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# Treating the Enemy: Victims of the Syrian Civil War in Israel

*Anthony Luder*

## Abstract

Between February 2013 and December 2018, many thousands of victims of the Syrian civil war crossed the closed border between the two warring states and received, at no cost, high-level and extensive medical and humanitarian care in Israel. Overall mortality rates were very low, and more than 40 Syrian babies were born in Israel. All the patients returned to Syria after their treatment which extended in some cases into many months. Severe medical disease, surgical conditions and the major traumas of war injuries were treated in in-patient and ambulatory settings. The story of this unique campaign contains many themes: military, legal, medical, social, humanitarian, ethical, media, personal and political. There have been very few, if any, precedents for a campaign of this nature involving two bitter enemies, over whose mutual border real and potential threats are constantly being played out.

**Keywords:** Israel, humanitarian medical treatment, Syrian civil war, Ziv Medical Centre

## 1. Research methods

This chapter is based on research conducted by the following means:

- a. Field work observation including visits to border areas, field hospital and other relevant sites
- b. Direct contact with staff, patients and members of civilian and military authorities
- c. Participation in staff questionnaire studies regarding the impact of the programme on civilian health workers and establishments
- d. Interviews with journalists, diplomats and foreign aid workers

Relevant references to background material and theoretical literature are included.

## 2. Introduction

One of the principal characteristics of *Homo sapiens* is that he is competitive and assertive. This has had no doubt a major influence on his evolution as a dominating and intelligent species, but there have been huge costs. Principle among these is

man's tendency to cruelty, violence and warfare. Indeed, it has been estimated that in the last two millennia, there have been very few years in which war has not been recorded somewhere on the globe. However, in parallel with this are the positive aspects of man's nature, and among these are charity, sympathy, empathy, compassion and generosity. In relation to conflict, these have been expressed in many ways including emergency and ongoing welfare campaigns, sustainable development initiatives, peace-making and preserving, refugee care and the provision of medical services. In particular the norms regarding the treatment of civilians and respecting their rights as non-combatants or casualties of war have been codified in numerous treaties and conventions since 1864 until the present day. These are jointly now referred to as "The Hague Conventions on Humanitarian Law and the Geneva Conventions" [1].

In time of war, the victims are frequently caught in a double bind of bad fortune. On the one hand, they are often the casualties of fighting, suffering both physical trauma and psychological damage; but equally times of conflict are often marked by outbreaks of disease and famine, and indeed pre-existing routine medical conditions, which are neglected, may lead to irreversible consequences and complications. On the other hand, available medical treatment and services may typically be very limited and of poor quality, especially for the civilian population.

### **3. Syria and Israel**

The State of Israel was officially declared on May 14, 1948, following the partition resolution 181 passed in the United Nations on November 29, 1947. This was the legal and political basis for the establishment of two states "for two peoples", and it was accepted by the Jewish state but rejected by the entire Arab world and most Moslem states then and until this day. Immediately Israel was invaded by five regular Arab armies with the intent of strangling the new Jewish state at birth, and among these was the Syrian army. An armistice with Syria was signed on July 29, 1949, notably being the last agreement to be signed and illustrative of the fact that Syria has traditionally been the most ferocious and inflexible of Israel's enemy neighbours. This reputation was reinforced after the 6-day war of 1967 and the Yom Kippur War of 1973. Israel prisoners of war were particularly badly treated by Syria including illegal denial of Red Cross rights, torture and other criminal acts. Syrian hostility and hatred for Israel has been a constant feature of its Middle East posture, and this has included gross anti-Semitic statements by Assad himself and other members of the regime. In addition, Syria has rejected various peace feelers sent out over the years even after Egypt, and later Jordan signed peace agreements with Israel in 1979 and 1994. On the Israeli side, attitudes towards Syria have similarly been marked by disdain and disgust. This intransigence and immovable hostility form the background for the state of relations between the two states and help inform the reader as to the mentality and attitude of the Syrian population which has been exposed throughout its life to the monopoly of hatred and fear provided by the Assad regimes. In the light of these facts, the campaign of humanitarian and medical aid for Syrians that took place in Israel between 2013 and 2018 is even more remarkable than the facts themselves.

