CONFLICT AND CARE: MIXED-METHODS RESEARCH OF ISRAELI HEALTHCARE PROVIDERS AND SYRIAN PATIENTS AND THEIR CAREGIVERS

by

SAVANNAH ELIZABETH SPIVEY

(Under the Direction of Denise C. Lewis)

ABSTRACT

Despite being in a state of war with Syria since 1967, Israel has provided immediate healthcare to Syrian children, civilians and fighters since early 2013. This research was conducted to understand how Israel and Syria's geopolitical and social history influences healthcare providers and Syrian patients in hospitals in northern Israel. Using a dialectic mixed-methods approach, I elaborate on the beliefs and experiences of healthcare providers who treated wounded Syrians in Israeli hospitals. Specifically, this study examined how healthcare providers balanced their medical ethical obligation to treat wounded Syrians with their personal beliefs regarding Syrians as a whole, considering the two countries' contentious history. Merging quantitative and qualitative data and applying a meta-framework of infrahumanization and cognitive dissonance, findings illuminate healthcare providers' experiences treating Syrian patients (Festinger, 1957; Haslam & Loughnan, 2014; Leyens et al., 2001). Participants experienced minimal, yet nuanced, dissonance in their patient caregiver-provider relationship regardless of their ethnic, religious, and occupational background. Most participants expressed how they reduced dissonance and recognized human qualities of each other during the

caregiving/care-receiving process. In a globalized society, where forced migration is a stigmatized phenomenon, human interaction and humanitarian involvement is often tainted by political rhetoric. The aim of this research is to represent a politically-charged case in which medico-humanitarianism was aided by human relationships and principles of basic healthcare. This research represents unique ethical and humanitarian demands relevant for healthcare workers and those with whom they interact.

INDEX WORDS: Healthcare, Israel, Syria, Refugees, Mixed-Methods, Cognitive Dissonance, Infrahumanization, Patient-Provider

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DEDICATION

I dedicate this dissertation to all individuals and families who have been forced to flee their homes due to violence, oppression, and fear. I also dedicate this work to those healthcare providers, volunteers, and general citizens of humanity whose words and actions contribute to the dissolution of barriers that separate and dehumanize us.

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This research would not have been possible without the support and cooperation of my advisor, Denise C. Lewis and my committee members, Desiree M. Seponski and Assaf Oshri. I would also like to acknowledge Dr. Richard Schuster (University of Georgia and University of Haifa) and Dr. Manfred Greene (University of Haifa) whose international perspective and professionalism made this research possible. Dr. Peter Gilbey and Dr. Arie Eisenman, Chamutal Moore, and the two social workers (names purposefully omitted) who worked closely with me at my research sites to coordinate this work. I would be remiss not to thank all who participated in this research with honesty and bravery.

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS .... #v

LIST OF TABLES .... #x

LIST OF FIGURES .... #xi

CHAPTER

1 INTRODUCTION AND LITERATURE REVIEW .... #1

Introduction .... #1

Literature Review .... #5

Philosophical Framework .... #15

Statement of Subjectivity .... #19

Research Questions .... #20

Rationale for Mixed Methods Research .... #20

Mixed Methods Research Design .... #23

Limitations .... #33

Chapter Sequence .... #34

2 THE INTERLOPING RESEARCHER: CONDUCTING MIXED-METHODS RESEARCH IN ISRAELI HOSPITALS .... #35

Abstract .... #36

Project Overview and Context: Navigating a Controversial Research Path .... #37

Research Practicalities ....#38

Research Design..#45

Methods in Action..#49

International, Controversial Research: Practical Lessons Learned..........#52

Conclusion ....#54

3 CONFLICT AND CARE: ISRAELI HEALTHCARE PROVIDERS AND SYRIAN PATIENTS AND CAREGIVERS IN ISRAEL............................#55

Abstract ....#56

Introduction..#57

Literature Review..#59

Methods..#64

Data Analysis ....#69

Findings..#71

Discussion ....#91

Conclusion ....#94

4 EFFORTS TOWARD HUMANITARIAN HEALTHCARE IN ISRAEL: HEALING THE WOUNDS OF SYRIAN PATIENTS................................#95

Abstract ....#96

Introduction..#97

Literature Review..#98

Methodology ....#102

Analysis..#109

Findings..#111

Discussion ... #122

Conclusion ... #125

5 CONCLUSION: MEDICO-HUMANITARIAN IDENTITY ... #127

Medico-Humanitarian Identity ... #127

Conclusion ... #128

REFERENCES ... #130

APPENDICES

A INTERVIEW PROTOCOL: HEALTHCARE PROVIDERS ... #139

B INTERVIEW PROTOCOL: SYRIAN REFUGEES ... #142

C SURVEY FOR HEALTHCARE PROVIDERS IN ISRAEL TREATING SYRIAN REFUGEES ... #145

D SURVEY FOR SYRIAN REFUGEE FAMILIES OR FRIENDS IN ISRAELI HOSPITALS ... #147

E INTERVIEW CONSENT LETTER ... #149

F SURVEY CONSENT LETTER ... #151

G HOSPITAL-1 ADMINISTRATION SUPPORT LETTER FOR EMPLOYEE PARTICIPATION ... #153

H SURVEY CONSENT LETTER: HEBREW ... #154

I INTERVIEW CONSENT LETTER: HEBREW ... #156

J HEALTHCARE PROVIDER SURVEY: HEBREW ... #158

K SYRIAN INTERVIEW CONSENT LETTER: ARABIC ... #161

L TRANSLATOR CONFIDENTIALITY AGREEMENT ... #163

M CODES USED IN PRELIMINARY QUALITATIVE ANALYSIS FROM ATLAS.TI© ....#164

N CODES AND CATEGORIES OF DEMOGRAPHIC VARIABLES ....#171

LIST OF TABLES

Page

Table 1.1: DATA COLLECTED AND RESPECTIVE ANALYSIS PROCEDURES...#26

Table 3.1: PROFILES OF PARTICIPANTS...#68

Table 4.1: DATA COLLECTION METHODS AND KEY TOPICS COVERED ....#105

Table 4.2: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS. ....#107

Table 4.3: MIXED FINDINGS FROM QUALITATIVE AND QUANTITATIVE INQUIRY ON MAJOR RESEARCH DOMAINS...#121

Table 4.4: BIVARIATE CORRELATIONS, MEANS, AND STANDARD DEVIATIONS ...#113

Table 4.5: STANDARDIZED PARAMETER ESTIMATES AND PERCENT OF HCP RESPONDENTS WHO AGREED WITH ITEM STATEMENTS FROM EACH FACTOR...#115

