grave misgivings about treating enemy soldiers who commit brutal atrocities.

Medical impartiality, however, is fraught with practical difficulties. The principle is clear enough. As Dr. Saeed explains, impartiality requires

healthcare professionals to provide treatment without discrimination. The Geneva Conventions regulate conduct in war and are explicit:

> The wounded and sick (civilian and military) shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention required by their conditions. There shall be no distinction among them on any grounds other than medical ones. (Geneva Conventions, Additional Protocol I, 1977, art. 10).

To remove any possible doubts, the commentary to Geneva Conventions makes the following teaching point:

> *Each belligerent must treat his fallen adversaries as he would the wounded of his own army*. (Geneva Convention I, Commentary 1952, art. 12, para. 2A).

Scarce resources, however, often complicate efforts to put this rule into practice and place additional stress on caregivers. A pediatrician deployed to a war zone explained to me how he ended up managing admissions in a combat support hospital. Mothers would besiege the front gate daily, hoping someone would care for their children. Some children were caught in the crossfire; others were just sick and injured in the way kids are. Most were turned away; there is only room for military casualties. But one of the hospital staff asks: What about the kids we hurt? What about our "collateral" damage? Shouldn't we at least tend to them? So the doctor asks: How many of you were hurt by our gunfire, missiles, or bombs? They all raise a hand. So a few get in, but not many. The rest, despondent, just leave. Telling the story back home, people wonder: What kind of pediatrician sends away sick children? "But we needed the beds for our own," comes the answer. "Our own?" comes the response. "Our own are grown men and women." Showing no patience for the bald demands of military necessity, civilian medicine embraces impartiality. It vigorously repudiates any notion of treating the sick and wounded based on the uniform they do, or don't, wear. So he stops telling his story. People want to hear M*A*S*H, but it's not that at all.

Ryan C. Maves, tells a similar story. Here, he describes medical rules of eligibility (or engagement) that evolved to treat the vast numbers of casualties from the wars in Iraq and Afghanistan. In clear contradiction to the Geneva Conventions, the medical rules of eligibility divide patients into distinct classes, each with different medical rights. The result is multi-tiered care depending on the patient's identity: 4-star care for Coalition soldiers, 3-star care for detainees, 2-star care for Afghan and Iraqi allies or civilians wounded by Coalition fire, and single-star care for everyone else (Gross, 2021). This system, so antithetical to civilian healthcare, was ethically disorienting for healthcare providers. Why should enemy detainees receive better care than Coalition allies? Why should severely burned civilians receive nothing but palliative care when state-of-the-art burn units were available for burned American or English soldiers? And, why were some children turned away from healthcare facilities?

Dr. Maves's outrage and indignation at the scathing news report claiming that American doctors abandoned their patients is entirely understandable. In response, it is important to understand that the newspaper article and its severe denunciation stem from the mistaken notion that impartiality is the sole criterion of wartime medicine in austere conditions. Scarce resources include personnel, fixed equipment, consumables, and time. When these are in short supply, it is not always possible to treat the sick and injured strictly based on medical need. The availability of follow-up resources and obligations under international law dictate different levels of care for the disparate actors that populate the battlefield. Similar cases may not be treated in the same way and, perhaps, should not be. On one hand, this prerogative is a *prima facie* violation of the impartiality provision of the Geneva Conventions, which prioritize care solely based on medical need. On the other, it recognizes the imperatives of military necessity.

Although some commentators view the obligation to preserve impartiality and treat without discrimination as absolute, situations arise in wartime that temper this assessment. First, the obligation to treat those who can best contribute to the war effort may override the duty to save lives when resources are scarce. The same logic guides mass-casualty

disaster triage where first responders my jump the queue and receive priority care so they may return and help others. Second, the quality of follow-up care for injured civilians is often very poor. Military hospitals might save burn victims' lives, but the long-term and expensive care needed to sustain and rehabilitate these patients was not available from the local healthcare system in Iraq or Afghanistan. Finally, medical personnel may appeal to "associative" obligations or an ethic of comradery to treat their own soldiers first, regardless of the severity of their wounds. Just as a parent need not rescue other children when their own are endangered, medics ministering to the needs of unit members may treat their comrades first. Morally, this is acceptable for two reasons. First, priority treatment for compatriots maintains a unit's fitness to fight. Second, it recognizes the paramount place of primary ties and the special obligations people owe friends, family, and, no less, comrades-in-arms. Indeed, when asked, soldiers often expect their medics to treat their comrades first despite any legal obligation to treat the wounded irrespective of nationality.

