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Reflections on Gaza: From clinical practice to humanitarian response

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As an emergency physician, I'm often reliant on checklists, guidelines, protocols and tools to support my clinical decision making. I recognise that I work in a system which requires coordination of care, collaboration with colleagues across disciplines, and an appreciation of patient-related risks and vulnerabilities, as well as associated factors and co-morbidities that all impact my clinical approach and decision making to bring about the best outcomes for my patients. Such tools and systems become even more critical when our health systems are under increased demand or a major incident occurs (such as a bus crash with multiple casualties bring brought into the emergency dept). It goes without saying that in mature health systems, staff are trained, accredited and up to date, adhere to ethical practice principles and standards, and work accountably for patient benefit. Where there are concerns around patient safety, it becomes our moral duty to speak up to raise attention to the issues we witness.

Healthcare delivery has historically played a significant role in highlighting issues of public concern, whether communicable diseases and outbreaks, or the harms of addiction or lifestyle choice on populations, amongst others. Indeed there has been an increasing focus on the impact of 'health inequalities' on the health of communities and by extension individuals, where it is recognised that wider determinants such as poverty, education or ethnicity may unfairly result in a greater burden of disease.

While many of us working in clinical practice may recognise the above description of the ecosystem in which we function as clinicians, I wished to further explore these perspectives through a humanitarian lens. While our clinical practice is centred on the relationship to our patients, and governed by ethical principles and codes of conduct, humanitarianism is focussed on securing and protecting access to human rights, such as the right to life, liberty and security, shelter, food and health. As such there is a natural alignment with healthcare provision and the noble integrity enshrined in the profession.

However, perhaps what is not always as well understood or appreciated by clinicians is the professional discipline of humanitarian practice, and the complex environment in which humanitarian response functions. This is also distinguished from (but has relevant alignment with) global health and development. While many clinicians are driven by the desire to act when witnessing a crisis such as an earthquake, or the needs of those harmed and displaced by conflict, it is critical to recognise the range of ethical principles, standards and approaches that enable any response to meet the intended 'humanitarian' aims. These systems and process have been the subject of development, research and advancement over the years, and represent a spectrum of practice and a professional discipline in its own right.

Familiarity with(particularly during times of conflict) the Universal Declaration of Human Rights, the Geneva Conventions and the Red Cross Code of Conduct, with the core principles of humanity, impartiality, neutrality, a nd independence, along with voluntary service, unity and universality, form the foundations of ethical humanitarian practice.

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Following the 1994 Genocide in Rwanda, the catastrophic failings of the international response resulted in the development of the Sphere Standards which represents a charter of minimum standards in humanitarian action. This now forms a key framework against which to benchmark response activities, and in doing so challenges organisations to focus on key aspects which are recognised to be at risk during a crisis. When considering the health section of the standards there are, for example, actions outlined for mental health, palliative care, and sexual and reproductive health, which are areas that are often neglected by organisations who respond impulsively and are unfamiliar with guidance. Well intentioned action can therefore risks harming certain vulnerable groups and communities by neglecting their essential health rights.

A further key development in the humanitarian sector was the establishment of the 'Cluster' approach which came about following the immense challenges and learning from the response to the Indonesian earthquake and subsequent Tsunami of 2004 which impacted swathes of the South Asian coast. The cluster approach emphasises the need for structured coordination amongst agencies and organisations responding to a disaster, and supports improved allocation and distribution of resources, as well as strengthening responsiveness to identified key priorities through reporting and surveillance systems. Again, if organisations are not part of the cluster system, the risk of duplication of work and mal distribution of already scare resources is increased, and again impacts the core focus on securing the essential rights of populations.