LIST OF FIGURES

Page

Figure 1.1: MAP SHOWING THE GOLAN HEIGHTS AREA BETWEEN ISRAEL AND SYRIA ....#3

Figure 1.2: VISUAL PRESENTATION OF PHILOSOPHICAL FRAMEWORK AND METHODS ....#16

Figure 1.3: GRAPHICAL REPRESENTATION OF MIXED METHODS DESIGN ....#24

Figure 2.1: MAP OF NORTHERN ISRAEL ....#39

Figure 2.2: VISUAL PRESENTATION OF PHILOSOPHICAL FRAMEWORK AND METHODS ....#41

Figure 3.1: MAP SHOWING THE GOLAN HEIGHTS AREA BETWEEN ISRAEL AND SYRIA ....#58

Figure 3.2: THEME MAPS SHOWING THE HIERARCHY OF THEMATIC ANALYSIS ....#72

Figure 3.3: DONATION CLOSET ....#76

Figure 4.1: GRAPHICAL REPRESENTATION OF PARTIALLY-MIXED CONCURRENT EQUAL STATUS MIXED METHODS DESIGN ....#103

Figure 4.2: RESEARCH QUESTIONS WITH PARADIGMATIC EMPHASIS AND METHODS. ....#104

Figure 4.3: SCREE PLOT SHOWING EIGENVALUES FOR THE THREE-FACTOR SOLUTION OF OUR EFA EXTRACTION OF DATA OBTAINED FROM OUR 10 ITEM SURVEY (N = 204).........#112

Figure 4.4: STRUCTURAL MODEL WITH THREE LATENT FACTORS AND RELATED ITEMS ....#112

Figure 4.4: STRUCTURAL MODEL WITH THREE LATENT FACTORS AND RELATED ITEMS ....#112

CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

Introduction

Sectarian conflict in the Middle East has resulted in what is commonly referred to as the Arab Spring (Joffé, 2011). Sectarian groups and opposition movements in countries such as Tunisia, Egypt, Libya, Syria, and Yemen have executed government coups throughout this historically factional region (Joffé, 2011). Joffé suggests such extreme social movements are the result of "collective manifestations of social disequilibrium," and typically begin with a "catalytic event" in order to gain stability and power (2011, p. 515). Syria, an unstable country bordered by Israel, Jordan, Iraq, Turkey and Lebanon, has experienced extreme internal sectarian violence since April 2011 (Hinnebusch, 2014). This so called Syrian Uprising has resulted in the exodus of over 4,000,000 refugees[1] who have fled to camps in neighboring countries for safety (UNHCR, 2014). Still, more than 7,500,000 are internally displaced within Syria because their homes and villages have been attacked or destroyed (UNHCR, 2014). Over half of Syria's population was either internally displaced or has fled the country since 2011 (The World Bank Group, 2016) Whether unable to escape their country due to political restrictions, travel difficulties, or fear of the risky journey, many Syrian civilians are unable to 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

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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.

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, 2014). However, on Syria's western border, the nation of Israel has been providing a unique form of humanitarian aid.

Statement of the Problem

Despite political tension caused by Israel's occupation of the Golan Heights land area between the two countries (see Figure 1.1), Israel's hospitals have quietly been providing healthcare to victims of the Syrian civil war since February 2013 ("Israel may set up hospital for Syrians," 2013; T. Sheleg, personal communication, July 29, 2015; Zarka et al., 2014). Ironically, Israel and Syria have been diplomatic enemies, 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). 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 have also fled to field hospitals along the border territory in the Golan Heights desperate for immediate care (Eisenberg & Benbenishty, 2013; Zarka et al., 2014). Considering the multifaceted history of the land and people of Israel juxtaposed with Syria's current refugee crisis and internal conflict, research is needed to illuminate issues facing all involved including Syrians and healthcare providers.

Figure 1.1: Map showing the Golan Heights area between Israel and Syria. This map also shows three primary cities where Syrian patients have been treated in Israel: Nahariya, Safed, and Tiberias (Reed, 2013).

To add to this complex situation, physicians, nurses, specialists and social workers in Israel's hospitals belong to a variety of ethnic groups, themselves, and many have experienced their own share of discrimination and conflict within Israel. Regardless of personal ethnic and religious background, Israeli healthcare providers are professionally and ethically bound to provide treatment to all wounded persons, including Syrians (Israeli Medical Association, 2009b). The wounded Syrians seeking healthcare include civilians such as women and children as well as rebel or nationalist fighters of all ages. Nevertheless, upon entering Israel, Syrians receive treatment for grave injuries inflicted as a result of the uprising in their home country (Eisenberg & Benbenishty, 2013; Zarka et al., 2014). Participants in this research included Syrian family members who accompanied severely wounded as well as Israeli healthcare providers who treated Syrian patients. This research examined the bidirectional perspective of healthcare providers who treated Syrians as well as Syrians, themselves, who were caregivers of the wounded in the hospital setting.

Significance of Study

The field of human development and family sciences has been expanding in recent years to include issues related to human rights for families around the globe (Dannefer, 2015; National Council on Family Relations, 2015, 2016). Because health and access to medical care is considered basic human right, this research has implications for researchers and policy-makers who continue to critically examine rights of families in a changing, globalized society (The United Nations, 1948; World Health Organization, 2008). With conflict in the Middle East continually shifting, refugee families and asylum seekers will continue to flee to neighboring countries, some of which may be historically discordant. This research illuminates one phase of refugees' plight around the world: seeking and receiving immediate healthcare.

Research like this is important because it introduces social, political, and historical context into the broader conversation of healthcare provision. Also, this study illuminates broader societal issues and questions surrounding providing healthcare to people considered 'enemies.' Finally, this research begs the question, "Can humanitarian efforts overcome personal biases or change beliefs?" Broader implications of this research include understanding how Israel's decision to treat Syrians influences the Middle East region as well as global humanitarian healthcare efforts. Each healthcare provider who has treated Syrian patients has a personal narrative (see Eisenberg & Benbenishty, 2013). In an attempt to present a comprehensive narrative of the situation from both the healthcare provider and Syrian perspective, I used mixed methods to collect, analyze, and interpret various data types. Further study should continually seek understanding of such complex humanitarian issues, especially concerning the growing refugee crisis around the globe and implications for medical ethics and practice.

