

## Article

# Humanitarian Aid, Security and Ethics

The Rise of a New Humanitarian Governance at Home

Hedva Eyal

*Ben-Gurion University of the Negev*

Limor Samimian-Darash

*Hebrew University*

Nadav Davidovitch

*Ben-Gurion University of the Negev*

## Abstract

The article examines the relationship between humanitarianism, security, and ethics in the case of the provision of medical humanitarian aid by Israel to casualties from the Syrian civil war, between 2013 and 2018. We argue that this humanitarian project differs from the type of humanitarian intervention commonly seen in conflict zones and can be identified as a new form of humanitarian governance. Our case study deals with humanitarian care provided in the country of origin of the medical and security forces involved, rather than in the country of the injured. In this articulation of humanitarianism at home a new nature of life governance and new subjects of security, emerge. We argue that the politics of life shifts and is subordinated to two different ethical frameworks founded on two different logics: that of the *human* (as in the type of medical treatment seen in traditional humanitarian aid provision, which is often related to short-term immediate treatment) and that of the *citizen* (the standard of care provided to all official residents of Israel. The conflict between these two moralities, the shifting standard of medical treatment, and the new medical-security space – together, raise a new set of ethical and political questions.

## Keywords

humanitarian aid, security, medicine, ethics, Israel, Syrian casualties

## **Introduction**

The civil war in Syria left many civilians – children, women, and men – grievously wounded and, among other things, destroyed the country’s medical infrastructure. In desperation, many wounded Syrians sought medical help in neighboring countries, including Israel, even though Syria and Israel regard each other as enemy states. Between 2013 and 2018, more than 5,000 Syrians were allowed to cross the border into Israel to receive medical humanitarian aid. We argue that this humanitarian project differs from the type of humanitarian intervention commonly seen in conflict zones and can be identified as a new form of humanitarian governance. Whereas humanitarian interventions in crisis zones generally involve *external* humanitarian forces entering a hostile or afflicted area and providing treatment to local populations in need, in this case humanitarian care was provided in the country of origin of the medical and security forces involved, rather than in the country of the injured. Moreover, Syria and Israel have been in a formal state of war since the establishment of the State of Israel and the 1948 Arab–Israeli War, with tensions breaking out into open conflict in the subsequent wars of 1967, 1973, and 1982. In recent decades, the border between Israel and Syria in the Golan Heights, considered a hostile border by both sides, remains heavily fortified.

In 2013, when the project examined here began, a military field hospital staffed by military physicians was established near the Israeli–Syrian border to provide immediate medical treatment to Syrian casualties arriving at the border. The types of treatment provided in this early stage were described by those who took part in the project as being similar to those “traditionally seen in humanitarian aid,” as they perceived it, which focuses on urgent needs and the treatment of severe injuries primarily to save lives (Ram-Tiktin, 2017). According to individuals interviewed, however, most of the casualties who arrived at the field hospital over time were suffering not just from the types of acute body injuries that are traditionally addressed in a humanitarian aid operation but also from various illnesses and diseases. Indeed, conditions with which casualties presented covered a wide range of health problems, including surgical issues (e.g. orthopedic problems, cleft lip), diabetes, cardiovascular problems, and hearing and vision impairments. It also became apparent that when Syrians decided to go to Israel to seek treatment, they usually did so after first receiving initial treatment in Syria; only when that was unsuccessful, usually after a few weeks had passed, would they go to the Israeli border to seek better treatment.

In time, the military began to transfer the Syrian casualties arriving at the border directly to Israeli hospitals inside the country, where they would receive further treatment. Most of the Syrian casualties who entered Israel were transferred to two main hospitals in the north of Israel, sometimes for weeks, months, or even more than a year. The two hospitals took different approaches to the treatment of the Syrian casualties. One opted to house the Syrian men in a space that was separated from the rest of the patients, locating only the Syrian women and children in the regular wards. The other hospital established separate rooms for Syrian casualties in various wards, and sometimes Israeli and Syrian patients were hospital-

ized side by side. Both of the hospitals reported that, within their boundaries, the Syrians received the same standard of care as Israeli citizens. During the time of their hospitalization, the Syrian patients were classified not as “refugees” or “asylum-seekers,” but as “Syrian casualties.”

The new humanitarian–medical–security space in which this project took place thus shifted the standards of humanitarian medical treatment by providing more complicated treatments, for longer periods of time, than “traditional” humanitarian interventions, particularly those provided by Israeli actors in medical missions abroad. In addition, the medical personnel involved in the project needed to reorganize the space and practices in which treatments were provided in the domestic Israeli context in order to enable the provision of humanitarianism ‘at home’.

Such a unique situation raises several questions. First, what was the nature of the new humanitarian space created by such an arrangement and the forms of governance it expressed? Second, what sort of ethical justifications were given for the humanitarian activity seen in this case? Third, what is the nature of life governed under this new security–humanitarian form, and how might it create conditions for the emergence of a new subject? In this new articulation of humanitarianism in conflict zones – which we term *humanitarianism ‘at home’* – the politics of life shifts and is subordinated to two different ethical frameworks founded on two different logics: that of the *human* (as in the type of medical treatment seen in traditional humanitarian aid provision, which is often related to short-term immediate treatment) and that of the *citizen* (the standard of care provided to all official residents of Israel, who, according to the Israeli National Health Insurance Law, are entitled to permanent healthcare and receive treatment over longer periods of time than the typical humanitarian patient). The tension between these two ethical frameworks gives rise to new ethical dilemmas in relation to how power is exercised, on whom, and under what conditions. That is, a new humanitarian space emerges ‘at home,’ and this creates a new relationship between the caregiver and the patient, as well as new moral dilemmas and questions regarding the relationships between security, medicine, and humanitarianism.<sup>1</sup>

## Methodology

The present article is the third in a trilogy on the subject of the humanitarian aid provided to Syrian casualties in Israel. In the first article (Samimian-Darash and Eyal, 2019), we argued that the hospital ward becomes a *boundary zone* that mediates between the two spheres of medicine and the military, as well as between two peoples – Syrians and Israelis. In the ward, the hospital staff, the Syrian casualties, and military personnel cooperate towards the common goal of the healing mission. This joint effort aimed at healing and addressing the needs of Syrian casual-

---

<sup>1</sup> This case study also raises the question of the uniqueness of military humanitarian practices in the context of security spaces and how they differ from other “at home” humanitarian activities involving other populations, such as migrant workers and asylum-seekers. While similar ethical questions are relevant in both cases, they are framed very differently in general and within Israeli society in particular.

