


Conflict and Care: Israeli Healthcare Providers and Syrian Patients and Caregivers in Israel

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Abstract

Israel has provided immediate healthcare to Syrian children, civilians and fighters since early 2013 despite being in an official state of war with Syria since 1973. We present qualitative findings from a larger mixed-methods phenomenological study to understand how the geopolitical and social history of Israel and Syria influences healthcare providers and Syrian patient caregivers in northern Israel. Theories of humanization and cognitive dissonance guided this study and frame the beliefs and experiences of healthcare providers who treated wounded Syrians in Israeli hospitals. Findings indicate healthcare providers and Syrian caregivers adjusted their beliefs to allow for positive healthcare experiences. Qualitative analysis revealed two major themes: supportive and hindering systemic elements contributing to the healthcare provider-patient-caregiver relationship. Internal psychological developments, contextual factors, and relational processes influenced humanization of *the other* within the relationship. This study illuminates unique ethical and humanitarian demands relevant for healthcare workers and those with whom they interact.

Keywords

doctor-patient, nurse-patient, communication, refugees, immigrants, migrants, war, ethics, moral perspectives, healthcare, Syria, Israel, humanitarianism

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Introduction

Syria, a country bordered by Israel, Jordan, Iraq, Turkey, and Lebanon, has experienced extreme internal sectarian violence since April 2011 due, in part, to the Syrian Uprising (Hinnebusch, 2014). The exodus of over four million refugees¹ who have fled to camps in neighboring countries for safety (United Nations High Commissioner for Refugees [UNHCR], 2015) has been labeled as the Syrian Uprising. Almost eight million people are internally displaced within Syria because their homes and villages have been attacked or destroyed (UNHCR, 2015). Unable to escape their country due to political restrictions, travel difficulties, or fear of the risky journey, many Syrian civilians still cannot return to their homes due to constant danger of being kidnapped, tortured, or killed. Violent factions such as the Islamic State, Jabhat al-Nusra, and many others continue to move throughout the country initiating conflict while ignoring civilian welfare (The Carter Center, 2015). Three of Syria's neighboring countries, Turkey, Jordan, and Lebanon, currently host the majority of refugees who have escaped Syria's borders (UNHCR, 2015). Many other hundreds of thousands

continue to flee to Europe as asylum seekers. However, on Syria's western border, the nation of Israel is providing a unique form of humanitarian aid.

Statement of the Problem

Israel and Syria have been diplomatic enemies while also existing somewhat peacefully as neighbors in a prolonged state of arms disengagement or separation of forces since the Yom Kippur war in 1973 (Israel Ministry of Foreign Affairs, 1974; Peretz, Labay, Zonis, & Glikman, 2014; The United Nations, 1974). Despite political tension caused by Israel's annexation of the Golan Heights land area between the two countries, Israel's hospitals have quietly provided healthcare

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to victims of the Syrian civil war since February 2013 (T. Sheleg, personal communication, July 29, 2015; Zarka et al., 2014). Complications surrounding Israel's aid to Syrians persist because, along with an increasing number of wounded women and children seeking treatment, rebels and nationalist soldiers also flee to temporary field hospitals along the border territory in the Golan desperate for immediate care (Eisenberg & Benbenishty, 2013). Considering the multifaceted history of the land and people of Israel, juxtaposed with Syria's current refugee crisis and internal conflict, the current research is needed to illuminate issues facing Syrians and healthcare providers (HCPs).

To add to this complex situation, physicians, nurses, specialists, and social workers in Israel's hospitals belong to a variety of ethnic and religious groups themselves, and many have experienced their own discrimination in Israel. Regardless of personal background or beliefs, Israeli HCPs are ethically bound to provide treatment to all wounded persons, including Syrians (Israeli Medical Association, 2009b). Among the wounded Syrians seeking healthcare are women and children civilians, as well as nationalist and sectarian fighters. Upon entering Israel, Syrians receive treatment for grave injuries inflicted as a result of the uprising in their home country (Eisenberg & Benbenishty, 2013). This research examines the perspectives of Israeli HCPs who treated Syrians, as well as the perspective of Syrian family members/caregivers who accompanied the severely wounded victims.

Significance of Study

With conflict in the Middle East continually shifting, refugees will continue to flee to neighboring countries, some of which may be historically discordant. This article illuminates one phase of refugees' plight around the world: seeking and receiving immediate healthcare. This research introduces the inclusion of social, political, and historical context into the broader conversation of healthcare provision, while highlighting broader societal issues and questions surrounding providing healthcare to people considered 'enemies.' Implications include understanding how Israel's decision to treat Syrians influences the Middle East region and global humanitarian healthcare efforts.

Literature Review

Inspiring this research is the pressing humanitarian issue of healthcare provided to refugees around the world. When disaster strikes a nation, whether due to natural or political causes, neighboring countries can face masses of injured, impoverished, and weary men, women, and children crossing their borders. Due to the urgency of many refugees' extreme medical needs, especially those from war-stricken areas, neighboring nations may offer healthcare assistance before official policies and funding can be established by

humanitarian aid groups (such as Medecins Sans Frontieres International; Jesuit Refugee Services; the United Nations High Commissioner for Refugees, or the International Committee of the Red Cross). Neighboring countries aiding the fleeing masses of refugees may have historically hostile relationships with those for whom they provide healthcare (see De Bruijn, 2009).

In the case of Israel and Syria in particular, historical disputes between the two nations are rooted in decades of political, religious, and ancestral differences. Healthcare providers in the aiding country (Israel), as well as wounded Syrian patients from across the border, hold personal beliefs related to their own experiences as Israelis or Syrians. Although no known empirical research has been published on this particular situation, studies have found issues of provider stigma faced by HCPs when treating unfamiliar, foreign minority groups (Ahsan Ullah, 2011; Burchill & Pevalin, 2014; Campbell, Klei, Hodges, Fisman, & Kitto, 2014; Sandhu et al., 2013). Although Israelis did not consider Syrian patients in Israel to be "refugees" according to the 1951 UN Convention on Refugees¹, they *were* considered people in a state of flight and peril, who had been injured as a result of persecution and/or war, and who may flee Syria seeking refuge upon release from the Israeli healthcare setting. Thus, research with and about HCPs treating refugee patients is both relevant and applicable to this study.

Barriers to Treating Refugee Patients

Healthcare providers can experience barriers when treating refugee patients. These barriers may be related to cultural, professional, or personal differences and perceived stigma (Glenn, 2000). Addressed most often are treatment barriers including a lack of cultural knowledge and historical precedence, the inability to communicate effectively and privately with patients, personal prejudices held by HCPs, difficulty establishing trust with patients, and systematic/procedural barriers that are beyond the HCPs' control (Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). Although past research has described racism and prejudice in the healthcare system, fewer studies have focused on the relationship and process of providing care, especially for wounded migrant and/or refugee patients.

Method

Methodological Approach

A hermeneutic, intentional phenomenological approach was used to conduct this research (Freeman & Vagle, 2013; Moustakas, 1990; Vagle, 2014), informed by tenants of ethnography (Bernard, 2006; Glesne, 2010). The overarching question was, "How do Israeli healthcare providers and Syrians in the hospitals experience the caregiving process?" To capture phenomenological nuances, we also asked,

“How does cognitive dissonance affect healthcare providers’ perception of themselves, their work, and their care to Syrian patients?”