Literature Review

Inspiring this research is the pressing humanitarian issue of healthcare treatment provided to refugees around the world. Whether due to a natural or political disaster, neighboring countries are sometimes faced with masses of injured, impoverished, and weary men, women, and children. Due to the urgency of many refugees' extreme healthcare needs, especially those from war-stricken areas, neighboring nations may offer their resources before official policies and funding can be established (UNHCR, 2014b). While not typically recorded, it is not uncommon for aiding countries to have a historically hostile relationship with those for whom they provide healthcare (see De Bruijn, 2009). However, more commonly associated with refugee healthcare are humanitarian aid agencies such as Doctors Without Borders, Jesuit Refugee Services, the United Nations High Commissioner for Refugees (UNHCR), and other similar groups.

In the case of Israel and Syria in particular, historical political, religious, and tribal disputes can be rooted in beliefs of healthcare providers in Israel (the aiding country) as well as in wounded refugees fleeing their homeland (Syria) (Eisenberg & Benbenishty, 2013). Though no known empirical research has been published on this particular situation in Israel, studies have explained certain barriers healthcare providers face when treating unfamiliar, foreign minority groups. While the Syrian patients in Israel were not *necessarily* considered 'refugees' according to the 1951 United Nations Convention on Refugees (see footnote 1), for purposes of this study I considered them people in a state of flight and certainly peril, who have been injured as a result of persecution and/or war, and who may flee Syria seeking refuge upon release from the Israeli healthcare setting. Therefore, research with and about healthcare providers treating refugee patients is not only relevant but also applicable to this study.

Research has shown that healthcare providers experience certain barriers when treating refugee patients. These barriers primarily include a lack of cultural knowledge and historical precedence, the inability to communicate effectively and privately with patients, personal prejudices held by healthcare providers, difficulty establishing trust with patients, and systematic/procedural barriers that are beyond the healthcare providers' control (Kelley, Kraft-Todd, Schapira, Kosowsky, & Riess, 2014). Overall, research has covered issues of racism and prejudice in the healthcare system, but less has focused on the relationship and process perspective of providing care, especially for wounded migrant and/or refugee patients.

In February 2013, the first patient arrived in an Israeli hospital. Since then, various media outlets have published their observations, claimed facts, and told the stories of both healthcare providers and Syrian patients ("Israel may set up hospitals for Syrians," 2013). For example, the following quote from one Israeli newspaper briefly explains the story of one young Syrian teen's treatment in Israel with her mother by her side:

> A Syrian teenager who was seriously wounded in Syria's civil war was released from Safed's Ziv Medical Center on Tuesday, after more than a month of surgery and rehabilitation. The 15-year-old girl was brought to the hospital by the Israel Defense Forces with serious shrapnel injuries to her left leg and stomach, after Syrian field medics amputated her right leg. Israeli doctors succeeded in saving her left leg, and found a donor to cover the costs of getting a prosthetic leg for her. She was released on Tuesday in good condition "I wish the Israeli people a happy new year and I hope there will be peace and we will be able to meet again in a more sane Middle East," the girl's mother said. The two will return to their homes in the Daraa region (Hayom, 2013).

This journalist mentioned several major themes of my research, including treatment of war-related traumas, repair and replacement of entire limbs through private donations, and the accompaniment of a family member from Syria prior to returning home. Included in the framework of my research are ethical issues related to providing healthcare for providers and patients considering the two countries' dynamic geopolitical relationship.

Further prominent issues coming to light in news media include Syrian children born in Israel (Ben, 2013; "Israeli hospital delivers Syrian baby," 2013; The Associated Press, 2013); the ethics of returning patients to the Syrian civil war-afflicted country 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 then return to Israel seeking follow-up procedures (Sela Eyal, personal communication, June 25, 2014). Not only do ethical medical issues exist regarding Syrians, but concerns extend to healthcare providers who have been charged by the Israeli government for whom they work with treating Syrians as their patients despite potential personal hindrances (Eisenberg & Benbenishty, 2013; Gilbey & Spivey, 2015). One Jewish Israeli nurse wrote candidly about her experience treating a Syrian patient on the eve of Eid al-Fitr (the end of Ramadan):

> The complexity of life in the Middle East has brought us together. While the distances are small, we have grown up worlds apart. Now his loneliness and the tragedy of his diagnosis have connected us. The connection is a sincere one. We care about him, and we want him to mend and heal. Our concern is professional and compassionate, and we are dedicated to his care. However, we are fond of him, too, and we worry for him, as we worry for the other Syrians (Eisenberg & Benbenishty, 2013).

This nurse's experience is unique, but the most interesting aspect of this anecdote is the candor and introspective humility with which she reflected on her complex position. My research supplements medical ethical research literature and illuminates voices of both healthcare providers and Syrians patients.

Mixed Methods Research

Although to date there has been no empirical research[2] published regarding Syrians receiving healthcare in Israel, the majority of health and medical caregiving research conducted with similar groups of vulnerable participants has been qualitative (Burchill, & Pevalin, 2014; Farley, Askew, & Kay, 2014; Maier & Straub, 2011; Reavy, Hobbs, Hereford, & Crosby, 2012). Alternatively, healthcare providers have typically been subjects of purely quantitative studies (Al Mutair, Plummer, O'Brien, & Clerehan, 2014; Breen, & McCann, 2013; Fields, 2011). Such discrepancies in methodology can be attributed to the availability and efficiency of both qualitative and quantitative data when conducted separately with populations representing disparate educational and literacy levels. As research methodologists emphasize, researchers should seek to answer a study's research question(s) and use appropriate methodologies to do so, considering characteristics of the given populations (Greene, 2007; Mayoh & Onwuegbuzie, 2015; Patton, 2002).

Mixed methods is actually a methodology in itself, yet it has rarely been emphasized as a unique methodology within related literature (Greene, 2007). One qualitative study by Higginbottom et al. (2013) used mixed methods to study refugees and their healthcare providers; however it is difficult to ascertain the extent to which methods, theory, data, and analysis were mixed it this study. Authors referred to a larger mixed methods study conducted in Canada, and separated the mixed study into several smaller studies (Higginbottom et al., 2013). They published qualitative data of female refugees' experiences with maternity services, seeking to understand experiences of refugees as well as the perspectives of healthcare providers and policy

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[2] Narrative editorials have been published on this topic (see Eisenberg & Benbenishty, 2013; Gilbey & Spivey, 2015); this research will be the first known empirical study on this topic.

makers. Unfortunately, Higginbottom and colleagues (2013) do not allude to implications of the larger mixed study, nor do they incorporate quantitative findings into their analysis or discussion.