### **4. The Syrian civil war and its effect on medical services**

In 2011, within what has ludicrously been called "the Arab Spring", one of most destructive and vicious wars recorded since the Second World War broke out in

Syria. Although its scope and extent has subsided considerably in the last year, even now in 2019, foci of fighting continue to be active in different parts of the wrecked country. The numbers of dead have been estimated as above 500,000, and the numbers of severely wounded and injured well over 2 million. Between 2 and 5% of the pre-war population have become medical victims, but the true numbers are unknown, and estimating these has been made very complicated by the existence of millions of internal and external refugees, within Syria, in massive camps on the borders of Turkey, Iraq, Kurdistan, Lebanon, Jordan and many more thousands who have risked life and limb to reach more distant havens. It is noteworthy that the Assad government regime has made a special target of the medical system in Syria [2–7]. More than half of all doctors in Syria have fled the country, and many hundreds have been deliberately murdered, mostly by Assad forces. Entire provinces and cities have been left bereft of even basic medical services. Of special note are the brutal tactics employed by Assad and his Russian allies in this respect; it was learnt from the Nazis in the Second World War that the elimination of medical care was a cheap and efficient way of forcing people to leave their homes and cleansing an area ethnically, and the Nazis indeed made special efforts to target medical facilities, being so clearly marked. The Russian government used this criminal method in many places, for example, in Chechnia and Afghanistan. In Syria the tactic has been extensively employed. Especially cynical is the “second-wave” tactic in which after an initial assault and after numerous casualties have been concentrated in care areas; these areas are then subjected to secondary attack, thus completing the initial lethal intent. The repeated use of banned chemical weapons has exacerbated the results of these barbaric actions.

The northern border of Israel in the Golan Heights adjoins the Syrian province of Daraa, home to about 200,000 people in normal times, but estimates put the number of additional refugees anywhere between 1 and 3 million. The city of Daraa and the surrounding areas became known as the cradle of the revolution in 2011 after 15 boys from prominent families were arrested after writing antigovernment graffiti, thus sparking mass demonstrations. It is estimated that about 5–7% of the pre-war population has been killed in the war. The entire area has been essentially without organised health services since the war broke out; this has naturally placed an enormous strain on the civilian population and placed in jeopardy the stability of continued civil life.

The border area with Israel is a zone of especial sensitivity. Since 1974 the frontier has been patrolled by a special UN force (United Nations Disengagement Observer Force (UNDOF)) and for the most part was quiet and stable. In the years leading up to the civil war, the Assad regime began to adopt new tactics designed to disturb this equilibrium, mainly through the establishment of terrorist groups primarily the so-called Front for the Liberation of the Golan. This was actually a front for the Lebanese terrorist organisation Hezbollah, which later became a prime Iran-sponsored ally of Assad in the war. During the war years, the border area itself came under the control of various groups, primarily the Druze in the north around the village of Hader, Syrian Democratic Forces in the centre and a small ISIS-Daish enclave in the south. Israel for its part declared an official policy of neutrality in the Syrian war, clearly holding Assad to account for his own numerous war crimes and responsibilities but officially favouring no group; Israel restricted its own actions in Syria to surgical strikes only whenever and wherever its own interests were threatened. While none of the rebel or unofficial groups were in anyway connected with Israel, nevertheless tacit areas of mutual interests became defined. Among these from the Israel perspective were the humanitarian imperative to aid a population in severe distress, the need for stability and continued quiet along the border, the prevention of massive waves of refugees congregating in the area and on the other

side the urgent need for humanitarian assistance for the local and refugee population including the provision of medical assistance for civilians and combatants alike. Thus a remarkable and in some ways unique programme of medical assistance was born, provided at no charge by Israel, for the citizens of its enemy neighbour Syria. There has never been a precedent for a campaign similar in scope and duration between two hostile neighbours, and therefore the nature of this event and its effects on Israelis and Syrians are of considerable interest and importance.