We approached this research purposefully, bridling our knowledge and judgments to understand the phenomenon at hand. Bridling is a technique in which researchers’ experiences are recognized as meaningful within the scope of the project, rather than bracketing in which researchers assume neutral objectivity. Assuming neutrality and complete objectivity was not only inappropriate in this study, considering our epistemology, but was also unrealistic considering the first author’s, Young’s, in-depth experiences living in Israel during a time of war (Operation Protective Edge) within the global refugee crisis due to the Syrian Civil War and growing terror of the Islamic State of Iraq and Syria (ISIS) (Dahlberg, 2006; Vagle, 2009, 2014).

Site Selection and Ethics

All primary data were collected in two hospitals in Israel in June and July of 2014 with HCPs and Syrian family members of patients. Follow-up observational data were gathered in July 2015 to elaborate on developments and changes occurring in Israeli hospitals with Syrian patients. Both sites were located in the geographic northern region of Israel, which is the most demographically diverse region of Israel (Israel Central Bureau of Statistics, 2010). Importantly, of the four Israeli hospitals treating Syrian patients at the time, the two data collection locations were the foremost and largest healthcare sites for Syrians receiving treatment in Israel.

This study was approved by the full Institutional Review Board at Anonymous (IRB) as well as the Anonymous Ethics Boards of both hospital sites, and the hospitals’ administrations. Participant consent was obtained using an anonymous letter of consent, which required verbal agreement with the interviewer prior to beginning interviews. For security purposes and as a culturally responsive measure, we chose to employ anonymous consent letters due to potential repercussions for both HCPs and Syrian participants. Due to hospital administrative requests, all HCPs, regardless of ethnicity or primary language, received Hebrew consent letters prior to interviews. Syrian participants received Arabic consent letters, which were read aloud and explained to them by an Arabic social worker who also translated during Syrian participant interviews.

Interviews were not audio-recorded for security purposes. The interviewer wrote detailed notes and quotes during each interview by hand. Immediately following each interview, the interviewer typed the hand-written notes along with personal ‘head notes’ on a protected computer (Creswell, 2003). All data were kept secure on a password-protected computer that was either with the interviewer or locked in a private room at all times.

Translation

Native Hebrew and Arabic speakers who were graduate students of the affiliated research universities translated the consent letters. They were chosen based on their high educational attainment and native language proficiency. Letters were back-translated by members of our research team and hospital administrators fluent in Hebrew and Arabic. Hospital administrations required researchers to distribute only Hebrew consent letters to HCPs; Arabic consent letters were provided to Syrian participants. Although Young (the interviewer) was not fluent in Hebrew or Arabic, only six participants requested verbal translation during interviews.

Aside from the three graduate student translators of consent forms, three verbal translators were used in this study. At one site, a female Jewish hospital employee partially translated four interviews with Hebrew speakers who did not speak fluent English. One Syrian interview at each site was fully translated by an Arabic social worker of the respective hospital. Two translators (one for HCPs and one for a single Syrian interview) signed a confidentiality agreement in which they agreed to cooperate with researchers and maintain complete privacy of participants’ personal information; one translator of a Syrian interview was forbidden from signing by a supervisor, but agreed to maintain confidentiality regardless. Finally, one Syrian interview was conducted with a participant who communicated using broken English.

Informants

In addition to recording daily observations, Young conducted in-depth, semi-structured interviews with 20 Israeli HCPs and three Syrian fathers of child patients. Criterion for participation was to be HCP who worked in the hospitals and had interacted with Syrian patients, as well as family members of Syrian patients receiving healthcare in either hospital. To include participants from all shift rotations, Young visited hospital departments during various times of day to explain the study. Participants were recruited for interviews via face-to-face interaction and using snow-ball sampling patterns (Patton, 2002).

Table 1 presents the demographic characteristics of the HCPs who were interviewed. Healthcare providers’ ages ranged from 20 to 66 years, with 11 male and nine female participants. Participants’ self-described religion is presented along with their described religiosity. Participants were categorized as “secular,” or “non-secular” depending on how they explained their religious practice. Several ($n = 6$) participants used the word “secular” to describe themselves, explaining they were non-believers and/or non-observers of a religion. Others ($n = 13$) either described themselves as religious or explained their practices and/or beliefs associated with their religion. These self-descriptions were essential for this study, in which religiosity is complex and tied to many other demographic characteristics, yet still relevant,

Table 1. Participant Demographics.

Syrian Caregivers (<i>n</i> = 3)				
Relationship to Patient (<i>n</i>)	Gender (<i>n</i>)		Age	
Father (3)	Male (3)		25–54	
Healthcare Providers (<i>n</i> = 20)				
Occupation (<i>n</i>)	Gender (<i>n</i>)	Age	Religion (<i>n</i>)	Religiosity (<i>n</i>)
Physician (7)	Male (7)	42–66	Jewish (7)	Secular (2) Non-secular (2)
Nurse (6)	Male (2)	35–60	Jewish (4)	Secular (4)
	Female (4)		Muslim (2)	Non-secular (2)
Social worker (2)	Male (1)	33–36	Muslim (1)	Non-secular (2)
	Female (1)		Christian (1)	
Other (5)	Male (1)	29–58	Jewish (4)	Non-secular (4)
	Female (4)		Christian (1)	Religious (1)

Note. Religion and religiosity are reported here as each participant self-identified during their interview.

due to Israel's complex demographic, political, and geographic composition.

All Syrian participants were males who self-described as Muslim, and were caring for their children who were patients in the hospitals; the fathers' ages ranged from 25 to 54. These three Syrian fathers were the only available Syrian participants who met the criteria for this study during the data collection period. Young, along with an Arabic social worker of each hospital, approached the fathers and asked whether they would like to participate in this research. Two Arabic social workers (who were also participants) were gate-keepers for speaking with Syrian family caregivers. Furthermore, these two social workers were integral to healthcare experiences of all Syrian patients treated in either hospital. They were trusted points of contact between hospital staff and Syrian patients; without their cooperation, this study would not have been possible. To begin conversations with Syrian participants, an Arabic consent letter was provided and read aloud by the social worker who also translated during interviews when necessary.

Healthcare Provider Interviews

The semi-structured interviews (*n* = 20) with HCPs were conducted in a private or semi-private setting (i.e., office or break room) in the hospitals and lasted 30 to 90 minutes. When a translator was not needed, interviews were conducted in English only. Interviews consisted of the following general themes: demographic information; care provider experience in the hospital; personal perception of conflict in Syria; balance of work ethics with personal beliefs; and life in Israel. For example, questions such as "Please tell me about any feelings you experience related to your job as a healthcare provider treating Syrian patients" were followed by more specific questions, including, "Explain if and how this conflict has influenced/changed your routine as a care provider."