## Burnout and Moral Injury

In all this, it is no wonder that many stories in the NIB collection reflect practitioner burnout and moral injury. While burnout comprises work-related stress and fatigue, moral injury reflects a particular form of anguish or anxiety that comes with the inability to fulfill one's moral duties. Among combat soldiers, moral injury arises when soldiers kill enemy soldiers, harm civilians in legally and ethically permissible ways, or are confronted by superiors who betray them and lead them into futile combat. Among healthcare professionals, moral injury can arise when triaging patients in exigent circumstances, allowing some to receive treatment and others to die. Lack of supplies, a constant danger to patients, and a sudden onslaught of military casualties leave providers to make difficult moral choices and unable to fulfill their professional duties completely. Vladyslava Kachkovska, Iryna Dudchenko, Anna Kovchun, and Lyudmyla Prystupa describe the dissonance between their "established moral and bioethical principles, our virtues, and the main goal of medicine—preserving human life and dignity—with the surrounding events caused by the war." In the face of an unrelenting crisis, Ola Ziara, a physician in Gaza, wonders whether her job is "worth it." "Who, she asks, "is looking after us?" Others, such as the exiled doctor writing in this volume, face a brutal regime that renders many of their efforts futile.

As they confront a harsh, dangerous and unforgiving reality, it is no surprise that some medical professionals ask: "Should I just leave?" As it turns out, in this collection of stories, some did and some did not, and the reasons for the authors' decisions are instructive. In two stories from Ukraine, Vladyslava Kachkovska, Iryna Dudchenko, Anna Kovchun, Lyudmyla Prystupa, and Yuliya Nogovitsyna decide to stay. Some reasons are personal; they do not want to leave or uproot family and friends. Other reasons are professional; medical professionals are duty-bound to aid those in need, especially when few others can take their place. But these feelings can arise anywhere and anytime when, for example, one leaves an inner-city job to take a safer, less angst-ridden position. Unique to many conflicts is the tight interdependence among compatriots that generates obligations of mutual aid combined with the urgent quest for justice and victory that motivates extreme sacrifice during war. Mutual aid is a pillar of the associative duties that inform medical care for compatriots. During war, individuals may forsake personal safety for the greater public good. That good may be the body politic's physical health that is so jeopardized by conflict. And, it may be the polity's reputational health, its honor, fortitude, and perseverance to prevail over aggression, brutality or terror. Under these circumstances, caring for the sick and injured must, nonetheless, be practicable, feasible and effective, an obvious condition absent in Myanmar.

Myanmar is a unique case describing healthcare workers who help wage a war against their own government. Providing medical services to dissidents, protestors, civil disobedients, and, in some cases, rebels and insurgents requires an

extraordinary political step many are reluctant to take. The dangers are grave. From the regime's perspective, aiding and abetting dissidents or rebels is, at best, a criminal act and, at worst, treason. Security forces constantly threaten and endanger the lives of medical workers. A ruthless police state undermined healthcare from within, as it fought doctors and battled the dissidents they cared for. Similar conditions illustrate the challenge of providing medical care after the Taliban return to rule Afghanistan, as Ayesha Ahmad writes.

In each case, doctors, nurses, and technicians must decide where and for how long to carry on against the government. Their medical and civic duties do not require suicide or a futile struggle at any cost. Despite the pain and frustration, they, like other dissidents, may decide to pull out. Their dilemma is among the most difficult civilians can face during armed conflict. As the exiled doctor from Myanmar, P. P. Kyaw explains, the hostile conditions present there may justify evacuation to protect one's family from danger and allow medical workers to reach international nongovernmental organizations (NGOs) so they may aid their people from afar. When one's government turns on its people and then takes every measure to silence those who object, deciding to leave is not to flee the fight but to regroup to fight and struggle another day.

## The Day-to-Day Struggle

Despite the hardships, the authors of these stories attest to extraordinary perseverance and ingenuity. During conflict, medical workers must care for one another, their families, and their patients in ways unprecedented in peacetime medicine. Consider the following examples.