ties transforms hostility into trust. The definitions of ‘enemy’ and ‘ally’ become blurred through the use of metaphors of ‘family’ and practices related to food, culture, and mixed languages (Arabic and Hebrew) involved in mutual efforts to communicate. In the second article (Eyal and Samimian-Darash, 2019), we observed that a security outcome indirectly emerged out of processes that sought to demilitarize the humanitarian project, a development that we termed ‘unintended securitization.’ Through this development, new purposes for the project evolved, including goals related to security and Israel’s public diplomacy efforts. The discourses that surrounded the project moved from the military into the medical–civilian sphere, and subsequently into the political sphere as the project took on diplomatic aspects that could be used to advance the security interests of the Israeli state. The humanitarian project also took on greater legitimacy within Israel as perceptions of its contribution to security purposes came to be seen as justifying its continuation. The current article examines the relationship between humanitarian aid, security, and ethics, and asks how a new humanitarian governance emerges and operates in this case.

Our research draws on interviews, observations, and media analysis. We conducted 20 semi-structured interviews, mostly during 2018–2019. Sixteen of the interviewees were hospital workers – physicians, nurses, social workers, and a physical therapist; two were security personnel; and one was a former member of the armed forces. Nine of the interviewees were women, and eight were non-Jewish Arabic speakers (Druze, Muslims, and Christians). The interviewees were selected because they had worked closely with the Syrian casualties. Arabic-speakers played a central role in the humanitarian project examined here, as Arabic-speaking staff not only carried out their professional roles as medical personnel but also acted as mediators and translators between the Jewish medical workers and the Syrian casualties. All of the interviews and observations presented have been anonymized.

Our research started towards the end of the humanitarian aid project, when only few Syrians remained hospitalized. Our decision not to interview the Syrian casualties themselves was a result of our inability ensure free and informed consent. Like refugees, the Syrian patients found themselves in a very vulnerable situation (Hugman et al., 2011), as they were receiving medical care from and were totally dependent on the medical system of an enemy state. Furthermore, we were concerned that they would identify us, as Israeli researchers, as part of the humanitarian aid project and might consent out of a sense of fear or obligation. Accordingly, our study was limited to the perspectives of the Israeli military and medical forces involved in providing medical care.

Observations were conducted at the main hospitals in which Syrian patients were hospitalized. In addition, we attended the International Bioethics Day conference at Ziv Medical Center in November 2018, where the main panel was dedicated to the topic of the humanitarian aid provided to Syrian casualties.

Media analysis was conducted through a systematic search of the main Israeli (Hebrew-language) news websites (*Haaretz*, *Yediot Aharonot*, *Ynet*, *Maariv*, *NRG*, *Globes*, and *Israel Today*), looking for references to the humanitarian aid project during the six years from 2013 to 2018. We retrieved 104 items of media coverage on the subject of the Syrian casualties, examined the chronological continuities in the narratives on the Syrian casualties and Israeli humanitarian aid, and analyzed the main discourses we encountered.

## **Humanitarianism, Governmentality and Emergency**

Studies of humanitarian medicine in conflict zones have mainly focused on the relationships and cooperation between state and non-state organizations (Abramowitz and Panter-Brick, 2015; Magone et al., 2011; Redfield, 2005) and the boundaries between external organizations and local or national arenas that can create tension between national and global considerations (Redfield, 2005). Within the framework of the governmentality approach, scholars have examined and identified the humanitarian space as a new venue of governance, in which new forms of governing such as “humanitarian government” (Fassin, 2012) or “benevolent dictatorship” (McFalls, 2010) have emerged. In scholarship that draws specifically of the notion of the “state of emergency” (Armitage, 2002; Schmitt, 1976), humanitarianism has been explained either as another version or as an extension of the state’s power to sustain the law under an emergency situation (i.e. Giorgio Agamben’s [2005] “state of exception”) and hence increase its control over life or “bare life.” In this regard, Scott Watson (2011) argues that humanitarianism can be seen as a sector of securitization that enables the implementation of emergency measures. In particular, the connection between the terms “emergency” and “humanitarianism” enables global and military intervention, which is framed as an ethical obligation and an action carried out in the name of “humanitarian morality” (Fassin and Pandolfi, 2010).

Some have argued that the instrumentalization of humanitarian discourse may have the unintended (or sometimes intended) consequence of justifying military intervention. Thus, according to many humanitarian actors, there is always a risk that the actual consequences of humanitarian activities might contradict their original intended purpose. Similar tensions can be seen in the case under study here. However, unlike in most humanitarian actions undertaken by Israeli and other actors, in this particular case treatment is provided in the home country of the military and medical forces involved in the project, rather than in the country of the injured. Thus, the provision of humanitarian medical treatment involves cooperation not with the state of origin of the patients/victims but with that of the doctors or humanitarian actors themselves. Accordingly, whereas most studies thus far have focused mainly on “external” interventions – that is, on cases where humanitarian forces enter a hostile area or crisis zone in which they provide treatment to local populations in need – in the current case Israeli medical forces exercise humanitarianism ‘at home’.

This new humanitarian governance also involves a new “politics of life,” “in that it takes as its object the saving of individuals, which presupposes not only risking others but also making a selection of which existences it is possible or legitimate to save” (Fassin, 2007: 501). In such a case, decisions are made as to which lives are worth saving or possible to save. Furthermore, the subject, the life to be saved, is also redefined in a way that leans more towards the *human* than towards the *citizen*. As Peter Redfield (2008: 164) explains, in order to address vital needs in a crisis zone, humanitarian aid “spread beyond the citizen to the figure of the human.” In other words, humanitarianism is founded on and operates through the distinction between the citizen and the human, where the humanitarian mandate addresses the human as a broader category that goes beyond that of the local citizen. While this shift within the humanitarian logic from the *citizen* to the (global) *human* subject is not new, our case highlights a different direction for and relationship between these terms. Although what is being provided in the case examined here is humanitarian aid, the patients who receive this aid remain classified within Israel under the locally specific category of “Syrian casualties.” These are neither global “human subjects” nor citizens of the state in which the humanitarian aid is given. Instead, the Syrian patients are classified under a unique, collective category that contains no specific identity or reference to the permanent position of a citizen.