A sequential mixed-methods study published by Smith et al. (2013) details the effectiveness of training developed by the International Rescue Committee for healthcare providers of refugees. Before and after completing the training, 106 healthcare providers in four countries completed a survey, and 40 participants were purposefully selected from the sample to elaborate on the phenomenon in an in-depth interview. Results demonstrated that while training was effective in promoting *awareness* of issues within refugee healthcare, individuals maintain their personal beliefs regarding treatment. Authors presented quantitative and qualitative results together according to their research question [i.e., findings were organized according to themes of "Attitude" (p. 5), "Respect for Patient Rights" (p. 6), and "Knowledge and Confidence" (p. 6)]. As is encouraged in mixed methods methodology, authors used both types of data to make inferences and implications, mixing at the interpretation level (Greene, 2007; Smith et al., 2013).

More broadly, overall healthcare has been prolific in mixed methods research. Cross-cultural healthcare research has incorporated mixed methods to aid in survey development and understanding of concepts related to treatment across cultures (including age cohort cultures) (Baker et al., 2010; Periyakoil, Stevens, & Kraemer, 2013; Wasti, Simkhada, Randall, Freeman, & Teijlingen, 2012). While some studies allot equal importance to both qualitative and quantitative portions of the research in the results sections, the data were typically presented separately in "Quantitative Results" and "Qualitative Results" sections of the manuscripts instead of being mixed in presentation (Baker et al., 2010; Wasti et al., 2012). Interestingly, Periyakoil et al. (2013) used both qualitative and quantitative methods with nursing staff at a long-term care facility, but only used survey data from the residents of the facility. In discussion

sections, several researchers integrated results to provide a comprehensive perspective of the data and implications (Baker et al., 2010; Periyakoil et al., 2013; Wasti et al., 2012). These studies were very different in their approach to mixing methods, but each is mixed according to the researchers' aims, questions, and hypotheses. As noted by many scholars of mixed methods, research questions are the central guide and starting point when designing a mixed methods study (Greene, 2007; Hesse-Biber, 2010; Onwuegubuzi & Leech, 2006).

Conceptual Framework

The conceptual framework for this research encompasses three primary, interacting theoretical perspectives. Cognitive dissonance, infrahumanization, and cultural dissonance theories informed this project's development, conceptualization and analysis of the data.

Cognitive dissonance. The theory of cognitive dissonance came to life in 1957 with Leon Festinger's seminal book, *A Theory of Cognitive Dissonance*, and scholars from the fields of Psychology and Sociology immediately took notice. Cognitive dissonance is a feeling one experiences when faced with a situation in which one's former belief contradicts a newly formed belief (Festinger, 1957). The contradiction in what one has believed with newly formed beliefs causes a sense of discomfort because it is difficult to mutually comprehend both beliefs. Festinger's theory emphasizes how people attempt to remove their discomfort upon experiencing two conflicting beliefs, thus employing any combination or use of three distinct but not mutually exclusive strategies. (Festinger, 1957, 1964).

According to Festinger's original theory, when an individual experiences dissonance, he or she will actively seek strategies to reduce or minimize their dissonance. Any of the three strategies Festinger offers can be employed in any order and/or combination. The first strategy is to focus on other previously held beliefs that support and thus, outweigh, the intrusive dissonant

belief (Festinger, 1957, 1964). Another suggested strategy is to reduce the importance of the newer, dissonant belief, which might imply that while the dissonance is still present, the discomfort is reduced because it becomes less of an important issue (Festinger, 1957, 1964). Finally, the more extreme cognitive strategy is to actually change his or her beliefs altogether in order to accommodate space for the new belief (Festinger, 1957, 1964).

Cognitive dissonance has strong implications for daily life. The discomfort people feel, the process of dealing with this discomfort, and the strategy or strategies they choose to help them deal with their discomfort ultimately influences their judgments and evaluations (Festinger, 1957). Judgments lead to choices and decisions, which, in turn, lead to actions. It is vital to understand how individuals in the hospital setting experience cognitive dissonance and how they strategize to cope with it. Healthcare providers' decisions lead to actions they take, which impact the health and well-being of patients in their care. Alternatively, cognitive dissonance plays a role for patients and their families as they reconcile their situation and status in the hospital setting. The judgments of patients and their familial caregivers influence decisions they make as they receive care; the interaction of their judgments and decisions plays a role in actions they take as recipients of healthcare.

Infrahumanization. Infrahumanization is a theory developed from social psychology and more rigid dehumanization perspectives (Leyens et al., 2001). Leyens and colleagues (2001) posited the idea of infrahumanization as a less abrupt form of dehumanization, emphasizing how people of an ingroup reserve and naturally attribute certain qualities and characteristics (termed "human essence") for their own group and do not attribute those qualities to others, known as the outgroup (Leyens et al., 2001, p. 407). Upon attributing human essence to one's own ingroup, the outgroup – by consequence - does not receive the same status. Rather, members of the

outgroup are attributed with an "infra-human essence," and they lack pure human essence which consists of uniquely human qualities including advanced language, reasoning, and sentiment (*sentiment* includes higher level, secondary emotions such as nostalgia, compassion, pride, remorse) (Leyens et al., 2001, p. 407).

Haslam and Loughnan (2014) compare infrahumanization with other dehumanization theories, and they conclude that infrahumanization uniquely emphasizes the reservation of human essence to one's own ingroup. Therefore, rather than consciously rejecting the outgroup, outgroup members are simply seen as *less* human because they lack advanced, uniquely human qualities, including certain "refined emotions" (Haslam & Loughnan, 2014, p. 402). Implications of infrahumanization are considered on a spectrum of cognition, spanning from a "lack of recognition of the outgroup's humanity" to an "active reluctance to accept [the outgroup's humanity]" (Haslam & Loughnan, 2014, p. 402). Regardless, authors note that human qualities are denied in many indirect and seemingly commonplace ways, including in the healthcare setting (Haslam & Loughnan, 2014).