## **5. Israeli humanitarian assistance and medical aid to Syrians**

At the end of February 2013 on a Saturday night much like any other, a routine Israeli Defense Forces (IDF) military patrol along the border with Syria came across a group of seven badly wounded Syrian combatants located close to the border fence. They were mostly unconscious and clearly in need of urgent medical care. A local operational decision was made, based on their medical condition alone, to take in these individuals and transfer them by military ambulance to the nearest hospital capable of caring for severe trauma, the Ziv Medical Centre (ZMC) in Safed, Northern Israel. No high-level command or political considerations were involved. Upon the arrival at the emergency room, which came as a surprise to the staff, the wounded were transferred to the trauma department, and all seven began complicated and prolonged investigations, surgeries and other treatments. All seven survived and were eventually returned to Syria by the military authorities. At the beginning this episode was considered to be an isolated exception, but in the subsequent weeks, repeated transfers of wounded Syrians were made, and it became apparent quickly that this trickle of wounded Syrians was becoming a flood. A public debate opened in the media and political echelons. The questions were difficult. Who were these combatants? Why should Israel get involved, and what would be the risks and costs? Should civilians also be offered medical aid? What was the legal framework? Would all the patients return to Syria, and could they return for follow-up? How would continued care be guaranteed in Syria? The Israeli government decided on a two-pronged policy:

1. Syrians who required medical assistance and who reached the border between the two states would be offered whatever aid they required on a humanitarian basis.
2. No Israeli soldiers or civilians would enter Syria.

These have remained the publically defined limitations of the medical assistance programme since then.

Israel has had a long record of offering high-quality humanitarian aid to victims of disasters all over the world. In the last decade alone, Israel has sent fully equipped medical missions to Africa, Turkey, Haiti, Nepal and other countries, often being the first and quickest among international efforts. The IDF has a full rescue system ready to deploy at short notice and on stand-by at all times. Although this arrangement had never been utilised within Israel's own borders, the equipment and procedures were prepared and were able to be put in place within a short time. It was decided to open a fully equipped field hospital near the border in the Northern Golan, close to the Druze village of Majdal Shams, as a first step. This facility had X-ray, laboratory, intensive care capabilities as well as a fully functional operating room and admission ward. Patients were initially treated there after undergoing triage and following stabilisation either returned to Syria or were transferred onwards

to one of the civilian hospitals in Northern Israel. During the years 2013–2018, the two hospitals mainly involved were ZMC as already mentioned and the hospital at Nahariya, although the hospital at Poriah and the Rambam hospital in Haifa also treated some individuals. The medical staff were mainly drawn from the reserve forces of the IDF and were in practice physicians and surgeons working in routine civilian practice all over the country. Thus the burden of this project fell indirectly on all the Israeli health system. The field hospital operated for various periods of time, depending on the flow of patients and the available resources. At one point the Assad regime forces began shelling the hospital (in line with their policy of targeting medical facilities as explained above), and this required determined countermeasures by the IDF to silence this. After a period however, it was decided that the optimal procedure was the direct transfer of patients to civilian hospitals, and the field hospital became inactive most of the time.

The transfer of patients in both directions across the border was at all times the sole responsibility of the IDF, with each transfer taking on the character of a fully fledged military operation. This was especially true after terrorist organisations launched sporadic attacks along the lines in an attempt to harm IDF forces in the course of their activities. Initial triage was carried out at the crossing points by regular IDF paramedical staff. Thereafter the patients remained under the responsibility of the military until they returned home, even when they were being treated in civilian facilities. The contacts and arrangements made by the IDF with groups on the Syrian side, for the purposes of coordination and logistics, are beyond the scope of this chapter. Nevertheless, it is clear that some form of communication existed and enabled fairly smooth operations to take place throughout this period.