Under the traditional humanitarian order, life is considered a venue of intervention if an immediate (emergency) health intervention is necessary to save lives, and there is no requirement to address long-term medical or socio-economic issues. In our case, however, the level of medical aid provided goes beyond that of an urgent intervention. As a result, the standard of care in the medical-humanitarian treatment shifts from that of ‘saving life’ to that of improving the quality of patients’ lives. Thus, the humanitarian standard of treatment is transformed here into something closer to the citizen’s permanent standard of care. Of course, there are differences between the ‘permanent’ standard of care to which citizens are entitled and the treatment of chronic illnesses in the context of asylum-seekers; nevertheless, the move from the acute to the chronic is meaningful, especially in this unique local context. In this articulation of humanitarianism and security ‘at home,’ the new humanitarian governance that we observe expresses a tension.

## **The Space of the New Humanitarian Governance**

Following the initial phase of the humanitarian project at the border, wounded Syrians were transferred to public hospitals inside Israel to receive treatment. Israeli physicians interviewed for this study emphasized that, for them, the proximity to ‘home’ that this entailed meant that this project was significantly different from other humanitarian aid activities in which they had been involved. Physician and former IDF officer Yoram Ardan described the difference as follows:

When I was in Africa when the Hutu and Tutsi were massacring one another, then you’re trying to do the best you can when you’re 7,000 kilometers from home with the limitations of the

military Hercules [Lockheed C-130 transport aircraft], or when we went to Macedonia to treat those who fled the fighting in the Balkans. Obviously, it's a lot less convenient for everyone, and you can't provide them with the best medicine, but still you bring [the doctors] closest to the theater of war ... and it's different when they come to you, because [then] you can give them everything. (Interview, 8 August 2018)

The distance from home, the limitations on resources, the need to mobilize equipment, and the brief duration of the stay in the disaster area or war zone structure the limitations of treatment in the conventional humanitarian space. The constraints of that space produce activity patterns that are adjusted to the disaster area (Ram-Tikin, 2017). These constraints do not exist in the new humanitarian governance seen here, which takes place on the 'home turf' of the attending physician. Accordingly, the kinds of medical treatment provided begin to change.

In the new humanitarian governance of the Israeli hospital, Syrian patients would be treated in the same way as hospitalized Israeli patients. Senior nurse Nichole Yaqub explained:

For us, they were like all patients. We treated them exactly the same: You get a ward; you get a bed... doctor's visit... you prepare them for surgery. Everything was just the same. It wasn't like, this one is Israeli, this one is Syrian. It was never like that, at any point... They received the most advanced treatments. (Interview, 6 November 2018)

According to Yaqub, and as other interviewees reported, the standard of care provided to the Syrian patients was identical to that received by hospitalized Israeli citizens. While we cannot confirm such claims by interviewing the Syrian patients themselves owing to the limitations explained above, still within the Israeli context, in the space of the hospital, treatments were similar. Senior physician Ofer White highlighted the difference between more traditional humanitarian treatment and that received by the Syrian patients and emphasized: "You can't afford to provide disaster medicine in a Western hospital. You just can't afford it" (Interview, 29 April 2019). In other words, the treatment provided to the Syrians went beyond that of a "humanitarian standard." Nevertheless, the hospitals needed to make various adjustments in order to be able to meet the unique needs of the Syrian patients, for example in relation to the supply of clothes and hygiene products and the meeting of social emotional and mental needs.

The medical staff reported having to deal with fear, anxiety, and suspicion on the part of the Syrian casualties. In addition, locating the Syrians next to Israelis – whether these were Jews, Druze, or Arabs, patients or medical staff – on occasion led to mutual hostility. With time, the suspicions on both sides were replaced by a growing sense of trust and even mutual affection. The medical teams needed to

take care of the daily needs of the Syrian patients, which led to the creation of unique relationships between patients and providers (Young et al., 2016; Zarka et al., 2018; Samimian-Darash and Eyal, 2019).

The Arabic speakers involved in the project were aware of their special position as mediators/translators between the Syrians and the Jewish medical staff. Nasreen Shehada, a social worker, treatment coordinator for Syrian casualties and Muslim women, illustrated the central role she played between the patients and the physicians through the example of a Syrian woman who arrived at the ward pregnant and was convinced that the medical staff people at the hospital were planning to take one of her babies after she gave birth, she asked Shehada to accompany her during the delivery to make sure nobody would take a baby from her. The connection enabled by having a common language thus became something that patients could hang on to and trust.

The new humanitarian governance is characterized by spatial and institutional boundaries. Many of these are imposed by the military, which in this case was responsible for transferring the wounded from the border to the hospital within Israel, and subsequently for returning them to the Syrian border after their treatment. According to occupational therapist Nurit Asayag, the Syrians were “in lots and lots of wards, and what identified them in fact... was that there was always some soldier standing outside the room. They were concentrated in a certain area in the ward. And there was a soldier” (Interview, 27 February 2019). In time, security companies hired by the military took over the responsibility for guard duties, whose purpose was to protect Israeli civilians and the Syrian patients from each other.

When casualties arrived at the hospitals, the provision of emergency medical care required coordination between the military and the hospital, and medical staff needed to be available in ways that went beyond what was ordinarily required of them. Hisham Sarur, a social worker and treatment coordinator for the Syrians, commented: “And then I start getting updates from the field: ‘A Syrian at his way to the hospital, a Syrian in a severe condition’” (Interview, 10 October 2018). Nurse Rakefet Osas added:

I would get phone calls in the middle of the night: “Three children are now crossing the border. Do you have the capability to treat this and that?” “Yeah, sure, let them through.... I’m informing the doctor.” “Wait. Go to ER.” (Interview, 22 January 2019)

As further described by Osas, the communication between the military and the medical staff included joint consultation and decision-making:

It is not that [the military] gives the orders. It’s on the level of consultations – how far I’m allowed to go with the treatment. “Listen, there’s a kid who needs rehabilitation. Does the IDF

approve it? What are my limits? He's already three months here in Israel." So, he tells me, "Listen, we have certain budgetary constraints, so maybe it's best that you take him back [to Syria] so that we can let more people in that I can treat..." These are considerations that you are suddenly exposed to, and you say, like, "Wow, I never knew there were those things that are beyond [proper treatment]." But then you sit [and think about it], and the doctor, as far as he's concerned, he continues [with the treatment]. And then I say, "Wait a sec. Before you decide about a certain treatment or rehabilitation, let's consult with the military."

