Neurosurgical Forum

LETTERS TO THE EDITOR

Humanitarian care: a plea for the consideration of ethical foundations and secondary effects

TO THE EDITOR: We read with interest the report by Forbes⁷ (Forbes JA: Elective neurosurgical humanitarian care in a deployed setting. *Neurosurg Focus* 45(6):E8, December 2018). Dr. Forbes presents a series of procedures performed on a cohort of 49 local Afghani patients during his deployment to Afghanistan in 2014. His stated intentions are the maintenance of proficiency for his surgical team and to “win hearts and minds” amongst the local population. We are certain that his efforts were well intentioned but we have concerns regarding his foundation for the provision of care and his understanding of basic principles of humanitarian care, as well as the role of medical operations in counterinsurgency warfare.

We acknowledge and agree with the need for such care. Worldwide access to surgical care is poor. It is estimated that 5 billion people currently lack access to safe, affordable surgical and anesthetic care.⁸ An estimated 5 million essential neurosurgical cases per year are not addressed in low- and middle-income countries.⁵ Multiple organizations, including the World Federation of Neurosurgical Societies (WFNS), the Foundation for International Education in Neurological Surgery (FIENS), and the International Society for Pediatric Neurosurgery (ISPN) are currently engaged in systematic efforts to develop strategies to address these deficits. In addition there is a long history of individual neurosurgeons being engaged in these endeavors.⁴

The desire to participate in humanitarian care is fundamental to the practice of medicine and it requires the clinician to “go to an area where good care is not available, to provide services that can make a huge difference in the health and welfare of a fellow human being, to provide this service freely and without personal gain.”¹¹ There are multiple examples of humanitarian efforts by neurosurgical providers over the past several decades.^{1,11} As evidenced by the Forbes article and others,³ noncombatants have frequently been cared for at deployed military medical facilities in Iraq and Afghanistan.

Sadly, no matter how well intentioned, any medical or surgical mission has the potential to do harm. Forbes references an outstanding article regarding ethical consider-

ations in the delivery of humanitarian care. Welling et al.¹² describe the “sins” of humanitarian medicine to include “leaving a mess behind, failing to match technology to local needs and abilities, failing to have a follow-up plan, allowing politics, training, or other goals to trump service while representing the mission as ‘service,’ and doing the right thing for the wrong reason.” They characterize the mindset for a successful humanitarian mission in which the provider would “go forth with pure motives, with a well-thought-out plan of action, including host nation physicians, avoiding the types of operations that lend themselves to long-term complications, and with a teachable, humble attitude.” We are concerned that Dr. Forbes has not fully absorbed this message.

Humanitarian care cannot be provided in a vacuum. Providers must understand local religious, economic, and political culture in the region where they practice in order to avoid pitfalls that are otherwise unseen.² They must understand and interact with the local and regional healthcare system. They must define an appropriate scope of practice to maximize the potential for good patient outcomes and ensure that appropriate follow-up care is available on departure. In the absence of appropriate follow-up and audit, the surgeons who violate these rules rarely see the poor results they produce.

Forbes' talent and enthusiasm is obvious and well described by the operative details he provides through the bulk of this article. Our major concerns lie in the detail that is not included regarding critical considerations in the delivery of humanitarian care. Forbes fails to explore whether the interventions performed were appropriate to the local social, medical, and political circumstances. We are unclear regarding his interaction with the local health-care system, and he does not elaborate on his interaction with the "Afghan neurosurgical trainee" whom he only mentions in passing. His comment regarding case 3 that "for unknown reasons, treatment was not rendered" to a 25-year-old Afghani with a large intraventricular tumor and hydrocephalus is unsatisfactory and possibly implies a poor understanding of the family circumstances as well as the local surgical facilities and capabilities.

Although the Forbes paper introduces several topics of interest to the deploying military provider, we question if his manuscript addresses them in a meaningful fashion. As a result of lower combat intensity, US casualties in combat have steadily declined over the past decade. We agree that a decrease in combat casualties has cre-

ated a legitimate concern for the erosion of skills during surgical deployments.⁶ Forbes rightly highlights this as a problem, one that will require thoughtful and multifaceted solutions. Examples include physician leaders engaging in mission planning to ensure that maintaining the competencies of surgical assets are considered on equal footing with security, logistics, and overall military strategy.⁶ Shin et al.¹⁰ discuss the role of civilian-military partnerships before and after deployments to maintain proficiency in active-duty providers engaged in low-volume surgical practice. However, engaging in care exceeding local standards with limited or no engagement of the local health-care system and unsustainable patient follow-up practices for the purposes of maintenance of proficiency under the guise of “humanitarian care” cannot be condoned from any perspective.