Interestingly, Glasford, Pratto, and Dovidio (2008) merged tenants of infrahumanization theory with cognitive dissonance by exploring within-group, or 'ingroup' dissonance as individuals' personal beliefs or values collide with the actions of the group to which they ascribe or belong (p.1057). In their study, participants were asked questions regarding U.S. versus Australian policy on providing healthcare to uninsured people in either country. They countered this response with questions regarding patriotism and humanitarian values. They found that participants employed strategies to reduce their dissonance by consciously de-identifying with their 'ingroup' as well as adhering to their own personal beliefs with value-laden activism employed as a way to combat the dissonant ingroup actions. Authors suggest that both strategies

may lead to eventual disintegration or weakening of the large ingroup, as individuals may spontaneously or consciously form subgroups with more similar goals in order to reduce their dissonant experience.

For purposes of my research, two primary ingroups were analyzed: Israeli healthcare providers and Syrian patients. Many subgroups were present within the larger frame of this study with divisions based on 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 hand, Israel's political leadership accepted some Syrians as patients on a humanitarian mission. On another hand, individual healthcare providers were asked to treat them with the best care possible within the scope of their ethical mandate as healthcare providers (Israeli Medical Association, 2009a, 2009b). Both levels of decision-making may have caused dissonant feelings among individuals from either ingroup. Finally, Syrian patients represent an ingroup who must reconcile their situation as vulnerable patients receiving Israeli care despite their ingroup's beliefs that Israelis are evil and will only cause them harm. This study analyzed factors associated with how healthcare providers employed strategies to reduce dissonance when treating Syrian patients.

Cultural dissonance. Cultural dissonance is similar to cognitive dissonance in many ways. When aspects of one culture collide with aspects of another culture, the person experiencing this collision of cultures must negotiate and reconcile cultural beliefs, which may involve engaging with difference – if not disagreement – in values, mores, and systems of understanding (Lewis, 2005). Like cognitive dissonance, cultural dissonance is an uncomfortable experience. In a hospital setting, for example, individuals from a plethora of backgrounds, beliefs, and value systems come together to treat patients (see Xu & Flaskerud, 2007).

Regardless of discriminant cultural values, the healthcare field values health, wellness, and lives 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. In extreme cases, such dissimilarity can cause tension and lead to different healthcare experiences for patients and providers (Card, 2007; Juth, Tannsjo, Hansson, & Lynoe, 2013). In order to reconcile culturally dissonant beliefs and avoid cultural clashes in the healthcare setting, most practitioners hold to a universal ethical standard of healthcare adapted from the ancient Hippocratic Oath written by Hippocrates in the fourth century, BC (Edelstein, 1943). Applied to the hospital setting, adopting and applying this Oath can be likened to the first strategy used to cope with cognitive dissonance which is to focus on former beliefs that completely outweigh the intruding, dissonant belief. (Festinger, 1957, 1964). The set of values established within the Hippocratic Oath outweigh dissonant beliefs healthcare providers may experience, thus lessening any discomfort.

Merging Theories: Medico-Humanitarian Identity

When these theories are merged and applied to this study, we propose the ways in which healthcare providers employed and developed a *medico-humanitarian* identity. In some cases, healthcare providers described coping with and employing strategies to reduce cognitive dissonance they faced as they treated wounded Syrian patients. In other cases, healthcare providers described applying their previously established moral and ethical beliefs to their professional setting as they treated Syrian patients. In all cases, healthcare providers' narratives explain how they attributed human qualities to Syrian patients and their caregivers in order to reduce any feelings of dissonance related to their cultural, religious, and political differences.

Philosophical Framework

In mixed methods research, a philosophical framework is often needed to guide and explain the research from several hierarchical – yet interacting – levels of understanding (Greene, 2007). Because mixed methods research promotes the concept of engaging paradigms which are traditionally engaged separately, philosophical frameworks are necessary to guide the researcher's understanding of the project overall (Greene, 2007; Mayoh & Onwuegbuzie, 2015). Figure 1.2 visually presents the philosophical framework for my dissertation research.

I used a dialectic paradigmatic stance to frame this study. A dialectic stance is a mental model that allows multiple philosophical frameworks to interact purposefully and dialogically (Greene & Hall, 2010). Furthermore, this stance allows different perspectives seen through different methods (i.e., qualitative and quantitative) to mingle together for the purpose of "engaging with difference," which is the guiding assumption of my mixed methods research (Greene, 2007, p. 26). A dialectic framework also encourages researchers to utilize a variety of methods to collect a diverse and textured aggregate of information. Under this framework, the researcher considers context, theory, and philosophical stance to make practical and ethical decisions throughout the research (Greene, 2007). With respect to ontology of qualitative and quantitative traditions**,** the dialectic mental model respects the realities of individual paradigms and does not *require* researchers to choose one over another. Rather, dialecticism emphasizes maintenance of paradigmatic principles while allowing them to engage with one another (Greene & Hall, 2010).

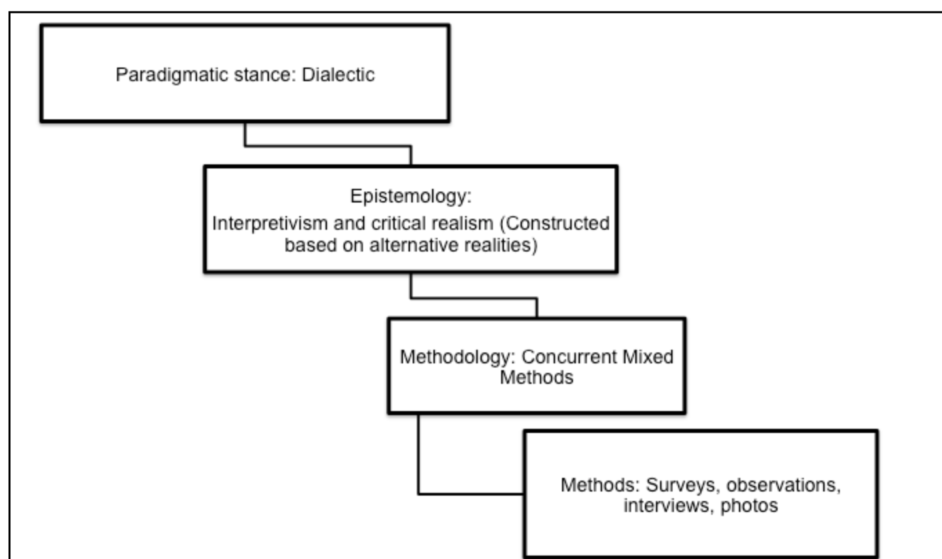


Figure 1.2. Visual presentation of philosophical framework and methods. This figure shows the relationship of various levels of the philosophical framework guiding this study.