Unlike in the *gray zone* described by Pandolfi (2008), which brings together numerous experts from various fields of expertise (medical, military, society, etc.) in humanitarian aid in disaster zones, here the hospital and the military share management duties and decisions. This management is not necessarily hierarchical, being characterized instead by professional partnerships, without mutual suspicion and alienation. This type of relationship – which we call *collaborative management* – can be explained by what Edna Lomsky-Feder and Eyal Ben-Ari (2000: 2) describe as *normalized militarism* whereby the military is assimilated without resistance by medical actors, on the one hand, and the medical field, a powerful institution within Israel, affects and influences military–security arenas, on the other.

Nevertheless, in the context of the new humanitarian governance, there has been no official policy that addresses the ethical question of who should be admitted to receive medical treatment in Israel, so that the relevant decisions are subject to the personal discretion of medical and military officials. While we received answers to some of our questions about how the system of shared management operated, answers to other questions – such as who makes the final decision when disagreement arises between the medical and the military officials, or where is the line or the (new) border between medical and security decision-making – remained vague. Ben Galil, a security guard, described a situation where the senior physician wasn't allowed to enter the room of a Syrian patient, even though it was his patient, because the doctor's name wasn't on the list (Interview, 6 May 2018). Here, security requirements reshaped the roles and power relations in the medical ward.

The authority granted to the military functions in parallel with that granted to the medical staff by the Ministry of Health – that is, the state. Oren Blue, a physician and IDF officer, explained:

[If] a 20-year-old dies in labor, this is an adverse event. When this happens to an Israeli woman, the ministry conducts an investigation. But when a Syrian dies at the hospital, I'm the examiner, I'm the investigator. (Interview, 6 November 2018)

The hospitals that provided treatment to the Syrian casualties were also asked to collaborate with the International Committee of the Red Cross (ICRC). As part of this collaboration, which began at an advanced stage of the project, so-called toolkits were distributed to the wounded, along with clothes and other basic necessities. Additionally, the ICRC came to examine the kinds of treatments being provided to the wounded Syrians.

Peter Redfield (2008: 160) has argued that the standardization of the toolkit approach in humanitarian aid provision represents a self-consciously *global* system that considers itself adaptable to “limited-resource environments worldwide,” and further suggests that this type of “humanitarian [aid] focuses on the moral imperative of responding to immediate human suffering.” Activities such as this, however, are far more relevant in the case of humanitarian aid provided in a war zone or disaster area, as an emergency activity, than to the kind of medical response provided in the case of the Syrian casualties treated in Israel.

Accordingly, in its involvement in this operation, the ICRC faced a new, unfamiliar humanitarian space. As coordinator Hisham Sarur described the ICRC’s arrival at the hospital:

Everything’s new to them, everything. They’ve never supported Israeli people in a hospital... Here, the procedure’s different. Here, you need to obtain a permit from the Ministry of Health, from the management [of the hospital], and from the military. Because I’m divulging very confidential information to my psychologist [who is sponsored by the Red Cross].

According to Sarur, the ICRC was required to follow procedures with which it was not familiar. Operating within the Israeli hospitals in which Syrian casualties were treated necessitated compliance with procedures dictated by government authorities, such as Israel’s Ministry of Health, which is the top authority over the medical teams involved in the project. The Ministry of Health is the state regulator, responsible for public health and guided by laws such as the 1996 Israeli Patients’ Rights Law, as well as traditional standards of patient care. The ICRC’s procedures, however, are informed by the requirements of disaster medicine; they deal with the provision of relief and medical assistance to vulnerable populations (regardless of their civil status) in war zones and disaster areas, and are grounded in international humanitarian law, applying the standards of “disaster medicine.” The tension between the differing roles of the hospital and the ICRC thus reflects the tension between the categories of civilian and refugee; between the local, as expressed by citizenship, and the global, expressed by humanitarianism and being human; and between routine standards of patient care and those of disaster medicine.

## **The Temporal Dimension in the New Humanitarian Governance**

The temporality of the new humanitarian governance is different from that of “conventional” humanitarian governance. Yoram Ardan, a physician and former IDF officer, explained the difference between the two in relation to the *duration* of treatment provided:

You know what you saw when you got there; you know what you see when you’re done; and you know that after you there’s nothing. Only dust remains. It’s different when they come here, to you, and we’re holding them here [in civilian hospitals]. Even in hospitals in Israel, nobody stands with a stopwatch ... not [even] the health funds that say, “EEG and two days at the hospital and then back home,” while these people stay on.

Whereas conventional humanitarian aid is often limited in time, within the new humanitarian governance treatment is given for longer periods and can be expanded to include the treatment of all medical needs.

Gabriel Peled was a member of the Israeli humanitarian mission to Haiti after the 2010 earthquake. He described the policy of medical treatment in a disaster area:

Access control according to [medical treatment] capabilities... We accepted only those we could really help. You don’t hospitalize in intensive care someone that has to be ventilated for a month; it’s better to save the ones you can.

In comparison with other forms of humanitarian assistance, the new humanitarian governance is relatively unlimited in terms of resources. Senior physician Ofer White described how the temporal dimension is related to the quality of treatment:

In disaster medicine, you make the minimum effort to save a life in the shortest time possible in order to treat a maximum number of patients. And the primary care is primary care. Afterwards, definitive care is required. The things you do in disaster medicine are unacceptable in this hospital, alright? You look at Western medicine ... it’s not easy, but the doctor who goes into disaster medicine needs to make a switch in their brain.

In most cases, particularly for Israeli medical personnel, disaster medicine in the conventional humanitarian case is provided in a location far from ‘home’, and the medical team can only stay there for a limited period of time. It is therefore impossible to provide comprehensive, long-term medical interventions. In contrast, the new humanitarian governance seen in Israel’s provision of medical aid to Syr-

ian casualties brings change in terms of both the location and the duration of medical humanitarian treatment (as well as in relation to access to resources).

Sami Zamir, a senior physician and former IDF officer, emphasized: “Thus, even when a little girl arrived in there with her arm almost torn off, the question asked was whether the arm could be saved. Definitely not how her life could be saved” (Interview, 11 July 2018). While the hospital operates according to routine standards of medical care, humanitarian aid operates under the standards of disaster medicine, aiming to bring immediate relief to those suffering and to save lives (Tickin, 2006: 35).