Many thousands of Syrians were transferred to Israel for medical treatment in the years 2013–2018. At the beginning all patients were treated as in-patients; however as time went on, it became apparent that the health needs of the entire population of the Daraa region required a significant expansion of the scope and nature of the programme. In late 2017 the head of the IDF announced that a major shift of policy had been decided upon. Henceforth not only severely injured or sick patients would be treated as in-patients but that a complete ambulatory system would be set up for the day care of patients suffering from all manner of routine medical problems. This initiative was coined the “Good Neighbours Initiative”, echoing an earlier and similar policy vis-à-vis Lebanon in the 1980s, called “The Good Fence”. A further feature of this remarkable initiative was to provide medical supplies and drugs to patients in Syria for up to 3 months after treatment in Israel. It was also widely rumoured that international medical aid agencies were also provided with security guarantees for their personnel working inside Syria. Following its promulgation, regular groups of Syrian civilians including women and children were brought by chartered buses to out-patients’ clinics at ZMC and Nahariya for clinic and day hospital treatment. Many additional thousands of patients thus benefited from the medical assistance programme, and all of this should be stressed at the highest professional level at no cost to the patients. This stands out in stark contrast to the situation in neighbouring Arab and Moslem countries where Syrian patients often had to pay dearly for medical care even when available, which more often than not was sporadic and often limited or sub-standard.

## **6. The nature of the Israeli medical assistance programme for Syrians**

For readers interested in reading further about the medical details of the injuries, diseases and suffering of the Syrian patients and the treatment that was given, they can do so in the book *Complicated War Trauma and Care of the Wounded: The*

*Israeli Experience in Medical Care and Humanitarian Support of Syrian Refugees* [8], written and edited by the staff of ZMC. A general summary will be given here. Approximately 80% of the in-patients treated were male, and about 20% were under the age of 18. Patients were treated in almost every department of the hospital but especially in intensive care, surgery, orthopaedics, paediatrics and obstetrics. Of note, 24 babies were born to Syrian mothers in ZMC during the duration of the programme. Many of the patients suffered from injuries during combat either directly or collaterally. Among these were severe limb injuries, head and neck, abdominal and chest injuries, and those requiring and plastic surgery. Often these patients required very prolonged treatment including repeated surgery, treatment for severe infections, pain relief and nutritional resuscitation. Almost all patients came with no medical records or documentation, making assessment doubly difficult. Patients who had received medical care in often from severe complications such as botched procedures, multiple resistant bacterial infections, and severe pathogens (such as polio which broke out in various places in Syria). In addition, increasingly patients arrived in Israel with medical problems such as congenital malformations, genetic disease, cancer as well as “routine” disorders such as cardiovascular disease, diabetes and neurodegenerative disease.

Mortality was surprisingly low among in-patients, <5%. Considering the severe condition in which many arrived, the complications and lack of medical documentation, this was an impressive achievement. The work of the orthopaedics department in limb salvage and rehabilitation was especially noteworthy with its chief being invited to lecture worldwide and the author of many books and articles. However, the medical and nursing staffs of all departments worked with commendable skill and efficiency for their patients. Nor were the psychological and social aspects neglected. Psychologists and medical clowns (“dream doctors”) working in Arabic provided invaluable support for these unfortunate people, who found themselves in a strange country, a country which all their lives they had been taught to hate, fear and despise, suffering severe pain and disability and above all being completely dependent on the goodwill and skill of caretakers with whom they had almost nothing in common. Social workers also worked hard to provide relief both as facilitators and educators, contact providers between the medical and military authorities and also provide the basics which the patients completely lacked such as clothes, toiletries, reading material and for the children toys and even tablet computers. Arabic-speaking teachers also provided educational materials and teaching programmes.

## **7. Media exposure and social and financial support for the Israeli Syrian medical assistance programme**

From the beginning the medical assistance programme was initiated according to local and operational requirements rather than as a result of a considered national strategy. This was reflected by the fact that no agreed budgetary arrangement existed. The costs were considerable, not the least of which was the provision of expensive re-usable medical devices that in many cases were lost to the hospital after the discharge of the patients. The former head of ZMC in a television interview stated that he was proud of the opportunity to express universal humanitarian values but that no one was footing the bill, which ran into hundreds of millions of shekels. Hospitals began to run up considerable deficits. This affected their ability to continue everyday operations. In 2017 this came to a head with the outbreak of industrial action at the Nahariya hospital. At a governmental level, there was a predictable interdepartmental dispute with the ministries of defence, health and