1. We had to consider how to manage our employees` protection along with continuous laboratory services provided under endless air alarms and bombings (Oksana Sulaieva, Anna Shcherbakova & Oleksandr Dudin).
2. The 224-page survey guide . . . seemed to provide extensive guidance on everything except for the only instruction I needed at the time—How to keep my teams [in Darfur] safe under fire (Ghaiath Hussein).
3. We discussed more than once whether we should stop evacuation and referral of children to European hospitals to sustain the Ukrainian childhood cancer care system and prevent it from degradation (Yuliya Nogovitsyna).
4. On those difficult days, it was necessary to bandage with a smaller amount of medical material, dilute (make a lower concentration) antiseptics in order to save money, and even use integrative medicine (various herbs and decoctions) in the absence of medicines (Artem Riga).
5. In conditions of an acute shortage of medical personnel, I had to teach patients how to care for and dress wounds, and how to administer intramuscular injections to themselves and to their comrades (Artem Riga).

There are two sets of stories here. The first two emphasize the intense frustration of ensuring adequate security for medical personnel, a job caregivers are not trained to perform. The risk of harm is intense during war despite the protection that medical facilities enjoy by law. In recent wars in Ukraine and Syria, for example, Russian forces continuously bombarded hospitals and clinics. Elsewhere, aid workers are often targeted. In these cases, local forces are hard-pressed to secure these defenseless facilities and safeguard personnel. Medical facilities enjoy immunity from harm only because of agreements between states and only because reciprocal immunity is mutually beneficial. But when states fight a state or non-state army whose forces cannot threaten their enemy's medical assets, then reciprocity breaks down, just as these stories describe. Only a rapid response from the international community might restore immunity. But at best, such responses are a long time in coming and medical workers, like those who tell their stories here, must improvise.

The second set of stories addresses medical challenges unique to wartime. Artem Riga confronts a severe shortage of consumables and personnel, demonstrating the keen resourcefulness to stretch each. These are lessons learned in the crucible of combat. Yuliya Nogovitsyna's dilemma is of extraordinary interest. Looking to the future, she wonders how the war will affect the future of her unit and the integrity of healthcare in Ukraine. This concern is remarkably foresighted, but there is no

clear path of resolution, and the question, like so many others, is left hanging in the air.

## Concluding Note: Just War and Just Medicine

> *I deployed with a surgical company in support of Operation Iraqi Freedom. Reflecting on the situation with a like-minded close friend, I was not sure—would this be a just war? A necessary war?* (Richard W Sams II).

The stories in this collection emphasize some of the most difficult ethical dilemmas of medicine and war. Working through each dilemma draws attention to the underlying principles of medical and military ethics. In peacetime, there is little connection between the two. Supported by a safe and secure state and reasonably stocked with appropriate supplies and adequate equipment, healthcare providers can focus solely on patients' needs and offer care without discrimination. Conflict changes this straightforward endeavor. No longer secure and often lacking indispensable supplies, medical workers, like all citizens, turn their attention to personal and national survival. No longer solely a medical mission, survival becomes an overriding military mission. Civilian and military casualties easily overwhelm peacetime facilities. Resources are diverted to military expenditures. Priorities of care change. Not all patients will receive adequate care, as first responders and combatants' needs may trump civilians'. Some patients, such as enemy soldiers or collaborators, may face severe discrimination. Rampant insecurity, danger, and risk threaten providers' families, patients, and colleagues. Caregivers burn out.

Waging war to restore peace and security are diplomatic and military missions that medical workers aid as best they can. As they do, many look beyond their stethoscopes to ascertain that the war they support is just, or that the war or regime they oppose is ruthless and unjust. No war is benevolent; each is its own humanitarian disaster. Nevertheless, healthcare providers, like any other citizen, must do their best to be on the right side of history. Medical care in wartime is only ethical if the armies it supports uphold humanitarian law, and lends no hand to aggression and terrorism. In this way, medical workers have a double duty during conflict. On the one hand, they bear witness to the suffering and atrocities of war in ways no other profession can. On the other, they must remain attuned to the difficult task of navigating the sometimes conflicting imperatives of medical and military ethics.

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