When the Syrian casualties first began to arrive, Israeli medical centers had to decide on the standard of care that they would receive. Would it be the standard of emergency humanitarian aid or that of general medicine? According to Hugo Slim (2015: 49), the goal of humanitarian treatment is to “save and protect individual lives so that they have the opportunity to flourish. It is not to determine how they should flourish and organize this flourishing... the goal is life.” Conversely, routine medical care is designed not just to save but also to improve a patient’s quality of life. By comparison, Peter Redfield (2005) describes how the ethical stances of Médecins Sans Frontières are against inhuman conditions, but the organization avoids situations of long-term dependency, since most of the treatment goes beyond immediate life-saving issues, this treatment can continue for months – new ethical dilemmas are raised, and the basic question as to what is the goal of the humanitarian aid comes forward. In the present case, there was concern that the ethics of disaster medicine would be confused with the ethics of the types of treatment ordinarily provided in Israeli hospitals, and that this would affect the professionalism and functioning of the hospital staff in the long run. Hence treating patients according to their identity and not according to their medical condition, which could lead to unethical conduct on part of the staff. As a result, in practice, the treatment provided to Syrian casualties in both of the Israeli hospitals that took part in the humanitarian project examined here was based on Israeli standards of care and the stipulations of the 1996 Israeli Patients’ Rights Law, founded on the ethical imperative to treat patients, even those who were not citizens, in cases where there was an immediate risk of loss of life.

Alon Zuk, a senior physician, compared the humanitarian aid given to Syrians in neighboring countries such as Jordan with the treatment provided in Israeli hospitals:

Suddenly we are seeing people with injuries received one or two months earlier, and not only injuries to the head or neck, but also to the limbs. They went to Jordan, where they were told: “Amputation – amputation or nothing.” They go back to Syria and then come to us... Here we have two amazing wards. They managed to save some of the limbs. Some of the limbs they didn’t save, of course, but they tried. (Interview, 29 April 2019)

The comparison being made here is between regular humanitarian aid and the new humanitarian form of governance – that is, between emergency and routine standards of care. Physician Jamil Jabareen, who visited a camp for Syrian refugees in Jordan, highlighted the differences between the conditions in a mass camp and those of a civilian hospital, and emphasized that the poorer conditions of the camp meant that little more than emergency medical services could be provided in such circumstances (Interview, 4 December 2018).

The treatments provided in the Israeli hospitals, on the other hand, included prolonged and sometimes recurrent hospitalizations – as, for example, in the case of treatments involving multiple surgical procedures. Jabareen told of a 16-year-old Syrian patient who arrived pregnant – for the third time. During the examinations, it turned out that her previous pregnancies had ended in caesarian sections performed in another Israeli hospital. Jabareen obtained the patient’s medical history from the other hospital. The extended treatments provided to some of the Syrian casualties thus produced medical records and follow-up procedures that are typical of routine medical practice.

Another aspect of the changed temporality of the new humanitarian governance seen in the treatment of Syrian casualties in Israel relates to the rehabilitation process. According to senior nurse Rakefet Osas,

The doctors would simply latch on to the child: “I can’t let him go home... There’s no way of rehabilitating them in Syria ... so you have to do everything here.” So massive physical therapy and massive occupational therapy, and if it’s burns and you need to get pressure suits, we would get people to donate pressure suits.

The medical teams devoted time and resources to providing rehabilitation processes that were adjusted to the needs of the Syrian casualties in the new humanitarian governance, including the preparation and fitting of prostheses, a procedure in which some staff members became highly proficient. The long duration of the stays of some of the Syrians at the Israeli hospitals, combined with the fact that most patients had no family or friends that could visit them, was also a formative factor in the new humanitarian governance’s sociocultural adjustments.

Thus, unlike an ordinary hospital ward, in which there are clear and predefined rules of conduct, the new humanitarian governance adapts itself to the Syrians, not only medically but also socio-culturally. This led to the creation of informal contacts in the intimate treatment space that developed between the staff and the Syrian patients. As senior nurse Nichole Yaqub described the conditions in the wards:

you could find at night, sit with somebody who can’t fall asleep, and listen to them – that’s what we’re doing over there. Look!

For example, in an ordinary CRE unit, the nurse treats only them, no matter if they're two or three or four. So, she also has time to reach into their souls. (Interview, 6 November 2018)

The temporal domain of the medical care provided under the new humanitarian governance also includes the time after the patients return to Syria. This was exemplified in the case of a Syrian girl who required regular insulin treatment. Prior to returning her to Syria, the hospital was preparing to provide her with insulin, but the girl did not have a refrigerator in her home in which she could store it safely. With the military's help, however, it was ascertained that there was a refrigerator nearby where the insulin could be stored for her. The new humanitarian time is thus fragmented – it “leaps” between spaces and includes the provision of post-discharge treatment – instead of continuous longer stays within the Israeli state, under the status of a refugee.

### **The Syrian Casualty as a New Subject**

Not only is the new humanitarian governance mechanism exercised over a new space and temporality, but it also promotes new subjects. As senior physician Alon Zuk pointed out:

You have Doctors Without Borders in the world, and that's something great. But then it has a lot of limitations. You take a specialist physician who does very heroic operations in Peru, in Colombia, whatever, in the Philippines, he goes there for two, three weeks, and operates on twenty or thirty children ... and disappears. And nobody follows up. Here, it's not the doctors who are without borders, but the patients who are without borders.

In most cases, refugees face strict surveillance and numerous restrictions in their attempts to cross international borders. In the new humanitarian governance, however, crossing the border is enabled and legitimized by the patients' injuries. It is their status as patients that allows the Syrian casualties to cross a militarized state border and travel to an Israeli medical center. Once a Syrian casualty crosses the Israeli–Syrian border, this movement activates both the military and the medical systems in Israel. Physician and former IDF officer Yoram Ardan explained:

You don't know who's coming, sometimes... they would show films where, in the beginning, four men arrive, unload from some vehicle, leave a wounded man on a stretcher, and disappear. Now you don't know if there's a bomb underneath the stretcher, or maybe he himself is strapped to one.

In each case, the decision to open the border is made by the army. Beyond the fact that the individuals permitted to cross the border are classified as casualties, the

reasons for allowing a particular transfer are usually not made clear. Senior nurse Osas recounted:

My heart was thumping until I got there, and I said, OK, what am I going to see? What? Am I really capable of treating such a thing? Finally, I get there, and I see eyes – anxious eyes. That’s what I see. Filthy, neglected, hungry – I just see frightened eyes. It’s something you don’t get to see in Israel.