Young aimed to earn trust of participants to carry out in-depth conversations regarding such sensitive topics. She opened each interview by introducing herself and explaining her interests in this research. Because this subject is politically charged, she intentionally described personal characteristics of her own life (ethnicity, religious tradition, age) to establish a pattern of respect and trust throughout conversations. She emphasized her goal to understand each participant's unique stories and personal experiences.

Syrian Caregiver Interviews

In addition to HCP interviews, Young conducted three individual, in-depth, semi-structured interviews with Syrian caregivers of Syrian child patients receiving treatment for injuries they suffered in Syria. Each interview was conducted in a private setting in the respective hospital (i.e., corner end of hallway, outdoor courtyard, and private office) and lasted 20 to 40 minutes. The interviews consisted of the following general themes: demographic information; experience in the hospital; balance of need for care with personal beliefs; life in Syria; personal effects of conflict in Syria.

Observations

For 8 weeks in 2014 and for 2 weeks in 2015, Young recorded daily observational notes in each hospital setting. Observations consisted of her thoughts, reflections, and ideas as well as recordings of setting, time, place, and context. Each day in either hospital, she sat in different areas (i.e., café, waiting rooms, emergency rooms, departmental break rooms, cafeteria, etc.) and recorded notes on the historical context, the mood, and the people. She also took notes on the political environment and how people were reacting to the news and current events.

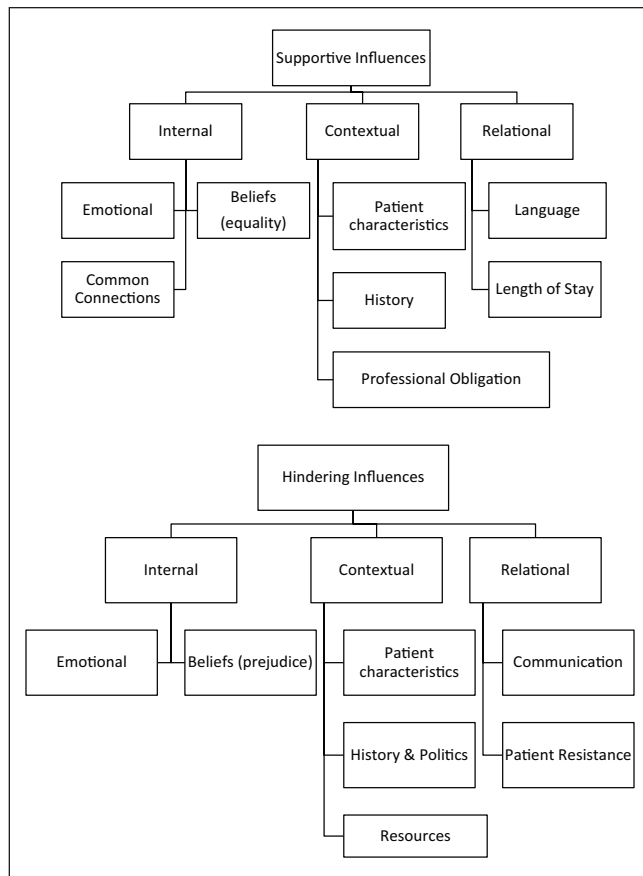


Figure 1. Theme maps showing the hierarchy of thematic analysis, including primary themes (supportive and hindering influences), secondary themes, and associated factors.

Data Analysis

Interviews and observational notes were analyzed using tenets of heuristic phenomenological methodology including five major phases: *immersion*, *incubation*, *illumination*, *explication*, and *creative synthesis* (Moustakas, 1990). The aggregate of data was organized into one chronological document including interviews and daily observations. Two researchers coded the data separately using Atlas.TI©, compared and discussed independent analyses to explicate themes and synthesize warranted assertions (Greene, 2007). Following independent analysis of healthcare provider data and Syrian caregiver data, a joint display was developed for comparative analysis. Young and Lewis analyzed the data, and all other authors contributed to the development and implementation of this research.

Findings

Findings are organized according to two primary themes: supportive and hindering influences on provision of healthcare to Syrian patients (see Figure 1). Secondary themes emerged including internal, contextual, and

relational processes participants experienced as providers or recipients of healthcare. These processes influenced HCPs when treating patients either helping them reduce their cognitive dissonance (supportive), or by making it more difficult and increasing dissonance (hindering). Because the majority of our data came from HCPs, our warranted assertions relied more heavily on their interviews. Syrian participants' interview data were integrated and presented as supplementary evidence with HCP data. To illustrate each subtheme, we present direct quotations, maintaining the integrity of participants' complex experiences.

Supportive Influences

HCPs discussed influences that helped them reduce dissonant feelings and humanize Syrian patients when providing healthcare. Within the supportive influences theme, we categorized supportive factors into subthemes of internal, contextual, and relational processes.

Internal processes. HCPs discussed internal processes including emotions, beliefs in equality, and perceived common connections that supported them as they provided healthcare to Syrian patients. These factors allowed them to reduce their dissonance and view Syrians from a humanitarian healthcare perspective.

Emotions. Sadness was the most commonly described emotion for HCPs, but they also described feeling frustration, detachment, optimism, pride, and compassion. For example, one young participant described her strong emotions about the war in Syria. She said, "I am very sad about the war, and I stopped watching the news a while ago because it was so sad for me." She was very emotional about this conversation, but she did not cry. "It is inhumane to kill people, for anyone to kill anyone."

A nurse described her colleagues' reactions to the initial arrival of Syrian patients as shocked because they were unaware of how terrible the situation in Syria had become. She said, "The staff are shocked at the poverty and lack of food, and very poor, uneducated." She wanted to bring one young boy home when she grew close to him after a few months, and told her own children what Israel was doing for Syrians and about her experience. However, the military did not allow her to bring him to her home to "show him something other than the hospital; something normal for a weekend." She and her children were very disappointed when he could not visit. A pediatric physician emotionally explained his professional journey since he began treating Syrian children and working with their families. He bowed his head, thinking hard about what he wanted to say: "It has been a professional challenge." He emphasized his compassion and emotion for the children and how purposeful he is about this work.

Belief in equality. It was extremely common for HCPs to discuss their belief in equality of human beings—especially in times of illness—a belief on which they focused when treating Syrians: “When they are stripped from their clothes and bear only wounds, healthcare crosses boundaries, religions, and cultures to treat the wounds.” A nurse explained how HCPs believed in equality for all patients. She said, everyone deserved treatment, regardless of their background. She believed the whole hospital was receptive and treated [Syrians] equally by giving them the most expensive treatments, surgeries, and equipment. She said that the doctors did not shy away from helping Syrians with all their ability, “The doctors give them the best treatment! Sometimes even if it is very expensive and needs a lot of surgeries, they do it all for them.”

Some HCPs, despite their ethnic or religious backgrounds, were more defensive about treating Syrian patients differently. One healthcare provider told Young,

What happened, happened. You are trying to get at the little details and pull things out of people but there is no difference here, you will not find a difference. We all are handling this just like we handle other patients.

On a separate occasion, an Arabic physician refused to be interviewed, telling Young he had “nothing to say” about the situation of Syrians in the hospital; they were “just like any other patient.”

