

Academic Medicine as a Bridge to Peace: Building Arab and Israeli Cooperation

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Can you imagine Canadian, Israeli, Jordanian, and Palestinian medical students singing, volunteering, and working together to develop programs to address issues related to global pediatric emergency medicine? Such a program was first held in Toronto in 2003 and continues annually. Can you imagine Canadians, Israelis, Jordanians, and Palestinians jointly teaching and developing solutions, via video teleconference, to address behavioral neurological problems affecting elderly populations? Such an initiative began in 2006 and continues to expand today. Can you imagine senior Jordanian and Israeli ear surgeons operating together, successfully carrying out pioneering cochlear implant surgery on deaf infants, on Jordanian national television? Such a surgery was performed in Amman in December 2003. Can you imagine every newborn baby in Jordan having her or his hearing tested? Such a program began in January 2005 as a result of Canadian, Israeli, Palestinian, and Jordanian service, educational, and scientific research cooperation, becoming national health policy in Jordan in 2007. All of this and much more are the result of the Canada International Scientific Exchange Program (CISEPO) and its cooperation network of knowledge.

CISEPO is an international cooperation network of academics, researchers, educators, medical, public health and allied health professionals, and students working as a team of individuals and institutions. During the past 15 years, through ongoing professional engagement and dialogue across religious, political, and cultural borders, CISEPO has created opportunities for building cooperation and trust, identifying and sharing

knowledge, building capacity, and leadership within key academic and health care institutions across the Middle East, serving as a role model for dialogue and cooperative development in regions of conflict.¹⁻³ CISEPO believes that sharing health expertise, techniques, and knowledge can build a bridge to peace.

Some argue that successful peace-building initiatives should start only after a political resolution has been established. CISEPO teaches that a bridge to peace is not a "bridge too far." CISEPO believes in harnessing academic theory and medical relationships for three very practical purposes—to turn war into peace, to turn despair into hope, and to turn poverty into wealth.

CISEPO initiatives are guided by a bilevel model for peace-building, which integrates project-specific goals for improving health services, clinical, and population health outcomes with meta-level goals for building cross-border cooperation and knowledge exchange.² CISEPO started as a Canadian nongovernmental organization to provide continuing medical education for Israeli, Jordanian, and Palestinian physicians in the field of otolaryngology and allied health disciplines. The priority need initially identified was hereditary deafness, a significant public health issue for Arabs and Israelis alike that is 6 to 10 times more prevalent in the Middle East than in the West. This nerve deafness, a genetic condition, has a major economic, social, and health impact on infants, children, their families, and entire communities in the Middle East. To find and treat disadvantaged Arab and Israeli newborns and infants in a comprehensive program, CISEPO brokered the establishment of the Middle East Association for Managing Hearing Loss in 1998. Today, this association thrives as the first joint Arab and Israeli professional association to address hearing loss issues in the Middle East.¹⁻³ Other successful projects established by CISEPO in recent years include providing residency training for Palestinians in

Israeli hospitals, conducting cross-border dental public health research, establishing Jordanian-Egyptian-Israeli-Canadian fellowships on dive and emergency medicine, creating youth social engagement through photography, and instituting the critical study of water pipe smoking cessation.

Building on these successes, CISEPO has expanded beyond otolaryngology to include medical education, public health, nursing, and other clinical disciplines. To broaden the scope and reach of such initiatives, American CISEPO was established as a sister network to work closely with the CISEPO family of programs. American CISEPO is a registered U.S. charitable organization and has initiated an exciting portfolio of cooperative projects ranging from organizing the first Arab and Israeli genetics conference in Jordan to supporting a cross-border cardiac resuscitation training program.

The success of so many CISEPO programs proves that, despite the many challenges, academic health initiatives in conflict regions can bring health professionals together in cross-border collaboration to build mutual respect, trust, and understanding, benefiting all who are involved.

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Teaching and Learning Moments

A Lesson in Ethics

A six-year-old boy was admitted to the pediatric intensive care unit one January morning. Asleep the previous night, he had wedged his face between his mattress and the wall. Most children could have extricated themselves easily, but this boy could not. He had cerebral palsy. By the time his parents found him, he had asphyxiated and suffered massive brain damage.

I was shadowing a pediatric intensivist as part of my graduate training in bioethics when the boy was brought in. She explained to me that nothing further could be done for him and that they would only keep him on the respirator until his family could gather to say goodbye. Later, I was in the room when the boy was taken off the respirator. He stopped breathing immediately.

In the minutes that followed, a detached curiosity superseded my immediate emotional reaction. I observed the shock and grief of the boy's family and noticed how expertly the clinical team worked. A social worker, chaplain, and several pediatric hospice nurses gently explained what was happening as the boy expired, made arrangements for grief counseling, and comforted the family. The resident, her eyes wet, ran down the hall to the staff restroom so no one would see her cry. I heard her sobs.

The nurses cried as they cleaned and bathed the boy's body, preparing it for the coroner. When I approached the bed, I noticed how his face had changed. Though he had been expressionless before, now his visage was different, unlike any I had seen. In life, there is a tenor to even the most impassive face that is only noticeable in its absence. I touched his hand. It was still warm.

Driving home, I could think only of the academic significance of this event. Before I began the rotation, I had been anxious to experience the clinical reality of medical ethics. I wanted the badge of office that comes with encountering horror with nonchalance. Now, my desire had been satisfied. I had seen death and learned how a hospital team works through it. During my time on the ward, I had witnessed a tragedy. How could I not be affected by the scene of a mother and father losing their child? Yet, my immediate reaction was dominated by fascination, rather than by compassion.

As this detached perspective slowly wore off, the visceral reality of what I had seen finally hit me. I began to think about what it must have been like for that boy to die unable to move, unable to breathe. I had the terrifying image of his face sandwiched between his mattress and the wall—the mattress ribbing impressed upon his cheek, the cold plaster wall hard

against his jaw. I kept imagining his heart racing, his breath speeding. I thought of the boy's parents unable to rouse him. Suddenly, I understood my initial reaction. I had internalized an attitude, a mode of thought and behavior, that I thought was expected of me. Determined to remain professional and eager to learn from this experience, I had allowed my role as an academic observer to override my human response to the suffering of the individuals involved.

My real education in ethics began that night. I learned that empathy is precious and fleeting; it evaporates readily under the stark light of clinical fascination. Interest in what a patient embodies can easily eclipse an empathetic understanding of who he or she is. This experience taught me that bioethics demands more of one than mere clinical detachment or analytical acumen. A deep understanding of morality requires insight into the emotional experience of individuals. Without some measure of personal emotional involvement, it becomes a hollow enterprise indeed.

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