Crossing the border from the Syrian battlefield into Israel – a border that divides armies, countries, and cultures – is a sharp transition into an unknown space. For the Syrians who make this journey, it also involves receiving a new status: they are neither a resident, nor a refugee or undocumented migrant. Instead, they are classified as “Syrian casualties.” This is a medical–military–political status that makes it possible for them to cross into the new humanitarian governance and to stay in this space. Each individual is identified by a number (a patient ID, similar to the citizen ID number used in Israel). In the absence of names or other identifying markers (the Syrians usually cross the border without any formal documents), communications between the military and the hospitals regarding the Syrians are based on this number.

Furthermore, the new humanitarian subject not only crosses borders but also challenges the medical knowledge of the caregivers. In 2013–2014, during the first years of the project, the Syrian casualties often arrived with combat injuries that the Israeli medical staff treating them had never seen before. As senior nurse Nichole Yaqub recalled:

The injuries were very severe. People arrived with no legs, with no arms, opened up from all directions. I mean, really, at first there were very severe injuries. Not only at first, you know, even a year or two ago. Not the last wounded that got here, before that – extremely severe injuries.

The wounded body, bearing the marks of violence, “reporting” the war beyond the border, becomes the immediate identity marker in the encounter between the Syrian patients and the medical personnel. One of the latter, physical therapist Areen Khatib, described how the process of discovering and understanding the injury and the injured passed through his body:

“These wounds tell us something about what happened to him on the way, to really arrive.... I mean, [there are some] cases that really stir something else inside us as therapists.”

Coordinator Hisham Sarur explained: “You start identifying who was a civilian and who was a fighter according to the shape of the wound and the acceptance of the loss of the limb – the leg, which is what happens most often.” The physical wounds attest to the patient’s identity and biography. The discovery process not

only helps in the treatment of the wound, but also reveals the traumas and losses the wounded carry with them and evokes a sense of empathy from the medical staff, who until that point were an enemy beyond the border.

Senior physician and former IDF officer Sami Zamir described the patients' fear of being questioned: "I suppose the same patients also [wonder], 'I'm being asked where I live, why? Will the police soon come to arrest me because I'm an illegal alien?'" According to Zamir, the patients experience such questions as a threat and are afraid that revealing their identities might put them at risk. Unlike in the traditional humanitarian space, in which often the doctor is the benevolent savior, precisely here, 'at home', medical personnel had first to acquire their patients' trust.

### **Ethical Dilemmas in the New Humanitarian Governance**

The new humanitarian governance operates in a space-time that differs from that of the traditional humanitarian space. Here, new humanitarian power mechanisms – such as concealed militarism – exist next to the old ones and must be examined. The new humanitarian governance is located within the hospital, which means that the military has to deal with medical authorities that enjoy a position of considerable power. As a result, the modus operandi in the present case poses various ethical dilemmas for the staff, and how they cope with and reach decisions on these dilemmas sheds light on the new and unique characteristics of this new humanitarian space.

The extension of the provision of humanitarian aid in space and time also raises a new ethical dilemma in relation to the suitability of the medical treatment provided for patients returning to Syria. Both Syrians and Israelis were concerned that the advanced nature of the medical treatments would betray the fact that they were provided in Israel, an enemy country, and that this might put the lives of the patients at risk (Zarka et al., 2018). Here, then, limitations on the sorts of treatment that could be provided were not the result of working under the conditions of a typical humanitarian aid program, but from the need for the patients to return to Syria. For example, instead of having a prosthesis made for him, one patient underwent 16 operations to save his legs. Benny Zaavi, a trauma center nurse, explained that an IDF casualty would have been fitted with a prosthesis in such a case, but a hi-tech prosthesis might reveal that the patient had been treated in Israel: "They'll understand who he is; they'll kill him.... You need the simplest things. Not hi-tech, lo-tech!" (Interview, 3 December 2018).

Thus, dilemmas exist not only in the choice between routine medical standards and disaster therapy, but also between the "medical good" of the patient and their future well-being under the shadow of war, which creates a complex mixture of medical and political considerations. Marten Abramowitz et al. (2014) have discussed a similar dilemma that occurred in a case where some anthropologists believed medical technologies had to be extended to everyone while others were concerned that this would be unsuitable for the conditions of a disaster zone and

therefore argued that lo-tech interventions designed to save lives were the only option. In a similar fashion, in relation to the rehabilitation process for the Syrian casualties in war-torn Syria, occupational therapist Nurit Asayag explained:

Our greatest frustration was, OK, we'll help [the girl] improve, but where is she going back to? What conditions is she going back to?... It's not even the question whether it's a motorized or an ordinary wheelchair. So, we'll give her long splints so that she can stand when she goes to the bathroom... You do the best you can, mainly thinking about the place she's going to. This means it's not the Israeli best but the wherever-she's-going-back-to best.

As a result, the staff had to learn about the conditions under which their Syrian patients lived, things that they had previously been completely unaware of – for example, what a patient's house and neighborhood (what's left of them) looked like; what the sanitary conditions were; what sort of water and electricity supplies existed. Without such knowledge, treatment and rehabilitation not only might be ineffective, but might also harm the patients (as a result of infections, lack of medicines, etc.). The choice to include rehabilitation as part of the humanitarian treatment thus posed various ethical dilemmas related to questions such as whether to provide medicines that required maintenance that was unavailable; whether to provide prostheses or other equipment that could not be used in an environment with dilapidated infrastructures; whether to conduct advanced surgical procedures that would require ongoing medical follow-up, etc.

The dilemmas that emerged in the spaces in which the Syrian casualties were treated are very different from those we find in the debates in the literature on humanitarianism and the usual ethical dilemmas or criticisms that anthropology has in the field. In contrast to other humanitarian spaces (e.g. Greece and Turkey), where populations are classified as refugees or “asylum seekers” (Cabot & Lenz 2012; Koca 2016), in the Israeli case the patients remain classified under the locally specific category of “Syrian casualties,” where it is their injury that secures them permission to enter Israel. In addition, the military decides on the location of treatment, thereby defining the legal and legitimate space and time (duration) in which the injured can stay in Israel. This is the empirical context in which our case study is presented, and indeed, this situation creates a gap between the humanitarian related to the asylum-seekers/refugees context vs. the military one. Beucu Togral Koca (2016), for example, discusses the gap between the humanitarian discourse and the security discourse: whereas the former works to help Syrian “guests” in Turkey, the latter frames their attendance in security terms, thus constructing them as a threat and risky outsiders. The security discourse conceals other political problems of racism, exploitation, discrimination, and inequalities. Hence, in addition to the initial humanitarian discourse that promotes the acceptance of Syrian refugees within the country, a security discourse also emerges, one that is turned against them, frames them as a threat, and legitimizes a particular

legal status and security apparatus designed to control them (e.g. through militarized border control and restricted access to social rights).