Syrian participants also expressed their belief in equal treatment by Israeli HCPs for their injured sons, which helped them trust HCPs’ decisions for their children’s care. All three Syrian fathers believed their sons were receiving equal, if not better than equal, treatment as patients in Israel. Notes from one Syrian father’s interview reflect their cumulative sentiments:

[My] son received perfect treatment at the hospital. The doctors and nurses did all they could for [my] son and [I am] very happy with the treatment. The doctors and nurses were respectful of [me] and kind. [I] did not notice any difference in care for [my] son; in fact, everyone was so enchanted by [my] son and [we] get a lot of attention because of him.

Common connections. Some HCPs described how they actively constructed common connections with Syrian patients in one way or another, which allowed them to humanize and reduce potential dissonance. By adapting their framework of empathy to extend to Syrian patients, HCPs reduced dissonant feelings and lessened any potential cognitive discomfort as a result of treating their historical enemy. For example, a nurse described how he and other nurses and doctors talk about watching Arabic Syrian TV shows and how this helps them learn more about what Syrians think of Israel and about their culture. Another participant explained how she connected with Syrian patients:

I grew up with TV channels from all the surrounding Arab countries (Egypt, Saudi Arabia, Lebanon, and Syria). I loved watching the Syrian TV shows and the music by the Syrian bands and singers. I learned about how they do not like Israel from watching these shows.

A male nurse also discussed how he knows about mourning in Syrian culture and takes it upon himself to explain differences to his colleagues. He said, “Syrians don’t have family to mourn with them, so staff members often mourn with them or in a mutual location with the patient.”

Some participants described extremely personal connections with their Syrian patients who reminded them of their own family or personal struggles. One nurse was emotional when she told the story of a pregnant Syrian woman who had to deliver her premature baby. She said, “Woman to woman, I felt for her. Mother to mother.” A pediatric physician also related to one of his Syrian patients, “[One] girl reminded me of my youngest daughter, something about her, and she even looked like my daughter a bit.”

The following quote shows a unique connection one participant expressed regarding her Syrian patients:

The Torah² teaches that everyone is connected. So I try to remember this when I doubt my work and it is hard for me . . . We have a connection with the Syrians, because everyone hates us. It is a civilian war. It reminds me of what the Jews went through in the Holocaust.

In addition to feeling connected and reducing cognitive dissonance, HCPs and community members physically connected by donating items for Syrian patients. Donations included clothes, hygiene items, and toys—mostly for women and children. Designated closets or hallway corners were filled with donations for Syrian patients and their family members. Because the staff knew how little patients would have when they returned to Syria, they provided more assistance to these families. A staff member said they are “more keen to help, so Syrians don’t feel lonely, by bringing toys and clothes—especially nurses with children around the same age. We feel a kinship with the children and the mothers.”

Contextual processes. Contextual influences were factors over which participants had less cognitive control yet still helped reduce their dissonance. These secondary factors included Syrian patient characteristics, HCPs’ awareness of their own personal history as well as their patients’ history within the greater historical time frame of this project,³ and professional obligation.

Patient characteristics. Depending on the Syrian patients’ characteristics such as gender, age, and appearance, HCPs were more or less likely to humanize them, and were able to reduce potential dissonance they felt treating injured Syrians. HCPs were especially sensitive to young, injured

children whom they perceived as victims of violence in Syria. Participants described patients' characteristics and provided examples of how comfortable they felt treating some Syrian patients. In particular, all HCPs ($n = 20$) described women and children as innocent civilians who did not prompt dissonant feelings.

HCPs described their heartbreak when treating injured Syrian women and children. One nurse said, "I see women and children . . . they are innocent . . . wounded so terribly . . . They are all so helpless, miserable, and afraid of war." She perceived her patients as victims of the violent conflict in Syria, and recognized their physical injuries as well as their psychological pain of surviving such "miserable" circumstances. Another participant described similar feelings regarding women and children, saying, "Women, we just want to love. It's the men who want to fight all the time." She said the political leaders—all men—were violent and wanted to fight: "It's not the women. So, I am never uncomfortable with women or children."

At the discretion of the Israeli Defense Force (IDF), severely wounded children found alone at the Israeli-Syria border are taken to an Israeli hospital via military ambulance; as the following quote explains, they are alone in the hospital indefinitely until family members can be found and brought in:

It is more difficult when children come without any family, because you know they are suffering. Some children come with no identification at all—no name, age, or anything to help the military find their relatives in Syria.

This participant did not know what happens to Syrians when they leave the hospital; she said that the hospital staff tries to find the patients' family and decides "how to handle them." The ambiguity was one of the hardest parts for her regarding this situation. Bringing in family members from Syria to care for a child in the hospital is not a simple task, but one pediatric physician described the effect parents had on child patients' recoveries:

There was a case of a young girl here, alone, who was doing poorly until her father showed up four days later, and then she rose like a phoenix (*he motioned with his body like a bird rising from the ashes, and smiled*). After this case, the hospital explained to the military how much the parents and relatives help with recovery and success rate of the young patients. Since then, the military has continued to bring parents in, or to locate them and bring them later. Parents change the outcome of their child's recovery.

HCPs also treated teenage boys, whose involvement in the fighting was never fully understood. One Syrian father explained what happened to his 16-year-old son; initially, an IDF ambulance brought his son to an Israeli hospital due to severe injuries caused by falling from the second floor of his home when a nearby bomb exploded. Due to the extent of his

injuries, he suddenly became paralyzed after arriving to the hospital. Healthcare providers treating him described their experience with this family as "very difficult because of their emotional state; the father and son are both very fragile" (observational notes, July 9, 2014). The social worker who advocated for them said the following about the boy's father:

He was very sad, scared, angry, frustrated, and upset because he feels completely helpless. I am trying to teach the father how to comfort the boy, talk to him, care for him, and understand him. The boy's lungs are very weak, and he cannot talk very much, if at all, so I am trying to teach the father how to understand his son without words and without getting too frustrated.

History. For some HCPs and Syrians, personal and professional history supported their ability to reduce potential cognitive dissonance. For example, one participant described the personal connection she made with Syrians through her family history, "My grandmother was actually a Jewish Syrian and experienced the Holocaust—it is inside of us." By "it," she was referring to the family relationship between the Syrians and herself. Furthermore, a Syrian father's personal history included finding out about Israeli healthcare by neighbors in Syria, which lessened his fear to come to Israel, "I was not afraid because I have neighbors who have come and returned to Syria and speak well of Israel."

Others discussed their professional history as HCPs during wartimes in Israel, specifically referencing the 2006 war with Lebanon. A nurse who had experienced the attack on the hospital in 2006 during Lebanon and Israel's conflict said, "I have a lot of experience with trauma and war casualties. This time, it is actual Syrians, some civilians and some fighters, instead of Israeli civilians affected by the Syrian war." She continued to explain how this Syrian war has resulted in many close contact injuries, saying "The Syrians patients were targets for injury by opposing Syrian fighters; therefore, this is a more extreme situation with more extreme cases. No shelters for the people—they are directly hit. They have no support, no family here." In the hospital, HCPs have to be the "voice of the patient" because there is no other advocate for them. She said when Syrians wake up in intensive care unit (ICU), they are treated "like any other injured person." She said HCPs may actually be *more* compassionate towards Syrians because they were caught in such a horrible situation. Reflecting upon how she felt about the Syrian civil war, she said treating Syrian's war injuries ". . . shows how close it is. The war is here."