One of the most relevant pieces of guidance for us as clinicians was that of Emergency Medical Teams (EMT), and the so-called 'Blue Book' published by the World Health Organisation following the chaotic international medical response to the Haiti Earthquake of 2010. With multiple teams deploying to the devastated area where the skills, capacities and resources did not meet the needs of the impacted population, the medical volunteer response more than likely caused harm in a range of ways from working beyond scopes of practice, duplicating work, adding further burden to overstretched services and infrastructure while draining and competing for existing limited resources. The EMT technical guidance and classification outlines the different types of medical teams which can deployed and emphasises the need for prior training specific for humanitarian disaster response, as well as a certification process once standards have been achieved. As such, there is recognition of the need to prioritise sustainable investment (in terms of both finance as well as personnel) into EMT development and deployment, which is again usually neglected by novice start-up or generic charitable organisations. The impacts of this can be far reaching in terms of significant harm to communities due to inappropriate medical practice as well as risk to volunteers who are unprepared for the tasks required of them, as well as the security and health risks they may be exposed to and unprepared for.

While the above elements of the codes of conduct, the Sphere guidance, Cluster approach, and classification of emergency medical teams represent key areas of core humanitarian practice, this is by no means comprehensive when considering the range of challenges we face when trying to deliver humanitarian action. Challenges such as the transition and handover of activities, especially in low-middle income settings where development of healthcare delivery requires further continuous investment. Other challenges such as climate change or political instability can further complicate or obstruct response and development plans. One of the most significant challenges of contemporary relevance is that of war and conflict. We have seen increasing attacks on healthcare, civilians and civilian structures in recent conflicts, whether in Syria, Yemen, Afghanistan, Myanmar, Sudan or the Occupied Palestinian Territories. Such flagrant violations of the principles of international humanitarian law and the Geneva Conventions makes the delivery of effective humanitarian assistance impossible. While the international community has developed governance systems, polices and tools to prevent and protect against such violations, it is clear from what we witness currently is that international norms and conventions which allow for sanctions, military intervention to support peace keeping, as well as prosecution for crimes against humanity, are all under threat of failure due to the geo-political environment in which conflict occurs.

Where does this then leave us as health workers who feel morally driven to act in the face of such injustice? Firstly is a re-examination of our spiritual selves. Without truly understanding our relationship with our Creator, and our total reliance on Him, we will struggle to persevere with the effort required to meet the needs of serving to address the multi-sector injustices (of lack of access to basic human rights) borne out through poverty, politics and people. Intimately linked is reflecting on intention. It is only through understanding what is motivating us to act, and then seeking to perform such acts with diligence and excellence will we recognise the need to advance our understanding and skills of the professional discipline of humanitarian health practice, as well as further Islamic

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perspectives on charity and good deeds to meet the needs of contemporary practice and contexts.

Despite the chaos and complexity of the current humanitarian response to the atrocities in Gaza, and the seeming futility of trying to apply the aforementioned principles of humanitarian practice, just in the same way that we do not discard the ethics, tools and guidances in our clinical professional practice, we must aspire to adhere to the approaches which have been developed as a consequence of much suffering and injustice, and to ignore the learning from these events will no doubt risk additional harm to those we aspire to serve.

It is inevitable that there will be new learning that will emerge given the current political and humanitarian failures, but they do not negate past policies. If anything, only by challenging ourselves to adopt and adapt the approaches will we be better placed to address the complex needs of this emergency. It also should prompt us to review our efforts and effectiveness. If we are unable to respond as smaller groups and organisations due to the inability to reflect and adapt in alignment to core humanitarian principles (in recognising that not all agencies will be able to fully adopt some of the guidance comprehensively), should we expending our efforts in other ways? The King's Fund outlines a simple framework to tackle health inequalities, which I feel aligns appropriately for our current humanitarian context and is described as three strategies of Awareness, Action and Advocacy. While many of us are focused on 'action' despite not having or meeting the relevant humanitarian practice competencies, perhaps we should focus our energies more significantly on advocacy to ensure humanitarian health access and protection of health in the broadest sense, as well as gather evidence and data so as to be able to credibly raise awareness of the injustices of the conflict and apartheid nature of the occupation in Palestine (which means additionally focusing on the West Bank, as well as the experiences of Palestinian refugee communities in regional countries).