Axiology

I mixed methods in a qualitatively-driven, multi-dimensional way, so to engage all qualities of the data and inform eventual inferences and meta-inferences (Mason, 2006). Employing a dialectic framework, I allowed my qualitative and quantitative data to interact with one another, which allowed space for both divergent and complementary inferences (Greene & Hall, 2010; Mayoh & Onwuegbuzie, 2015). In this way, I holistically represented how healthcare is experienced by providers and patients' caregivers. The dialectic philosophical stance shines brightest when the time comes to compile inferences and meta-inferences gathered from the mixed analysis and interpretation of the research process (Greene & Hall, 2010).

In true dialogic fashion, I mixed and linked inferences gathered from one set of data with those gathered from another set (Mason, 2006). I engaged in a back-and-forth conversation with co-researchers, with myself, and with the data in an earnest attempt to listen fully to the story and

the meta-messages emerging from the data. I do not naively use the word "emerge," here, as I am aware of my own subjectivity within this research and the implications of my position. However, I bridled my own knowledge and judgments as I sought to understand the phenomenon at hand (Dahlberg, 2006; Vagle, 2009, 2014). Bridling is a reflexive phenomenological understanding of the researcher's experience and intentionality (Dahlberg, 2006; Vagle, 2009, 2014). Bridling is unique from *bracketing* one's self from her research because the researcher recognizes her reflexivity and interaction with the research as meaningful rather than assuming objectivity outside of the research (Dahlberg, 2006).

Greene and Hall wrote, "Dialectic consequentiality is an easing of the tensions, the violence, and the hatred that divide different peoples, one from another" (2010, p. 140); I cannot conceive of any situation more appropriate for applying this stance than Israeli healthcare providers treating Syrian patients in Israeli hospitals in the summer of 2014. Thus, I confidently applied dialectic inquiry as the framework and lens through which to conduct my research.

Epistemology

I have explained mid-level theories guiding this study (cognitive dissonance, humanization, and cultural dissonance). In addition to these concepts, higher-level theoretical frameworks guided me through this research process, specifically interpretivism and critical realism.

Interpretivism. Interpretivism values pluralism and understanding within research (Greene, 1994; Hesse-Biber, 2010). Differing perspectives and contrary conclusions are welcomed, and an interpretivist epistemology challenges the need for consistent inferences upon analysis of one's data. Recognition and respect for diverse perspectives among researchers and participants is a key feature of interpretive research (Greene, 1994; Hesse-Biber, 2010). This

point is salient when applied to my data collection process as an outsider both in terms of language, religion, nationality, and ethnicity (see Chapter 2 for a manuscript explicating this introspective process). Interpretivism embraces tension and "aims to understand how individuals make meaning of their social world," which was a goal of this research and is integrated within the research questions (Hesse-Biber, 2010, p. 104). An interpretive stance was preferable for this study due to the many cultural and language differences between the participants and me.

Critical Realism. Critical realism also informed my research. This type of realism encourages "responsible rationality," and rejects the idea of true and objective reality, but acknowledges layered domains of individual realities and how they interact with one another (Maxwell & Mittapalli, 2010; Roberts, 2014, p. 1). Roberts wrote that for qualitatively-driven research, such as this mixed project, critical realists can claim "qualified objectivity" within the research topic in order to pragmatically explain perspectives and assumptions, and to provide a rationale context through which to understand the question(s) (Roberts, 2014, p. 2). While not the original intention of critical realist philosophy, some researchers have been inspired by critical realism to develop action-oriented studies (see Houston, 2010; Wilson & McCormack, 2006). Causality is considered pragmatic in nature, and determined through qualitatively-driven examinations of social phenomena and subsequent unpredictable interactions among participants within a context (Roberts, 2014).

Importantly, the researcher's relationship within the research and alongside the participants is an essential element of consideration and design of a critical study (Maxwell & Mittapalli, 2010). Critical realism epistemology requires extreme, constant reflexivity from the researcher(s) engaged in the project with the goal to "capture some of the unique social relations evident in the context at hand" (Roberts, 2014, p. 2). Finally, essential in this perspective is

recognizing that all explanations and inferences drawn from data are grounded in the research context (Maxwell & Mittapalli, 2010). For purposes of my study, the context not only included Israeli hospitals, but I considered international context as refugees continue to cross borders around the Middle East fleeing persecution.

Statement of Subjectivity

As essential as theoretical guidance is for research of any nature, flavor, or color, the researcher is ultimately the human being who conceives, connects, and infers from data and experience. Where a researcher situates herself on relevant axes can determine not only the questions (s)he asks, but subjectivity also carries implications for the inferences (s)he will make from the data collected. In my research presented here, I perceived my subjectivity as equally a part of my philosophical framework as my paradigm, epistemology, and methodology.

It is also vital to stress how I conceptualized the influence of my very presence in Israel on my research. I viewed my presence as relevant to aid in my understanding of people who enter a new place seeking something. Like Syrians entering Israel seeking healthcare, I also encountered and interacted with Israelis from diverse backgrounds, all the while asking them to help me. I asked for help with my research, but I also needed help navigating, translating, and even finding food to eat. Like both Syrians and Israeli participants of this research, I found myself confronted by difficult ethical situations such as knowing whom to trust with information I garnered by talking with healthcare providers, administrators, and Syrian patients and family members.

My choice to do research abroad as a foreign person in a strange place was a purposeful attempt to allow myself a sliver of a refugee's perspective. It is likely that I will never be a refugee person, myself, and I recognize this limitation in my work. However, I argue my

experience as an outsider doing this research, trying with utmost sincerity to understand their experiences from the perspective of one who is considered privileged, educated, and powerful, is an essential contribution to academic literature and policy. Those with power in our global society are often *also* those with whom my perspective resonates. People like me, who are not refugees and have not experienced similar struggles, are the politicians, researchers, and lobbyists of our world. Whether we like to face this fact or not is irrelevant to the reality that certain privileges and voices are heard more clearly than others. The power behind my voice is relative to the setting in which I speak, and through my research I hope to amplify those whose voices are mute, soft, or ignored.