Current historical context played a meaningful role in the healthcare experience for both HCPs and Syrians in the hospital. At the time of data collection, a controversial conflict ensued between Israel and Gaza known as Operation Protective Edge. Young observed HCPs and community members in Israel mourning for those who died as a result of this conflict in Israel and in Gaza. Many were saddened by the deaths and injuries caused by Operation Protective Edge.

When asked to explain how the hospital environment is affected by interaction of ethnic differences, the history of Syria and Israel, and present day situation between Israel and Gaza, a physician said, “When Israel is at war, we are all Israelis. I have never sensed any glimpse of political conflict in the hospital.”

Professional obligation. A major subject discussed with HCPs was their professional role treating Syrian patients. Many believed it is not their job to judge patients but only to treat them with the best care available. A staff member simply said, “It’s my job to treat all people.” Although at times, treating Syrian patients did not align with their personal beliefs, which led to feelings of cognitive dissonance. Another participant considered it her job to treat the wounded despite her personal preference:

I worked in orthopedics with the men, and I could tell they were rebel fighters. I did not like working with them, but I knew it was my job and I had to do it. You just get a feeling, and you know something is not right.

In addition to dissonance due to personal beliefs, two male participants were obligated both to the healthcare system and to the military as reserve members of the IDF. One described how strange it felt to hold both positions, explicitly stating his personal conflict with treating Syrian people.

They are from the enemy country after all! I was a soldier in the Special Forces 25 years ago, and I was trained to *protect* Israel from Syrians. Now, I have to treat them! I am currently serving as a doctor of the tank division ready to attack Syria—my unit is actually now serving in the Golan. Now, I am treating “Syrian civilians” (*makes quotation sign with his fingers in the air*). If roles were reversed, I don’t think Syrians would treat him as a human. I believe that. I know that!

The other reserve IDF member explained how he separates his roles as a doctor and a soldier, “When I am a doctor, it is my job to make people better, no matter who it is. When I am a soldier, it is my job to kill people.” He said that he copes by letting go of the responsibility. He realizes someone else makes the decisions about treating Syrians, and he executes his job, which is to treat whomever is in front of him. It is not his decision whether to treat them, and he is glad he doesn’t have to decide.

HCPs discussed professional aspects of treating Syrian patients compared with treating Israeli patients, including working with a team of doctors across the hospital. One American Israeli dual citizen elaborated on differences between healthcare in Israel and the United States, emphasizing the team-like atmosphere of Israel’s hospital system, “My overall experience is positive, medical care is more team-like in Israel, and doctors must work together across departments to provide the best treatment for the patients.” As an orthopedic surgeon explained, war injuries are

extensive and complicated, typically requiring attention from a range of physicians in the hospital, “Because of bomb blasts, there are often multiple traumas.” Typically, he only treats patients with orthopedic issues, not neurological, neck, or ophthalmological injuries. He said, “With war-related injuries, Syrians need treatment for multiple traumas, not only orthopedic. Each department works together to ensure the patient is treated in the best manner possible.” He estimated about half of the Syrians require *only* orthopedic operations, while at least 80% have other trauma needs as well. A physician described how HCPs work together to treat patients following a professional code of ethics, “Religion has no effect on how doctors cut here,” meaning they work equally to treat patients. “After all, we all follow the Hippocratic Oath, and Jewish doctors also follow the Hebrew Oath by Rambam, which says ‘Treat everyone as if they are your son’” (Edelstein, 1943; Israeli Medical Association, n.d.).

Relational processes. In addition to internal and contextual processes, relational processes including sharing a common language and patients’ length of stay allowed HCPs and Syrians to humanize and reduce cognitive dissonance.

Language. Although it is uncommon for Israeli non-Arabs to speak Arabic, most all Arab Israelis speak both Arabic and Hebrew. Sharing Arabic language with Syrian patients allowed *some* HCPs to build trusting relationships throughout the course of treatment. Even speaking only a few words of Arabic was helpful for both HCPs and patients to humanize one another. Syrians expressed how much more they trusted doctors and nurses to whom they could communicate effectively. One nurse said, “It was easier for the Arabic-speaking nurses and doctors to communicate with Syrian families because of language.” Not only did participants speak of the *ease* of communication, but they also described how sharing language facilitated more empathy from HCP to patients. Another nurse said, “The Arabic speakers relate and have more empathy with Syrian patients because they can speak to them.” Elaborating on this point, a nurse explained the following:

When the Syrians first arrive, they are afraid at first, but the Arabs make it easier for them. It’s not just the language, it is something else, but I don’t know what . . . they feel safer to speak with us. They open up to Arabs more.

He said it was more than a language issue, because if a non-Arab person spoke Arabic, he or she would not be able to gain Syrian patients’ trust or connect with them as well as Arabs could. He said, “I don’t know what it is, but there is something more there.”

Of the 15 HCPs who did not speak Arabic before the Syrian patients began arriving for care, nine described learning Arabic to interact and provide better care, which led to

humanization of their Syrian patients. One participant explained her personal experience communicating with only a few Arabic words to her patients:

I have personally changed since one year ago. My perspective and attitude have changed because, you know, at first it was very strange for us Jewish to have the Syrians here. But now, I have even learned some Arabic words...The Arab nurses don't even understand the war in Syria and all the different sides. It is so mixed up and complicated; even Arabic speakers cannot keep up with sides or reason for the war.

Syrian participants also expressed their relief when they discovered they could communicate with Arabic-speaking Israeli HCPs. One Syrian father said, "Despite what I heard about other Syrians' experience in Israel, I was surprised so many people spoke Arabic. I wasn't sure there would be Arabic speakers or people in Israel, only Jewish. So that was a pleasant surprise." Another Syrian father was also happy to be in Israel and with his son's treatment, saying it was "excellent, better than excellent." He appreciated how his son's doctor and nurses treated them very well and with respect. They explain things to him through a social worker; he said, "They also speak a little Arabic when they can."

Length of stay. The relationship between HCPs and Syrian patients was also influenced by patients' length of stay in the hospitals. A nurse said, "After they have been here a few days, they begin talking to the Arab nurses." Another nurse said, "It takes a few days to gain trust." It took time, but some Syrian patients and HCPs developed a bond. One participant described how one of her patients whose trust developed slowly into a friendship with his healthcare team and another patient who took much longer to trust them. "After one and a half months, he had just begun to become nice. He was 50 years old." She discussed how his age might have had an effect on his slow pace of gaining trust. "He was more suspicious. For him, it was much harder to be nice, but after time, he was one of the team." He started to joke, smile, and cooperate with them when they provided care to him.

From the Syrian perspective, one father explained while he was in the hospital for 13 days, he had time to consider his family's future. He actually hoped to move to Israel after his son was released from the hospital. He said, "I have so much time to think, and I want to ask if my family can move to Israel where it is safe." He said there are constant bombs in Syria, "Syria is my home, but is a dangerous place to be. We don't want to live in fear."