Finally, Forbes discusses the delivery of humanitarian care as “in line with the counterinsurgency platform originally advocated by General Petraeus.” While seemingly counterintuitive, we would assert that the opposite is in fact true. Rice and Jones⁹ provide an outstanding review of the role of medical operations in counterinsurgency warfare.⁸ They state that in the setting of counterinsurgency operations, medical operations should be conducted “only if they are likely to cause the local population to become more reliant on and confident in their indigenous medical institutions, supporting the strategic counterinsurgency goal of legitimizing the native government.” Forbes lists 5 cases performed as “revisions following previous surgeries performed by outside surgeons.” One could infer a negative impact that such cases had on perceptions of the local population regarding the capability of Afghani medical facilities. Rather than establishing trust and confidence, medical missions may in fact delegitimize host-nation government and healthcare institutions, running counter to the desired military objective.

In summary, although Forbes was able to perform a series of 49 non-combat-related cases in an austere environment, his contention that the humanitarian care provided was implemented effectively or safely cannot be supported based on the information provided. We question if military objectives supporting a counterinsurgency effort were achieved. We strongly question the wisdom of applying first-world interpretations of beneficence and justice to care delivery in the third world by providers who are poorly informed about local culture, politics, and the indigenous healthcare system. Although we cannot disagree that increased surgical volume improves the proficiency of the surgical team, it undermines the beneficence of a mission that was deemed “humanitarian.” We plead for careful consideration prior to providing elective neurosurgical humanitarian care in a deployed environment.

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Disclosures

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Response

The following is a response to the letter to the editor submitted by Martin et al. In this letter, the authors question foremost “the wisdom of applying first-world interpretations of beneficence and justice to care delivery in the third world.” In the ensuing response, I will identify criticisms put forth by Martin et al. that I believe are valid.

I will clearly outline the robust ethical construct in place at the Craig Joint Theater Hospital (CJTH), which I believe has been inaccurately portrayed by Dr. Martin. I will clarify the very important issue of postoperative follow-up. I will seek to ascertain Martin et al.'s impression of access to basic neurosurgical care in Afghanistan. I will answer specific questions put forth in their letter, including those regarding the care of the patient described in case 3. Ultimately, I will ask the reader to honestly evaluate the serious implications of the philosophy espoused by Martin, Harkness, and Edwards—which would have sought to fundamentally deny access to neurosurgical care to the patients discussed in the original manuscript.

On valid criticisms: I believe Dr. Martin is correct to criticize wording used in the introduction, which was written in such a manner to highlight the potential benefits of provision of humanitarian care (HC) to military leadership. While only military leadership has the power to re-establish HC at Bagram, the sole concern of the providers who delivered care was benefit to patient and family. In failing to convey this message, I have neglected to honor the hard work of so many nurses, physicians, and medical technicians who worked tirelessly and compassionately in this pursuit.

On the robust ethical construct in place at CJTH: every operation performed at CJTH required validation at a weekly ethics panel held on Monday nights. This process is clearly referenced in the paper (page 8, paragraph 2).

The weekly multidisciplinary ethics panel was mandatory for all providers who participated in humanitarian care. In this panel, we meticulously reviewed the clinical history, findings on physical examination and available imaging, the effect of the untreated condition on quality of life, the natural history of the disorder, alternative options for treatment that might exist in the region, associated surgical risks, and anticipated benefits. In these meetings, emphasis was placed on provision of services able to provide a substantial difference in the health and well-being of a fellow human being. No surgery could be approved without consensus from the group—which included approximately 15 military providers. On many nights, we agonized for hours over the best course of action for the patients we discussed. Our perspective changed as our understanding of the capabilities of adjacent institutions in the region evolved. Dr. Martin's letter incredulously fails to acknowledge these weekly ethics panels, despite their clear reference in the original manuscript and additional written and verbal communications provided to him confirming both their crucial role in this discussion and their inaccurate representation in his response, prior to final publication of his letter. Such an omission can only be viewed as deliberate. As such, his letter falls short of an honest evaluation of patient care at CJTH.

On postoperative follow-up: It is critical to recognize the difference between data presented in the manuscript, which are inherently limited to Neurolog entries logged during the primary author's deployment, from actuarial, comprehensive follow-up provided. The manuscript clearly states that various patients required additional follow-up beyond dates reported in the *Results* section. The data available for retrospective review was limited to personal

Neurolog entries, which by definition did not include information from additional visits with antecedent deployed neurosurgical personnel (it would have been exceedingly difficult to retrospectively obtain this information, which is stored locally at Bagram Air Force Base [AFB]). As a rule, patients who underwent spinal decompression and/or peripheral nerve surgery noted to be doing well 3 months postoperatively were not required to return for additional, scheduled follow-up. For all other patients, lengthier follow-up was required. Dr. Martin's characterization of postoperative follow-up as "unsustainable" is categorically incorrect. During time spent deployed, I routinely evaluated patients receiving humanitarian care who had been operated on as many as 5 years prior to my arrival by preceding, deployed neurosurgeons. To date, patients with a history of a surgical procedure performed at CJTH are still able to gain access to the hospital and/or outpatient clinic through the CJTH portal of entry.

