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

TO THE EDITOR: We read with interest the report by Forbes’ (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. An estimated 5 million essential neurosurgical cases per year are not addressed in low- and middle-income countries. 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 (ISPAN) 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.

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.” There are multiple examples of humanitarian efforts by neurosurgical providers over the past several decades. As evidenced by the Forbes article and others, 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 considerations in the delivery of humanitarian care. Welling et al. 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. 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 healthcare 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” 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 Jones\(^9\) provide an outstanding review of the role of medical operations in counterinsurgency warfare.\(^9\) 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 Afghan 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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References

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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.