Hindering Influences

In the balance of supportive and hindering factors to treating Syrian patients, we found *fewer* overall obstacles to reducing cognitive dissonance and humanizing Syrian patients. Participants discussed fewer hindrances or difficult experiences related to treating Syrian patients.

Internal processes. Sometimes, emotions and prejudicial beliefs of Syrians or of Israelis made it difficult to use cognitive strategies to reduce dissonance and humanize each other.

Emotions. Anger, fear, and hurt were the most common hindering emotions expressed by both HCPs and Syrians. A nurse described Syrian patients as always "angry and suspicious" when they first arrive and "for a few days or weeks sometimes before they begin to trust the nurses and care providers." When asked how he felt about treating Syrian patients, a physician expressed fear and prejudice, saying, "If they can do this to each other, just think what they could do to us! What kinds of people do that to each other?" A participant who worked closely with Syrian patients expressed frustration with a young patient's father who was taking advantage of the care his injured son was receiving. He said what the Syrian father was doing to try to manipulate the hospital was "disgusting" and "very wrong." He said, "I try to talk to him (*the father*) about this, but it still makes me very angry that someone is trying to take advantage of his own child's injuries."

Syrian fathers discussed emotional difficulty they experienced with the healthcare process upon their arrival to the hospital. According to a social worker at one hospital, one of the Syrian fathers was "very angry and emotional at the beginning of his arrival and stay in the hospital, but he has since calmed down some and no longer cries or is angry with people."

In another case, a 4-year-old Syrian boy was badly burned when a bomb exploded, and he was tremendously afraid after he woke up in the Israeli hospital despite the social worker's best efforts to comfort him. While working with this patient, she tried to comfort the boy with an electronic tablet she found in the nurses' station. The cartoon playing on the tablet only comforted the boy for about 5 minutes. She said tablets were either purchased or donated specifically for Syrian children by the local community. As the boy listened to the social worker talk to his uncle, he began crying and even his uncle could not understand him through his sobs. The boy would not make eye contact with anyone and was gazing off with a worried and angry look on his face. He was very upset and very confused. The social worker said the boy's father died in Syria in a car accident and the boy did not trust anyone at the hospital.

Prejudicial beliefs. Some HCPs expressed their own prejudicial beliefs of Syrians or prejudice they perceived from Syrians toward them, both of which hindered humanization and increased cognitive dissonance. Referring to Syrians, a physician said, "They are infected with a venomous hatred for Jews . . . as people, but not necessarily for Israel or Israelis." Another physician described a story in which an Israeli military veteran was captured and tortured in a Syrian hospital. He said he thinks about this story when he treats Syrian patients in his hospital and wonders, "Who can treat a

human being, even an enemy, like that? They are animals!” Although some HCPs expressed their difficulty treating Syrians due to their beliefs and past experiences, most were able to reduce dissonance over time as they developed relationships with Syrian patients.

Contextual processes. Certain contextual factors beyond HCPs’ control made reducing cognitive dissonance and humanization difficult. Factors included Syrian patients’ characteristics, current historical and political events, and resources used to treat Syrian patients.

Patient characteristics. Depending on Syrian patients’ appearance, gender, and age, HCPs discussed difficulties treating them. Perceived religiosity influenced their perception of Syrian patients. Several attributed their fear of male Syrian patients to beards because this signified their strict allegiance to the Muslim religion, which HCPs connected with disdain for Israelis. For example, when one participant worked with men aged 18 to 22 years and saw their beards, she said,

I knew they were religious and I was nervous to be around them. I had intuition they were bad people, rebels, and while I did what I had to do, it made me nervous and I was not comfortable with them.

She worked in orthopedics with Syrian men, and “could tell they were rebel fighters,” noting, “I am uncomfortable with any extremely religious person.”

In addition to adult men, some adolescent male Syrians were brought to the hospitals with war injuries. HCPs expressed feeling conflicted about these patients, wondering if they were fighters or civilian victims. When asked if she was uncomfortable treating young male Syrians, one participant said she does not ask how they were injured, “Sometimes I do get uncomfortable when young boys of 13–15 years come in. I don’t want to know what they could do in a different situation.”

History and politics. At the time of data collection (Summer 2014), Israel and Gaza engaged in what Israel referred to as Operation Protective Edge—a violent conflict that resulted in deaths on both sides. In addition to what was happening between Israel and Gaza at this time, HCPs and Syrian patients were also balancing their understanding of the historical relationship between Israel and Syria. At times, their judgments hindered their ability to humanize those from the other group. Reflecting on the current events, a participant expressed how it became difficult for her to treat Arab patients. She said after the three Israeli boys were kidnapped the violence increased, “We were all just shocked that they were dead. We were so sure they were alive.” After this event, “it became very hard for me to take care of the Arab people in the rehabilitation department.”

For some, it was difficult to reduce dissonance when treating Syrian patients due to historical tensions and past events between Israel and Syria. Referring to long-term historical tension, one physician said, “Nobody remembers history between Israel and Syria, and nobody cares.” Another physician explained his belief that Israel should treat Palestinians injured in the current conflict (Operation Protective Edge) before helping Syrians:

It is more humane to treat the Palestinians than the Syrians . . . because we have no political relationship or connection with the Syrians. They’re fighting themselves—let them do what they want. Palestinians are our neighbors; we already help them with supplies, so hospital care as well makes sense.

Resources. Use of resources was a prime cause of frustration at the hospitals. Treating Syrian patients was a costly decision from the Israeli perspective. Expenses were high due to the extent of Syrians’ war-ravaged bodies and need for multi-departmental treatments including prostheses, extensive recovery time, and providing basic necessities for patients and their families (i.e., food, facilities, beds). Human resources were also extensive as HCPs prioritized injured Syrian patients before Israeli patients according to the urgency of their injuries. A physician explained prioritizing Syrian patients:

It can be hard because Israelis come in with scheduled elective surgeries, but my resources and time are obligated to treating immediate wounds of Syrian patients. The elective surgeries in the hospital for Israelis haven’t stopped, but the Syrians have increased . . . so sometimes it is hard to find time for Syrians and Israelis because we are still obligated to our Israeli patients.

Israeli patients waited longer for scheduled services due to Syrian patients’ need for immediate, life-saving care. Resistance from HCPs was also due to lack of resources to treat both Israelis and Syrians without causing tension. One physician said he “heard people saying the Syrians should go somewhere else because they were frustrated about a longer wait for Israeli patients.” Sometimes, he overheard staff questioning why they were doing this for Syrians, especially when the hospital was crowded with them. He said, “People are only grumbling over coffee; there is no big rebellion or anything like that, just complaints.”

Because of their extensive injuries and need for multi-department care, HCPs from across the hospital made frequent, lengthy visits to Syrian patients. For example, a participant discussed the resentment from colleagues because she spends more time with Syrian patients, “They say things to me like, ‘They (*Syrians*) wouldn’t do the same for us,’ and ‘Why [do] you spend so much time with them?’”