On Martin et al.'s impression of access to basic neurosurgical care in Afghanistan: in their letter, Martin et al. suggest that the providers at CJTH had a limited understanding of the local and regional healthcare systems. They imply that the neurosurgical care provided at CJTH could have been freely accessed elsewhere in the region. During 6 months spent at Bagram working hand in hand with Afghan physicians, we became painfully familiar with the profound barriers to medical and surgical care routinely faced by local civilians. Early in our experience, we evaluated an adolescent male with a complex brain tumor known to be benign from a previous biopsy performed in Pakistan. We worried about the capabilities of CJTH and about potential operative morbidity associated with resection. We did not fully understand the capabilities of adjacent institutions. The patient was discussed at the CJTH multidisciplinary panel, where the group recommended that the patient seek neurosurgical care outside CJTH. He was seen very soon after by a neurosurgeon in Kabul, who recommended that he return to Pakistan. Surgical care was never rendered. Six weeks later the young man herniated. His brother carried him through the Korean gate of entry that afternoon. Together, we grieved with the family. We pored over the decision we had made to turn the young man away. Martin et al. are unlikely to protest our decision to deny neurosurgical care to this patient. They would have disregarded any attempt at treatment as "outside an appropriate scope of practice" and/or "out of touch with local religious, economic, and/or political culture." However, we were left with the reality that the young man's death could have been prevented with timely and appropriate neurosurgical intervention. Analogous situations presented themselves in future encounters—as described in cases 3 and 6 in the manuscript. These patients were provided with appropriate neurosurgical care at CJTH and recovered uneventfully following surgery.

Afghanistan is one of the poorest countries in the world.¹ It has the third highest infant mortality rate in the world.⁴ The medical establishment has been decimated by a state of near-perpetual warfare that has raged on for the past 40 years.³ Afghanistan is known as one of the most dangerous places in the world to provide humanitarian aid—a designation that has severely limited the ability

On specific questions posed by Martin et al.:

- provision of services able to provide a substantial difference in patient health and well-being. In subsequent comments, they criticize procedures they perceive as outside “an appropriate scope of practice” without any consideration of effect on patient quality of life. Martin et al. irresponsibly avoid a discussion of what would have happened to these patients without treatment. The reader must honestly evaluate these comments with attention to the serious implications regarding patient care not openly discussed. Martin would have denied care to the patient in case 4, who undoubtedly would have progressed to complete paralysis without treatment. Instead, this patient regained the ability to ambulate—with reclamation of full strength in her lower extremities postoperatively. He would have denied care to the patient in case 3, who would have died unnecessarily without surgery—but instead went on to resume a normal life postoperatively. These patients are nameless and faceless to Martin, but they are patients and families we came to know well. They are patients we carefully approved for treatment after a long discussion in a peer-reviewed setting based on the substantial improvement in quality of life we felt we could provide. I openly question the decision to render broad and overreaching value assessments by authors with minimal knowledge of individual patient circumstance and an incomplete understanding of the profound ramifications associated with denial of care.

In every single patient who underwent humanitarian surgery at CJTH, approximately 15 military physician officers expressed with consensus that offering treatment was the ethically correct course of action. These physicians saw the patients before surgery, in the immediate perioperative period, and after surgery. They were painfully familiar with the profound barriers to basic neurosurgical care that these patients faced and the serious implications associated with denial of treatment. Importantly, these providers were also familiar with the excellent clinical results that could be consistently achieved with meticulous preparation—even in a setting with limited resources. The care we provided 1) was ethically sound and 2) provided a treatment that otherwise would not have been available to the patients involved. The treatments rendered 3) successfully altered the course of the disease with outcomes comparable to what would be expected in the US and other developed countries, and 4) in completing the aforementioned objectives, also helped to further the surgical education of Afghan providers.

The Craig Joint Theater Hospital has provided a stable neurosurgical presence at Bagram AFB since 2007. Inside this hospital, at this very moment, scores of highly trained military physicians and surgeons routinely spend only a fraction of their deployment cycle directly involved in patient care and/or medical education. These providers have the time and the expertise and the compassion to provide vital assistance to a population of local civilians and providers in desperate need of humanitarian aid that will not be filled in the absence of a military presence. Martin, Harkness, and Edwards argue we should do less. I argue we can and should do more, and plead that first-world interpretations of beneficence and justice be extended to care delivery in the developing world.

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