Similarly, in relation to Greece, Heath Cabot and Ramona Lenz (2012) have shown how negative images are attached to the new Syrian migrants by accounts that portray migration to the Greek islands as an ‘invasion’ of young (mostly Muslim) men, and how, as a result of such perceptions, a security discourse emerges.

Being a “casualty” is a new status that allows for humanitarian discourse and humanitarian activity within the sovereign territory of the foreign state, a kind of space within a space – a new humanitarian space that exists within the national space and simultaneously operates according to both humanitarian standards of care and the state’s own rules regarding the provision of healthcare to civilians, which go beyond the standards of temporary humanitarian care.

In other words, the Syrian casualties are in a “state of exception,” coming from a part of Syria in which Assad’s rule does not exist and no other government has control. The humanitarian response seen here was made possible by the fact that the patients came from an area that was not formally under state control, and they were not classified either as citizens or as refugees. This is part of what made it possible for them to travel to the territory of the State of Israel and to cross security borders. Indeed, it seems that the humanitarian aid program described in this article was stopped once Assad regained control of the area. We argue that the logic of denying a medical response as a state of exception and lack of status does not work here, but the opposite is the case: it is the exception that allows humanitarian aid.

Second, international humanitarian agencies like the Red Cross are accustomed to using what Peter Redfield refers to as a toolkit, using a similar set of tools for all types of crisis. Humanitarian tools are usually short term. In this case, the Red Cross’s intervention was viewed somewhat negatively by the caregivers, since the type of aid that the organization provided to the patients was irrelevant given the types of treatment they were receiving. Since this was not a short-term humanitarian crisis, but instead a program providing long-term medical treatments that often involved long stays in the hospital and the meeting of a wide range of patients’ daily needs, the provision of blankets and clean water seemed inappropriate and out of place.

Accordingly, we argue that the literature has so far dealt with instances in which a dystopian position could be taken that characterizes the writing of humanitarianism and the literature on the “state of exception,” which regards the mechanisms of government as mechanisms of power as they are. This position is becoming stronger as the country speaks as a source of power and violence, state terror, so it is likely that the framework of analysis will also be similar in this regard. However, even though we come up with a particular theoretical foundation, this case teaches us that the newly created space gives rise to new ethical dilemmas and therefore

requires us to reframe our theoretical and ethical concerns and conclusions. Questions about the intersection of security, medicine, humanitarian practices, emergencies, and lifesaving take on a new meaning in this new governmental order.

## **Acknowledgments**

This research was funded by the support of the Levi Eshekol Institute at the Hebrew University of Jerusalem. We thank, Tereza Kuldova, the Editor-in-chief of the *Journal of Extreme Anthropology*—and the journal’s anonymous reviewers for their thoughtful comments.

## **Author Bios**

*Dr. Hedva Eyal* is Postdoctoral Fellow at the Gender Studies Program at Ben-Gurion University of the Negev. She is lecturer At Sapir Collage at the Department of Public Policy and Administration, and at Haifa University’s Department of anthropology. Her research deals with medical anthropology, notably medical experimentation on humans, reproductive technologies, the relations between medical science, State and society in the Israeli context, and feminism.

*Dr. Limor Samimian-Darash* is senior lecturer at the Federmann School of Public Policy and Government at the Hebrew University, Jerusalem. Her research focuses on preparedness and security, the governance of risk and uncertainty, and scenario thinking/ planning. Her recent publications include *Modes of Uncertainty: Anthropological Cases* (University of Chicago Press, co-edited with Paul Rabinow, 2015); “Governing Future Potential Biothreats: Toward an Anthropology of Uncertainty,” *Current Anthropology* (2013); “Practicing Uncertainty: Scenario-Based Preparedness Exercises in Israel,” *Cultural Anthropology* (2016).

*Prof. Nadav Davidovitch* is an epidemiologist and public health physician He is a Full Professor and Director, School of Public Health at the Faculty of Health Sciences, Ben-Gurion University of the Negev in Israel. His research interests: health policy, public health, vaccination policy, one health/ecohealth, comparative healthcare systems, public health ethics, and global health. He authored or co-authored over 140 papers and book chapters, co-edited six volumes and books and published his work in leading medical and health policy journals, such as the *New England Journal of Medicine*, *Lancet*, *Clinical Infectious Diseases*, *Emerging Infectious Diseases*, *Journal of Pediatrics*, *Vaccine*, *Social Science and Medicine*, and *Law & Contemporary Problem*.

## **References**

Abramowitz, Sharon, and Catherine Panter-Brick, eds. 2015. *Medical Humanitarianism: Ethnographies of Practice*. Philadelphia, PA: University of Pennsylvania Press.