Research Questions

The overarching research question for this study was, "How do Israeli healthcare providers and Syrians in the hospitals experience the healthcare process?" This question accounts for qualitative and quantitative data from both Israeli healthcare providers and Syrian caregivers. In addition to the primary research question are one quantitative and one qualitative subquestion (Tashakkori, & Creswell, 2007). Each addressed a specific aspect of the project and aided in answering the overarching question. The quantitative subquestion is, "How can HCPs experiences treating Syrian patients be categorized and understood?" The qualitative subquestion was, "How do HCPs explain their experiences treating Syrian patients considering their personal beliefs?"

Rationale for Mixed Methods Research

Definition of Mixed Methods

Mixed methods research is defined as a methodology that embraces multiple paradigms for the purpose of rich and engaging research (Greene, 2007; Mason, 2006). Both qualitative and

quantitative methods are used to inform the research questions, and inferences drawn from the research can be either divergent or convergent, sometimes even held in what Mason calls "creative tension" (Greene, 2007; Mason, 2006, p. 9). Overall, mixed methods research strives for a more complete understanding of the research topic by involving "multiple ways of knowing" (Greene, 2007, p. 13). This definition is particularly fitting for my study because of the complexity situated within multiple perspectives and understandings of one central phenomenon.

Suitability of Mixed Methods Research

As noted by Greene (2007), a research design should always be dictated by research questions(s). A mixed methods approach was most appropriate to use to answer my research questions due to the socially complex nature of this project. First, the political environment surrounding the research project contextually, philosophically, and historically warranted special consideration of how I could attain the most comprehensive data to answer my questions and "develop a better understanding" (Greene, 2007, p. 98). I considered the potential for social desirability participants might experience when answering my interview questions. Collecting qualitative data was essential as well for the same reason. The use of anonymous survey data allowed me to collect data without my direct presence impeding on the process. I also considered my subjectivity as an essential reason for using a mixed approach. Healthcare providers and patients in the hospitals were curious about my presence and my reason for asking such personal questions. Regardless of the method, this study warranted using multiple, mixed methods due to the risk of social desirability influencing data collected from both quantitative and qualitative methods.

Mixed Methods Purpose

It was important to allow the different types of data to complement each other by providing clarification, elaboration, and sometimes illustration of complex social ideas or issues (Greene, 2007; Mason, 2006). Thus, I used mixed methods for the purpose complementarity, defined by Greene as seeking comprehensive understanding of one phenomenon by including data that address different aspects of that phenomenon (Greene, Caracelli & Graham, 1989; Greene, 2007). The goal of complementarity is elaboration – not necessarily convergence – of data.

The phenomenon of interest was cognitive dissonance and humanization experienced during the healthcare provision process between Israeli healthcare providers and Syrians in the hospital either being treated or caring for patients. Quantitative data were collected to address specific opinions related to the phenomenon of interest. For example, participants answered questions regarding their feelings toward their citizenship, job duties, and ethical obligations using a Likert scale (see Appendices C and J). I also collected qualitative data through ethnographic methods (in-depth interviews and observations) (Bernard, 2006; Glesne, 2010; Patton, 2002). Qualitative data delved deeper into participants' personal experiences, stories, and beliefs related to the larger phenomenon being studied. Healthcare provider interview questions focused on how participants balanced their personal beliefs with professional obligations, feelings about living in Israel, and living next to a country in the midst of a civil war (see Appendix A). When using a complementary purpose, the different types of data I collected "elaborated, enhanced, deepened, and broadened" upon each other to form meta-inferences and interpretations (Greene, 2007, p. 101).

Mixed Methods Research Design

I used a partially mixed concurrent equal status design, wherein qualitative and quantitative data were collected simultaneously (Leech & Onwuegbuzie, 2009). The data collection process was purely parallel because the data were collected separately and at the same time (Natasi, Hitchcock, & Brown, 2010). Throughout analysis, I used crossover tracks analysis (depicted in Figure 1.3 with arrows) to allow the data to dialogue with each other throughout the analysis and interpretation stages (Greene, Benjamin, & Goodyear, 2001). Preliminary results from each set of data were recorded separately, but throughout the full analysis of each set I allowed the data to interact and inform each other by using joint displays (Lee & Greene, 2007). Joint displays are used in mixed methods research to arrange qualitative and quantitative data in the same visual presentation, usually a matrix, in order to apply the chosen analytic framework to all included data (Lee & Greene, 2007). In this study, mixing was integrated and occurred throughout analysis and interpretation (Greene, 2007). After all data were organized and analyzed in an integrated fashion, I compared and contrasted the overall interpretations to develop meta-inferences and overall interpretations (Greene et al., 2001).

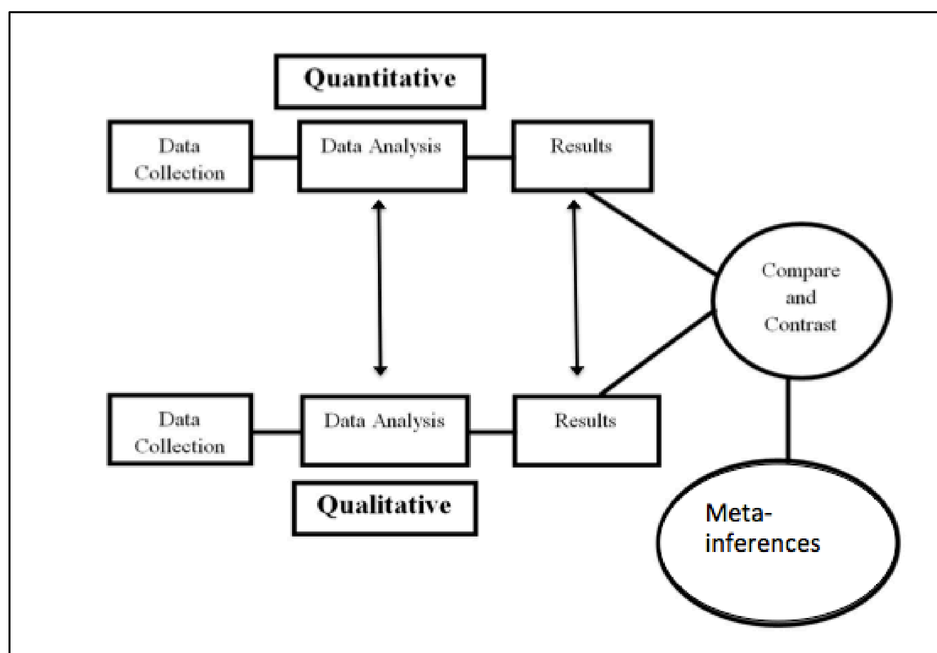


Figure 1.3. Graphical representation of mixed methods design. This figure demonstrates the design of steps taken within this research.