the treasury all trying to shift financial responsibility on another department. On the other hand, local communities in the Galilee, both Arab and Jewish, opened their hearts and pockets with a constant stream of philanthropic donations both of money and articles. Yet while this surprising response reflected the quality of Israeli society, it was insufficient to bridge the budgetary deficiencies. In addition, hundreds of foreign delegations of journalists, diplomats, politicians and public organisations visited the hospital and the patients (while being careful not to photograph faces), and these sometimes also resulted in valuable donations and support, but still not sufficient to cover the huge costs incurred. It is important to stress that while for the most part the existence and nature of the humanitarian programme were never a secret, no major publicity initiatives were undertaken by the government. The publicity that occurred was mostly restricted to occasional reports by news agencies and written and video reports in online sites [9]. Surprisingly, this meant that large parts of the Israeli public itself were not aware of the programme and its nature, and this was even truer abroad. It could be argued that this low-profile publicity policy was a mistake, yet the whole issue was highly sensitive from Israel's standpoint, and there were arguments for limiting exposure. Interestingly, the head of ZMC has been invited to light a flaming torch at the national independence celebrations in 2019 as a tribute to the people who worked in the programme and its results, yet this is taking place only after the programme has ceased. This no doubt reflects the dilemma that Israel faced and faces with respect to the public face of this programme.

## **8. Legal and ethical aspects of the Israeli medical assistance programme for Syrians**

One of the important points to study with regard to this programme was the legal and ethical framework in which it took place. The patients who came to Israel came for different reasons. At the start many were unconscious when they crossed the border so that one could not talk about voluntary or consensual transfer. Once in Israel, the individuals were the legal responsibility of the IDF and military law, yet their status was ill-defined. Unlike prisoners of war or refugees, groups that are covered by clear frameworks of international convention and law, the Syrian patients were not defined as either nor were they tourists. They came or were brought usually without documentation of any kind. This meant that these patients had no defined legal standing nor, therefore, defined protection. It is certainly my belief backed by extensive experience and exposure that the human and medical rights of these patients were rigorously safeguarded at all times by the dedicated medical and hospital staff that treated them, yet nevertheless the theoretical possibility of a breach of rights existed, and if this had occurred in practice, the patients would have had little legal or other recourse beyond the unsure solution of military law. This must certainly be a source of concern for any similar scenario whether in Israel or in any other country faced with a similar situation. An example of this nonoptimal situation was the restriction on transferring patients to other medical facilities in Israel in the case of need. The limitation on this was enforced and backed by a decision of the Israel Supreme Court. In one prime example, a paediatric patient requiring a bone marrow transplant could not be treated in Israel (for medical and social reasons) and needed transfer to an academic centre in an Arab country. This could not be done via the safe and direct route through Israel but rather via a return to Syria. Although in this case the transfer was completed without incident, it was certainly arguable that the patient's best interests could have been better served.

Another area of ethical concern relates to the area of research. There is no doubt that the huge amount of experience gained and the complexity of the medical challenges faced required documentation and reporting. In many cases clinical protocols and techniques required modification and alteration, and the results of the study of these constitute a form of clinical research as defined by the Israel Ministry of Health. Clinical research in Israel is governed by the principles of the World Health Association's Declarations of Helsinki and other international standards, as given expression by the regulations and laws extant in Israel. Principal among the tenets of ethical clinical research is the requirement for full explanation to be given to the participant and also for his or her voluntarily given free, informed consent to be recorded on a signed, approved consent form (or in the case of minors or others unable to give legal consent, the agreement of their legal custodian). Putting aside the legal complexities of compliance with these requirements in the case of non-citizens with undefined status, there is the ethical issue of consent from someone who is completely dependent on the medical institution in which he finds himself or herself. Even assuming that the participant can be fully informed, how free can his/her decision be? On the public stage, it is also highly problematic to what extent these dependent noncitizens can be included in clinical research. The settlement of these weighty issues required a high degree of professional and ethical wisdom yet remained in the last resort a kind of ad hoc approach.