In addition to human and material hospital costs, there were expenses for Syrians’ initial care and transportation by the IDF, Israel’s military unit. Members of the IDF not only brought Syrians to the hospitals in Israeli military ambulances

but also guarded doors to patients' rooms and escorted Syrian patients throughout the hospital when needed; members of IDF remained at the hospital as a precautionary measure at all times, day and night.

Relational processes. HCPs and Syrians experienced relational barriers to building trust including communication and patient resistance. Communication was difficult due to language differences and non-verbal cues expressed from HCPs or from Syrian patients who refused treatment.

Communication. Language barriers persisted as the primary hindrance to reducing cognitive dissonance. Although Arabic HCPs were asked to treat Syrian patients whenever possible, non-Arabic physicians, nurses, surgeons, and other providers treated Syrians as well. In fact, depending on schedules and types of procedures needed, non-Arabic speakers were sometimes the only HCPs available. A non-Arabic-speaking nurse described the difference in care when Arabic speakers are involved:

Arabic speakers help other doctors understand the whole person's trauma—emotional, cultural, and physical. This affects the healing process and changes the perception of the staff to the patient when they can understand them and have a background or context for each patient. Sharing the information makes the treatment much more personal.

HCPs explained Syrian patients did not have anyone to advocate for them in Israeli hospitals, and sometimes, Arabic staff members carried this responsibility. When asked “if he relates to them in any other way besides just Arabic language,” one participant answered with the following explanation:

Syrians want to speak to an Arabic speaker, this is more comfortable for them . . . The patients are not able or just do not share detailed stories; many are so injured they cannot speak anyway. Syrian patients are more frightened. They have no safety net like Israeli patients have. No one is here to comfort them or be their advocate.

Two Arabic social workers who participated in this research “were the vanguard of communication with all Syrians due to their role as social workers and their Arabic language and ethnicity” (Spivey & Lewis, in press). Young's observations of one social worker helping a Syrian patient and his family illustrate the frightening realization patients encounter when they wake up in Israel, where the language is unfamiliar:

She spoke to the Syrian family first without me and then I joined to listen, and so she could introduce me. The patient's name is Aden (*pseudonym*) and he is 4 years old; he was in a car accident and suffered external trauma to the head. The skin all around his face and on his head was burned. It was red and dark in many

places from scrapes and burns. Almost his entire forehead was burned and raw. He had a long cut going from the top of his head to the back, and it was fresh from the accident. He was crying almost nonstop while [the social worker] and the boy's uncle tried to comfort him, telling him he would soon be back with his family in Syria. [The social worker] told me he was crying because he woke up here and didn't know where he was and what language everyone was speaking. He was hungry but did not want to eat because he said he wanted to go home and eat with his mother.

Patient resistance. Although rare, when Syrian patients resisted care with non-verbal cues, HCPs struggled to create a trusting patient-provider relationship. They described how some patients would not allow anyone to treat them, no matter what language they spoke. Although social workers were primarily communicating with Syrian patients and families about their experiences, nurses were also conscious of Syrian patient resistance. A nurse described a terrified and resistant patient:

One Syrian man is currently here and has been here one week. He will not take the sheet off of his face all week. Over the last few days, he has begun to speak to the Arab nurses, but not showing himself. He is so scared, but we cannot talk to him or understand him.

Another nurse described how, despite efforts to help, one teenage male patient would not allow HCPs to treat him:

I remember only one patient all year who was very angry the whole time—a 15-year-old boy. He would not talk—only wanted to go home to Syria. He was so afraid; he couldn't release the fear. He asked to leave after only 3 days. He was angry and spoke very badly about Israel and the staff trying to help him.

She described this patient with sadness, not bitterness, and believed he was too young to understand. She said, “He was brainwashed. When you are older, you look at things differently. You begin to understand more and change your behavior as a result, but he was so young.”

Discussion

Our research illuminates the need to recognize and understand critical issues of supportive and hindering beliefs and behaviors surrounding healthcare to refugees. This article places qualitative data from a larger mixed-methods study into a framework of two interacting theoretical perspectives: cognitive dissonance and inhumanization.

Cognitive dissonance is a feeling one experiences when former beliefs contradict with newly formed beliefs, causing the person to use strategies to reduce an uncomfortable dissonance of two conflicting beliefs (Festinger, 1957, 1964). Healthcare providers can encounter cognitive dissonance when treating

long-term smokers with lung cancer who continue to smoke or alcoholics who continue to drink. One strategy is to minimize dissonance by focusing on beliefs that support and, thus, counteract intrusive dissonant beliefs (Festinger, 1957, 1964). Another strategy is to reduce the importance of newer, dissonant beliefs; while dissonance is still present, discomfort is reduced because the issue is considered less important (Festinger, 1957, 1964). Finally, the most dramatic cognitive strategy is to actually change one's beliefs altogether to accommodate space for their new beliefs (Festinger, 1957, 1964).

Cognitive dissonance has strong implications for daily life. The discomfort people feel, coping with this discomfort, and strategies they use to cope ultimately influence their judgments and evaluations (Festinger, 1957). Judgments lead to choices and decisions, which, in turn, lead to actions. Healthcare providers' decisions influence their actions, and their actions affect the health and well-being of patients in their care. Patients and family caregivers may also experience cognitive dissonance as they reconcile their situation in the hospital setting. Patients' and family caregivers' judgments influence actions they take as recipients of healthcare. It is vital to understand how individuals in hospital settings experience cognitive dissonance and how they strategize to cope with it.

Infrahumanization was developed from more rigid dehumanization perspectives found in social psychology (Leyens et al., 2001). Infrahumanization emphasizes how people naturally attribute certain characteristics (termed "human essence") only to those within their own group (ingroup) but do not attribute those same qualities to others (outgroup) who are considered *less* human (Haslam & Loughnan, 2014; Leyens et al., 2001, p. 407). Outgroup members receive an "infra-human essence;" meaning they lack uniquely human qualities including advanced language, reasoning, and sentiment (*sentiment* refers to secondary emotions such as nostalgia, compassion, pride, remorse; Leyens et al., 2001, p. 407). Human qualities can be denied in seemingly commonplace settings, including healthcare (Haslam & Loughnan, 2014). Infrahumanization theory challenges humanitarian aid workers, including HCPs, who may struggle to recognize or accept the human essence of those they perceive as outgroup members in their care (Haslam & Loughnan, 2014).

Interestingly, Glasford, Pratto, and Dovidio (2008) merged tenets of infrahumanization theory with cognitive dissonance by exploring ingroup dissonance as individuals' beliefs collided with actions of the group to which they ascribed or belong. Participants used strategies to reduce their dissonance by consciously dis-identifying with their ingroup as well as reinforcing their own beliefs to combat dissonant actions of their ingroup. We suggest using such strategies may eventually lead to disintegration or weakening of the larger ingroup, as individuals spontaneously or consciously form subgroups with more similar goals to reduce their dissonant experience.

Regardless of discriminant cultural values, the healthcare field values health, wellness, and life of all sick, wounded

people (Edelstein, 1943). Despite this principle value system in the healthcare philosophy, providers and patients may associate with diverse groups and viewpoints. Extreme dissimilarity can cause tension and lead to different healthcare experiences for patients and providers (Juth, Tännsjö, Hansson, & Lynöe, 2013; Walton & Kerridge, 2014). To reconcile dissonant beliefs and avoid cultural clashes in the healthcare setting, most practitioners follow a universal ethical standard of healthcare adapted from the Hippocratic Oath written by Hippocrates in the 4th century, BC (Edelstein, 1943; Israeli Medical Association, n.d.).