- Abramowitz, Sharon, Meredith Marten, and Catherine Panter-Brick. 2014. "Medical Humanitarianism: Anthropologists Speak Out on Policy and Practice." *Medical Anthropology Quarterly* 29(1): 1–23.
- Agamben, Giorgio. 2005. *State of Exception*. Chicago, IL: University of Chicago Press.
- Armitage, John. 2002. "State of Emergency: An Introduction." *Theory, Culture & Society* 19(4): 27–38. DOI: doi.org/10.1177/0263276402019004002
- Eyal, Hedva, and Limor Samimian-Darash. 2019. "Unintended Securitization: Military, Medical, and Political-Security Discourses in the Humanitarian Treatment of Syrian Casualties in Israel." *Conflict and Society: Advances in Research* 5: 55–71.
- Bornstein, Erica, and Peter Redfield. 2011. "An Introduction to the Anthropology of Humanitarianism." In: *Forces of Compassion: Humanitarianism Between Ethics and Politics*, edited by Erica Bornstein and Peter Redfield, 3–30. Santa Fe, NM: School for Advanced Research Press.
- Cabot, Heath, and Ramona Lenz. 2012. "Borders of (in)visibility in the Greek Aegean." In *Culture and Society in Tourism Contexts. Volume 7*, ed. Antonio Miguel Nogués Pedregal, 179–179. Bingley: Emerald Press.
- Calhoun, Craig. 2004. "A World of Emergencies: Fear, Intervention, and the Limits of Cosmopolitan Order." *Canadian Review of Sociology and Anthropology* 41(4): 373–395. DOI: 10.1111/j.1755-618X.2004.tb00783.x
- Davidovitch, Nadav, and Benjamin Langer. 2018. "Securitization of Public Health Preparedness in Israel and Palestine: A Challenge for Public Health Ethics." In: *Bioethics and Biopolitics in Israel*, edited by Hagai Boas, Yael Hashiloni-Dolev, Nadav Davidovitch, Dani Filc, and Shai Lavi, 23–40. Cambridge: Cambridge University Press. DOI: 10.1017/9781316671986
- Fassin, Didier. 2007. "Humanitarianism as a Politics of Life." *Public Culture* 19(3): 499–520. DOI: 10.1215/08992363-2007-007
- Fassin, Didier. 2012. *Humanitarian Reason: A Moral History of the Present*. Berkeley, CA: University of California Press.
- Fassin, Didier, and Mariella Pandolfi, eds. 2010. *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*. New York: Zone Books.
- Feldman, Ilana. 2007. "Difficult Distinctions: Refugee Law, Humanitarian Practice, and Political Identification in Gaza." *Cultural Anthropology* 22(1): 129–169. DOI: doi.org/10.1525/can.2007.22.1.129.
- Gottlieb, Nora, Dani Filc, and Nadav Davidovitch. 2011. "Humanitarian Practices vs. Human Rights Advocacy: The Case of the Israeli Open Clinic." *Social Science and Medicine* 74: 839–845. DOI: doi.org/10.1016/j.socscimed.2011.07.018.
- Hugman, Richard, Eileen Pittaway, and Linda Bartolomei. 2011. "When 'Do No Harm' Is Not Enough: The Ethics of Research with Refugees and Other Vulnerable Groups." *The British Journal of Social Work* 41(7): 1271–1287.
- Koca, Beucu Togral. 2016. "Syrian refugees in Turkey: From 'guests' to 'enemies'?" *New Perspectives on Turkey* 54: 55–75.

- Lomsky-Feder, Edna, and Eyal Ben-Ari. 2000. *The Military and Militarism in Israeli Society*. SUNY Series in Israeli Studies. Albany, NY: State University of New York Press.
- McFalls, Laurence. 2010. "Benevolent Dictatorship: The Formal Logic of Humanitarian Government." In: *Contemporary States of Emergency*, edited by Didier Fassin and Mariella Pandolfi, 317–334. New York: Zone Books.
- Magone, Claire, Michaël Neuman, and Fabrice Weissman, eds. 2011. *Humanitarian Negotiations Revealed: The MSF Experience*. Oxford: Hurst. Available at: <https://www.msf-crash.org/en/publications/humanitarian-negotiations-revealed-msf-experience> (accessed 23 February 2020).
- Masco, Joseph. 2008. "Survival in Your Business: Engineering Ruins and Affect in Nuclear America." *Cultural Anthropology* 23(2): 361–398. DOI: [doi.org/10.1111/j.1548-1360.2008.00012.x](https://doi.org/10.1111/j.1548-1360.2008.00012.x).
- Pandolfi, Mariella. 2008. "Laboratories of Intervention: The Humanitarian Governance of the Post-Communist Balkan Territories." In: *Postcolonial Disorders*, edited by Mary-Jo DelVecchio Good, Sandra T. Hyde, Sarah Pinto, and Byron J. Good, 157–186. Berkeley, CA: University of California Press.
- Ram-Tiktin, Efrat. 2017. "Ethical Considerations of Triage Following Natural Disasters: The IDF Experience in Haiti as a Case Study." *Bioethics* 31(6): 476–475. DOI: [10.1111/bioe.12352](https://doi.org/10.1111/bioe.12352).
- Redfield, Peter. 2005. "Doctors, Borders, and Life in Crisis." *Cultural Anthropology* 20(3): 328–361. DOI: [doi.org/10.1525/can.2005.20.3.328](https://doi.org/10.1525/can.2005.20.3.328).
- Redfield, Peter. 2008. "Vital Mobility and the Humanitarian Kit." In: *Biosecurity Interventions: Global Health and Security in Question*, edited by Andrew Lakoff and Stephen J. Collier, 147–171. New York: Columbia University Press.
- Samimian-Darash, Limor, and Hedva Eyal. 2019. "Friends and Foes in the Boundary Zone: New Military–Medical Spaces in the Treatment of Syrian Casualties in Israel." *Res Militaris ERGOMAS* 6: 1–15.
- Schmitt, Carl. 1976. *The Concept of the Political*. New Brunswick, NJ: Rutgers University Press.
- Slim, Hugo. 2015. *Humanitarian Ethics: A Guide to the Morality of Aid in War and Disaster*. Oxford: Oxford University Press.
- Ticktin, Miriam. 2006. "Where Ethics and Politics Meet: The Violence of Humanitarianism in France." *American Ethnologist* 33(1): 33–49. <https://www.jstor.org/stable/3805315>.
- Watson, Scott. 2011. "The 'Human' as Referent Object? Humanitarianism as Securitization." *Security Dialogue* 42(1): 3–20. DOI: [doi.org/10.1177/0967010610393549](https://doi.org/10.1177/0967010610393549).
- Wikan, Unni. 2013. "Review of Didier Fassin's *Humanitarian Reason: A Moral History of the Present*." *Ethos* 14(4): 1–3. DOI: [doi.org/10.1111/etho.12033](https://doi.org/10.1111/etho.12033).
- Young, Savannah S., Denise C. Lewis, Peter Gilbey, Arie Eisenman, Richard Schuster, and Desiree M. Seponski. 2016. "Conflict and Care: Israeli Healthcare Providers and Syrian Patients and Caregivers in Israel." *Global Qualitative Nursing Research* 3: 1–15. DOI: [/doi.org/10.1177/2333393616666584](https://doi.org/10.1177/2333393616666584).

*Eyal, Samimian-Darash & Davidovitch – Humanitarian Aid, Security and Ethics*

Zarka, Salman, Morshid Farhat, and Tamar Gidron. 2018. “Humanitarian Medical Aid to the Syrian People: Ethical Implications and Dilemmas.” *Bioethics* 33(2): 1–6. DOI: 10.1111/bioe.12463.