## **9. The effects on society and the region of the Israeli Syrian medical assistance programme**

The medical assistance programme in Israel for Syrian patients certainly had important effects on everyone involved. These will be discussed by category:

### **9.1 Hospital staff**

Many staff members either have fought on the Syrian or Lebanese front themselves in various wars or have or had close family members, friends, colleagues, neighbours or acquaintances who were involved in or wounded, hurt or killed in such fighting. Possibly worse are those who suffered the egregious cruelties and tortures of imprisonment in Syria. These experiences certainly made it very difficult sometimes for those involved to relate to Syrian patients as any other patient. At times the Syrians added significantly to the burdens of an already overworked and understaffed hospital. There were occasions during which there were insufficient resources available for regular Israeli patients because of the large numbers of Syrians. No doubt these facts, combined with the medical complexities of these patients and the resulting extra burdens of work placed upon the staff, led to a degree of dilemma, resentment and even resistance among staff members. I am not aware that these feelings ever rose above the level of occasional grumbling and discontent, yet the hospital certainly had to devote resources to the psychological well-being of staff members, via individual and group discussions and focus groups. On the other hand, when the new hospital director took over his post in 2015, one of the first things he did was to organise hospital-wide consultations about whether to continue or cease the programme of humanitarian assistance, and the conclusions were loud and clear to continue. On a simple human level, when one is faced with suffering and distress, one feels an inner compulsion to help, and this is augmented by one's professional obligations. As Churchill plainly stated regarding a moral obligation, "one can do no other". But dealing with these feelings and dilemmas engenders a cost. In 2016 these issues became the subject of detailed

study, and the results of this have been published [10]. This study concluded that the ability of staff to function was influenced by hindering and facilitating factors and that it was important to identify these in order to minimise the former and strengthen the latter.

## 9.2 Society in Israel

The support by gifts and actions that was forthcoming from all aspects of society has been referred to already. To some extent this was the result of identification with civilians caught up in the maelstrom of war and by events beyond their control. There was a widespread hope and belief that good deeds speak from themselves and that inevitably the provision of medical aid would contribute in some way to changing attitudes and opinions on both sides of the border. On a more general level, the national media gave scope to the expression of pride in the altruism and selflessness of a country surrounded by hatred and ferocious aggression responding with kindness and (expensive) humanitarian action. This speaks to the basic Jewish value of “healing the world” (“*tikkun olam*”), in which every individual is enjoined to help making the world a better place. There is also the strong associated memory of the holocaust during which Jews were the defenceless victims of merciless cruelty, murder and oppression. There is a national consensus that Jews, of all people, cannot therefore stand idly by while similar suffering falls on others.

## 9.3 Syrians

This is the most difficult category to understand, partly because of the natural reticence, suspicion and fear they had in talking freely (something they are not used to in their home country) and partly because of the confusion engendered by the circumstances of their stay in Israel. Given the limited evidence available, one can say that some patients expressed gratitude for the kindness shown to them, and one would like to hope that this and the reactions of their friends and neighbours may lead to positive changes among some Syrians. This hope was reinforced when some Syrian refugees in Europe published blogs stating that the real enemy of the Syrian people was Assad and that Israel was their friend [11]. On the other hand, the Assad regime and its Iranian-Hezbollah allies are exploiting the humanitarian programme to make conspiracy and other mendacious claims against Israel. The last word on this certainly has not been written, and it is still too early to know whether and what the long-term outcomes will be.

## 10. Conclusions

The Israeli and Syrian programme of humanitarian and medical assistance between 2013 and 2018, devoted to the victims one of the bloodiest wars since World War II, has many unique characteristics, and among these are the setting of one state affording aid to citizens (combatant and non-combatant citizens of an enemy state), the nature and treatment of the medical issues involved, the ethical and legal problems associated and the short- and long-term effects on people on both sides. It has been stressed that the provision of medical treatment is a humanitarian imperative even for (perhaps especially for) the enemy, but this also impacts political and strategic interests and may create serious dilemmas for the people involved. This chapter has summarised the events and posed more questions than for which there are available answers. It is the author’s hope that the reader’s interest will be stimulated and that the various issues raised will lead him to constructive

reflection. Medical treatment is a professional imperative, but it may often lead to unexpected and wider results. Whether this will happen and to what extent, time will be needed to judge. In the meantime it is the author's hope that decision-makers and ordinary citizens will strengthen their determination to help those in need even in the most difficult and extraordinary of circumstances.

### **Conflict of interest**

The author was a staff member of Ziv Medical Centre during the period described in the chapter.

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