In the Israeli hospital setting, adopting the Hippocratic Oath can be likened to the first strategy used to cope with cognitive dissonance: Focus on established ethical tenants and beliefs that completely outweigh intruding, dissonant beliefs (Festinger, 1957, 1964). Some Jewish practitioners may also apply Rambam's doctor's prayer, which includes the phrase, "Grant me the physical and mental strength to be forever prepared to help the poor and the rich, the good and the bad, my love and my enemy," or the Oath of the Hebrew Physician, which includes, "[I] will aid the sick irrespective of whether they are converts or gentiles or citizens, whether they are ignominious or respected" (Israeli Medical Association, 2009a). Under such circumstances, values established within the Hippocratic Oath outweigh dissonant beliefs HCPs may experience, thus lessening any discomfort.

This research also reveals the infrahumanization that takes place within the patient-provider relationship in spite of historical or political strife. Since the first patient arrived in an Israeli hospital in February 2013, various media outlets have published reporters' observations, claimed facts, and told the stories of both HCPs and Syrian patients in Israeli hospitals. For example, an Israeli newspaper briefly explained the story of one young Syrian teen's treatment in Israel with her mother by her side. The article described a teenage girl treated for "serious shrapnel injuries to her left leg and stomach, after Syrian field medics amputated her right leg" (Hayom, 2013). A prosthetic leg was donated prior to her return to Syria, and her mother was quoted wishing "the Israeli people a happy new year" and peace, hoping to "meet again in a more sane Middle East" (Hayom, 2013). This statement touches on three key findings from our research. The first is the infrahumanization across Israeli/Syrian relationships during the treatment of war-related traumas. The second represents ethical standards applied across geopolitical boundaries to uphold professional oaths through the repair and replacement of entire limbs. The third is the openness of Israeli hospitals to treat Syrian patients and to encourage family members to accompany and remain with the patient prior to returning to Syria.

Further issues mentioned in news media include Syrian children born in Israel (The Associated Press, 2013; Ben, 2013; "Israeli Hospital Delivers Syrian Baby," 2013), the ethics of returning patients to the war-afflicted Syria following treatment and without knowledge of follow-up care or consistent

availability of medicine (Lubell, 2013; “Syrians Treated in Israel Return,” 2013) and Syrian patients who are treated in and return to Israel for secondary treatment (S. Eyal, personal communication, June 25, 2014). Not only do ethical medical issues exist regarding Syrians but they also extend to HCPs who have been charged by the Israeli government to treat Syrian patients despite potential personal hindrances (Eisenberg & Benbenishty, 2013; Gilbey & Spivey, 2015). Our research adds to medical ethical research literature, illuminating the voices of both HCPs and Syrian patients. Although others focused on provider stigma (see Ahsan Ullah, 2011; Burchill & Pevalin, 2014; Campbell et al., 2014; Sandhu et al., 2013), we found little to support stigmatization of Israeli HCPs.

For purposes of this article, two ingroups were considered: Israeli HCPs and Syrian patients. Many subgroups were present within the larger frame of this study divided by race, occupation, religion, and religiosity. The Israeli political decision as well as Israeli healthcare provider decision to provide healthcare to Syrians from across the border are decisions that are at once converging and separate. On one level, Israel’s political leadership accepted wounded Syrians as patients as a national humanitarian mission (Ahren, 2015). On another level, individual HCPs were asked to treat them with the best care possible within the scope of their ethical mandate as HCPs. Both levels of decision making may have caused dissonant feelings among both Israeli and Syrian individuals. In addition, Syrian patients reconciled their situation as vulnerable patients under Israeli care despite their ingroup’s beliefs that Israelis are evil and will only cause them harm.

The cognitive dissonance and inhumanization framework in this article provide a strong foundation for understanding supportive and hindering beliefs and behaviors. Cognitive dissonance, for example, was diminished by HCPs’ recognition of similarities across the two culture groups in terms of familial relationships. HCPs set aside political differences as less important than the human condition and concentrated, instead, on the needs of patients. As described by Festinger (1957, 1964), both Israeli HCPs and Syrian patients and their accompanying family member changed their beliefs to accommodate new understandings of the relationship between the HCP and the care recipient. Such a change in beliefs is similar to the dis-identification with one’s own ingroup described by Glasford et al. (2008) and the identification across groups of multiple, shared human traits. This finding is primarily contrary to other research, such as that of Kelley et al. (2014) who found multiple barriers associated with racism and prejudice. Although Israeli HCPs and Syrian refugees held dissonant feelings, most overcame those feelings through a *rehumanization* of the individuals with whom they interacted.

Limitations

Primary limitations of this study included issues of power, language differences, and a small Syrian caregiver sample.

Although we considered Young’s positionality as a religious and ethnic outsider to be a strength of this research, her demographic qualities also contributed to power-related weaknesses due to not being taken seriously, or because participants assumed she would prefer them to answer a certain way. Language limitations made conducting this research more challenging, and we depended heavily on translators to collect some interview data. Finally, our Syrian patient caregiver sample was small and homogeneous (three Syrian male fathers of child patients) due to a limited availability of participants at the hospital sites during the data collection period. We were not permitted to interview Syrian patients directly due to their vulnerable status, but doing so would have been beneficial to this research. Future research should examine direct patient-provider relationships in similar situations and include patient caregivers to provide a comprehensive representation of the healthcare process. Further studies should focus on complex ethical humanitarian issues, especially concerning the growing refugee crisis and implications for medical ethics and practice.

Conclusion

This research provides detailed insight into the relationships and healthcare process between patients, their caregivers, and HCPs. Although the longevity of Israel’s healthcare for wounded Syrians is uncertain, it is important to recognize the notable humanitarian phenomenon that has occurred since the first Syrian patient received Israeli healthcare in 2013. Healthcare providers expressed overwhelming medical humanitarian beliefs regarding their care for Syrian patients. Although it was sometimes a personal struggle to overcome and cope with the dissonant professional and personal beliefs, cognitive strategies allowed HCPs and Syrian patient caregivers to humanize each other and benefit from the process. Participants in this research were able to lay aside personal differences for the purpose of healing and saving lives, even the lives of their enemies. There is more to be learned from this research than just academic knowledge. These providers demonstrated how coming to know patients as human beings is an answer to inhumane conflict.

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1. As defined by the 1951 UN Refugee Convention, *refugees* are defined as those who are outside the country of their nationality due to persecution or fear of persecution based on

race, religion, nationality, social group, or political opinion and are unable or unwilling to return.

2. The Torah is composed of the first five books of the Old Testament, and is regarded as divine teachings from God for guidance for the Jewish people ("Torah," 2014).
3. Data were primarily collected in the summer of 2014, during which time Operation Protective Edge began. Operation Protective Edge was a violent conflict between Israel and Gaza and resulted in many Israelis' and Gazans' deaths.

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