It is perhaps through these means we can transition our thinking beyond just traditional response to a crisis, but towards a civil rights movement to bring about the necessary political change as which occurred in apartheid South Africa, Colonial India or 1960s USA.

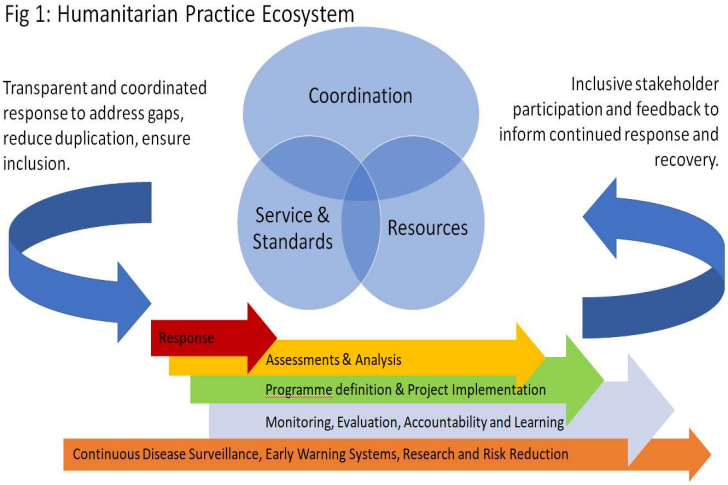
While I have stayed away from a deeper theological examination of humanitarian action, it is no doubt a noble endeavour to alleviate the injustice of lack of access to basic human rights. I hope that by sharing my perspectives having worked and volunteered in the humanitarian and global health development sector for more than 20 years, I have shed some light and a challenge to us all of the need to engage with humanitarian and global health competencies as disciplines in their own right if we are sincere in our intentions and efforts to make a meaningful impact to the communities and peoples we profess we wish to help.

These efforts not only relate to planning our personal and professional development in the sector, but additionally how we create and develop the education, research and improvement systems necessary for us to operate with faith, patience and excellence.

About the Author:

Dr Najeeb Rahman is an Emergency Medicine Consultant working in the UK and additionally a trustee of the charity Doctors Worldwide. He has volunteered and worked in a range of international settings during both disaster response as well as health development. He was a recipient of the RCEM William Rutherford International Award 2017, and has qualifications in humanitarian assistance, public health and is currently reading for a masters in global healthcare leadership.

Fig 1: Humanitarian Practice Ecosystem



Further Learning Resources :

Universal Declaration of Human Rights
https://www.un.org/en/about-us/universal-declaration-of-human-rights

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The Geneva Conventions
https://www.icrc.org/en/war-and-law/treaties-customary-law/geneva-conventions

Code of Conduct
https://www.ifrc.org/our-promise/do-good/code-conduct-movement-ngos

The Sphere Standards
https://spherestandards.org/handbook/

Overview of the Cluster Approach
https://emergency.unhcr.org/coordination-and-communication/cluster-system/cluster-approach#:~:text=The%20IASC%20recommends%20that%20country,should%20co%2Dlead%20the%20cluster

Health Cluster
https://healthcluster.who.int/resources

Emergency Medical Teams
https://www.who.int/emergencies/partners/emergency-medical-teams

Humanitarian Competencies
https://www.uk-med.org/wp-content/uploads/2021/01/UK-Med-Competencies_Framework-Core_Competencies.pdf

Global Health Competencies
https://www.cugh.org/online-tools/competencies-toolkit/

Refugee and Migrant Health Competencies
https://www.who.int/publications-detail-redirect/9789240030626

King's Fund: Tackling Poverty
https://www.kingsfund.org.uk/sites/default/files/2021-03/nhss-role-tackling-poverty.pdf