Nursing in the world’s war zones

Jasmine Malone reports from an international symposium that discussed the dilemmas facing staff who provide health care in regions of conflict.

Abstract

This article describes the difficult decisions faced by healthcare workers providing treatment in conflict areas to civilians as well as combatants. While endeavouring to provide the best possible care including, where practicable, follow-up treatment, they daily face the risk of kidnap, attack, takeover of hospital facilities, the seizure of drugs and medical equipment, as well as having to negotiate checkpoints. Care is provided in conflict zones by charities and military medical facilities.

Keywords

Red Cross, Red Crescent, volunteers, conflict zone nursing, field hospitals

In times of conflict, running successful healthcare teams, either as part of a military operation on the front line during combat or as a head nurse in a field clinic for a charity, can involve a spectrum of challenging conditions. It can range from the practicalities of providing first aid to healthcare workers and patients being in mortal danger.

The danger to healthcare staff working overseas was highlighted last month with the announcement that the International Committee of the Red Cross (ICRC) is suspending humanitarian activities in Peshawar and Karachi, Pakistan. The move follows the beheading of British nurse Khalil Dale, who was working for the ICRC in the country when he was abducted in January.

As well as the risk of being kidnapped, staff and patients face the possibility of violence, of attack using explosives, of armed entry and takeover of hospital premises, and of seizure of medicinal and other supplies and equipment.

From a professional perspective, healthcare workers can be confronted, in emergency medical facilities, for example, with sudden surges in the number of patients with complicated wounds that require urgent care. Healthcare workers also operate under less visible risks. Often the fact that they are treating patients of unknown affiliation can put them at risk of assault, and ambulances are frequently attacked as suspected carriers of fugitives or arms.

Conflict

Such challenging circumstances and the need to provide efficient care and safe environments for healthcare workers to work abroad were the themes discussed in April at an ICRC symposium, entitled Health Care in Danger. Speakers included Surgeon Rear Admiral Lionel Jarvis, the Royal Navy’s medical director general, who explored the need for increased awareness of safety issues for healthcare workers in conflict zones and the urgent requirement for better administration of national and international laws to ensure safe health care to staff and patients.

‘During conflict, health care goes from being a human right to a commodity,’ explained Admiral Jarvis. Last July, the ICRC published a study of violence in healthcare settings in 16 countries involved in conflicts, which cites 655 violent incidents over two and a half years. Thirty three per cent of the incidents were perpetuated by local state armed forces, 37 per cent by other armed groups and the rest by unidentified groups. The violence affected non-governmental organisations (35 per cent), local healthcare services (26 per cent), and Red Cross or Red Crescent organisations (17 per cent).

Of the violent incidents, those involving explosives were the most damaging. In total, 1,834 people were hurt or killed, of whom 9 per cent were healthcare personnel. Hospitals, field clinics and other premises were damaged in 18 per cent of incidents and ambulances were damaged in 5 per cent.

For a head nurse, clinic and staff management in a conflict zone makes already difficult decisions even more challenging. Regular dilemmas can involve
basic administrative challenges such as determining safe working hours or secured passage to patients through locally agreed ceasefires, managing and prioritising treatment during sudden influxes of high numbers of patients from combat or other incidents, and dealing with ongoing threats and attacks to the clinic, staff and support workers.

Phillipa Parker is a nurse who has faced these challenges. She is head of the ICRC health unit, based in Geneva, Switzerland. The unit oversees all the ICRC’s operational healthcare activities while co-ordinating the provision of first aid, primary health care, hospital care and physical rehabilitation, as well as the health care of people in detention, in more than 60 countries.

She has been in post since 1984 and worked in healthcare programmes in Afghanistan, Bosnia and Herzegovina, Iraq, Pakistan, Somalia, Sri Lanka, Sudan and Rwanda, and on the Thai-Cambodian border. She was awarded the Queen’s Service Medal in 1990 and the Florence Nightingale Medal in 1993.

Speaking at the ICRC symposium in London, Ms Parker described some of the challenges she has faced in conflict zones. Often immediate danger, such as shelling, armed attacks on clinics and staff, or an overwhelming influx of patient numbers on limited facilities, are not the most confounding dilemmas faced by management in a conflict region.

‘Decisions that go against the rules are often made when we simply have no other choice,’ she said. While managing an ICRC field hospital in Iraq, for example, she and her colleagues introduced strict rules on hospital access and visiting hours; generally, no visiting before midday. This would allow nurses to work unhindered and improve clinic organisation and maintenance, as well as to provide ongoing treatment for patients.

Safety

Rules and regulations, however, can be hard to enforce in the extreme circumstances of conflict situations. For example, when Ms Parker was on duty one day several soldiers from the national army came to the clinic and asked to visit a wounded comrade. When she denied them access, citing the standard visiting hours, she noticed something hard digging into her ribcage. She realised that her denial had caused offence and one of the soldiers had pulled out a gun. She immediately stepped aside.

Although this was an impulsive decision, Ms Parker then had to face the question of how to deal with the consequences: by allowing in these soldiers, she had set a precedent that could jeopardise all the work done by clinic nurses to ensure adherence to visiting hours, while also imparting the message that clinic rules could be overturned by force.

Balancing safety, treatment and efficient clinic management against the cultural needs of patients and staff are further challenges of nursing management in conflict settings.

For example, Ms Parker described having to decide where to place female patients in the hospital in Afghanistan, while maintaining the level of modesty required by local culture and religious beliefs. Local female patients need to be out of the sight of any male visitors, officials or other people who may walk through the clinic, so it was agreed to establish a women’s ward on the third, and top, floor of the field clinic. However, the decision was made solely on the basis of gender, rather than any treatment needs or overall patient safety.

The clinic eventually came under fire and shelling, sustaining significant structural damage, particularly to the top floor and windows. Apart from the female ward, all wards were evacuated or patients taken to the basement for cover. The staff had only stairway access to the third floor and most of the female patients were forced to stay there because many were in traction or were otherwise difficult to move. They were consequently in grave danger.

‘Our training would have foreseen this challenge,’ said Ms Parker. ‘But the cultural issues forced us to allocate patients to floors using modesty as a priority instead of practicality. Consequently, vulnerable patients were left at risk.’

Curfews, particularly for female patients, also pose a treatment challenge for staff. Spaces in
field clinics are usually limited, and patients are encouraged to attend day clinics for treatment.

In one instance, a handful of female patients attending Ms Parker’s clinic in Afghanistan, having waited all day for care, were still being treated after the 7pm curfew. Ms Parker and her staff realised that this late running would cause problems for patients at home that could hinder future treatment or attendance at the clinic. The staff attempted to drive them home in an ambulance, but were faced with 20 or so checkpoints and many interrogations. This was because it was late and the ambulances were not carrying critical patients, so the crews were suspected of sabotage.

‘This leads to the question of how far you go trying to provide what people expect and need because of their culture and how far you go overstepping regulation for safety,’ said Ms Parker.

‘While in Baghdad, we were approached by NATO forces operating their own field hospitals in the area,’ said Ms Parker.

‘At the time, the ICRC nurses were working in the local hospital that had good surgery, but it was a tricky environment. Although the hospital was good, there were no extras, and we would often treat patients who had come from the NATO hospital, who had received much more advanced treatment. It was an ongoing challenge to explain that our conservative care would be the best treatment under the circumstances.’

### Sustainability

Discrepancy in treatment was also addressed at the symposium by Admiral Jarvis. Citing the main challenges faced by his medical staff on the front line, he explained that it was his team’s responsibility to treat every patient in need. However, often correct aftercare is not included, and decisions about this care can be difficult to make.

‘One of our biggest challenges is that there are no black and white answers,’ he says. ‘Using Afghanistan as an example, only 5 per cent of patients we treat are British military; the rest include allied forces, local national forces and local people. We look after those injured from conflict and civilians caught up in conflict, but our responsibility for others is where dilemmas arise regarding treatment during conflict.’

Military clinics operate with the expected high standard of efficiency and often with more supplies than those organised by smaller, charitable organisations, but the problem of sustainability of treatment is faced by everyone. Although treatment decisions are made with good care in mind, often the aftercare and rehabilitation are simply unavailable to patients. ‘We have a serious challenge on our hands, and we have to accept that we are treating to a standard that may not be sustainable locally,’ says Admiral Jarvis.

Military and non-governmental organisations, including charities and relief organisations, often collaborate to help one another deliver the best available treatment needed. Herein, however, lie additional challenges in management decision making.

Often, first-aid relief clinics are run with minimal staff, and sharing the burden of emergency care, specialist knowledge, staff and materials is invaluable to patients and staff. But in challenging environments, where perceived alliances with any number of enemies, whether in a political, national or religious context, can put clinics at risk, and such assistance can turn into dangerous endeavours.

### Responsibility

Citing her experiences in Afghanistan in the run up to international forces pulling out of an area, Ms Parker said: ‘We were approached by generous, well-intentioned officials from the nearby NATO hospital, which was closing down as the troops were moving out. Before their departure, the NATO medical officials offered to rehabilitate our hospital, adding extremely valuable diagnostic equipment. The equipment was definitely needed, and more so after the NATO forces had left.

‘However, they informed us that the work would take six months,’ said Ms Parker. ‘But at the ICRC we have a long-term commitment to the local people we treat. We cannot accept military personnel coming to the hospital to work and make our staff and clinic a target for six months while we are there, even though the offer was generous and would have improved the treatment we provided our patients in future.’

Choosing between compromising current care and improving long-term treatment for patients may make the decisions taken in circumstances of conflict seem at odds with those that would be made in peace time. ‘It is our responsibility to be aware that sometimes there is not a right or a wrong,’ said Ms Parker.

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**Find out more**

The International Committee of the Red Cross report, Health Care in Danger, is available at [www.icrc.org/eng/resources/documents/publication/p4072.htm](http://www.icrc.org/eng/resources/documents/publication/p4072.htm)

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