Site Selection

All primary data were collected in two hospitals in Israel in June, July, and August of 2014. Additionally, follow up observational data was gathered in July 2015 in order to elaborate on how changes involved in the logistical situation in Israeli hospitals with Syrian patients. The University of Georgia Internal Review Board (IRB), the Helsinki committee (equivalent of IRB in Israeli hospitals), and hospitals' administrative staffs granted access to the hospitals. Both sites were located in the north of Israel, which is the most demographically diverse part of the country. Importantly, of the four Israeli hospitals treating Syrian patients at the time, these two were the largest and primary sites of care for Syrians arriving to Israel for treatment.

Sampling Strategies

To recruit participants, I used snowball sampling procedures (Patton, 2002). I began by building relationships with employees in various departments during early visits to the hospitals. I explained my study to potential participants by visiting hospital departments at various times of day and speaking with employees. Sometimes an employee who was already familiar with the study accompanied me for translation and clarification. With each visit and explanation, I presented a letter of permission to collect data from hospital administration and the Helsinki committee. Participants included physicians, nurses, national service officers, nutrition specialists, medical student interns, social workers, occupational therapists, psychiatrists, and anyone else who qualified by treating a Syrian patient at some point since they began arriving to the hospital. Participants were recruited for interviews via my face-to-face interaction and using snowball sampling (Patton, 2002). I distributed surveys and I conducted face-to-face interviews at both sites. While it is possible that participants I interviewed also completed a survey, it was not a requirement or an expectation, and the interviews were conducted separately from the surveys.

Methods

Methods used for this study were inclusive of multiple participant groups. I used a total of six different methods throughout this research including two different surveys, two different interview protocols, photography, and observations. Table 1.1 presents the methods by showing the data I collected, the amount of data collected shown in parentheses, and the analyses conducted for each set of data. All data collection instruments were translated into respective Hebrew and Arabic languages. For the purpose of transparency, I have included all documents (English, Hebrew, Arabic) in this dissertation.

Table 1.1
Data Collected and Respective Analysis Procedures

Data Information	Observations	Healthcare Providers		Syrian Patient Caregivers
Data Collected	Notes and Photos	Interviews (20)	Surveys (204)	Interviews (3)
Analysis	Open coding and thematic qualitative analysis of notes/photos	1. Data Cleaning 2. Data Reduction (Coding) 3. Qualitative: Thematic Analysis 4. Quantitative: a. Exploratory Factor Analysis b. Confirmatory Factor Analysis 5. Comparison/Contrast of Data 6. Inferences		1. Data Cleaning 2. Data Reduction (Coding) 3. Qualitative: Thematic Analysis 4. Comparison/Contrast of Data 5. Inferences

Healthcare provider survey. Prior to leaving for Israel, my research team developed a two-page survey for healthcare providers (including staff, nurses and physicians). Surveys were translated into Hebrew and Arabic as well as provided in English. Translation of healthcare provider surveys into Hebrew was conducted by one native Hebrew speaker who, at the time, was a PhD candidate studying Public Health at Haifa University. Healthcare provider surveys were also translated into Arabic by two undergraduate native Arabic speakers from Lebanon who were students at the University of Georgia studying Human Development and Family Science and Nutrition and Dietetics. The Arabic surveys were not actually used following hospital administrative preferences; all healthcare providers completed Hebrew language surveys.

Upon data collection at the hospital site, I explained the study to head nurses or other available staff throughout the hospitals, and they informed their departmental staff and made surveys available for them to complete anonymously. Typically, blank surveys were left on departmental main desks and in break rooms. Surveys were only provided in departments where Syrian patients had been treated. Surveys were anonymously completed and consent letters were

attached to each survey (see Appendices C, F, H, & J). Participants were not asked to sign consent forms; rather, I purposefully used anonymous consent letters as a way of being culturally responsive to their needs and in order to protect their identity and sense of security. Healthcare providers completed a total of 204 surveys.

Syrian caregiver survey. My research team developed a separate two-page, anonymous survey intended for caregivers of injured Syrian patients in each hospital. Two Lebanese college students at the University of Georgia translated this survey into Arabic and checked the other's translation. In Israel, hospital employees aided me in recruiting Syrian participants through snowball sampling procedures. Upon meeting each Syrian participant, I introduced myself and asked participants to complete the short survey, which was provided to them translated into Arabic and read by a social worker who signed a translator confidentiality statement (Appendix L). Although two Syrian caregivers completed the survey, I chose not to use their surveys as data for analysis due to the small sample and potential misunderstanding of the survey items.

Healthcare provider interview. In addition to the anonymous quantitative survey, I conducted 20 individual, in-depth, semi-structured interviews with healthcare providers who treated Syrian patients. Each interview was conducted in a private (office) or semi-private setting (i.e., break room or shared office) in the hospitals, and each interview lasted between 30 and 90 minutes. A hospital employee translated when the participant did not speak English. Each translator signed a confidentiality agreement prior to the interview (see Appendix L). The 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. Interviews provided participants with a way to express their

perspective and explain their role as a healthcare provider to Syrian patients in their respective Israeli hospital.

Syrian caregiver interview. In addition, I conducted three individual, in-depth, semi-structured interviews with Syrian caregivers of Syrian patients receiving treatment for injuries obtained resulting from the conflict in Syria. Participants agreed to a consent letter, which did not require their signature. This was a culturally responsive choice of the research team due to the vulnerable nature of the Syrians in the hospital. We did not want to record any potentially identifiable data from participants. Each interview was conducted in a private setting within the respective hospital, and each interview lasted between 20 – 40 minutes. For two of the three interviews, two different hospital social workers translated for participants who did not speak English. Translators signed the confidentiality agreement prior to each interview (see Appendix L). I conducted the third interview alone with a participant who spoke using broken English. 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. Interviews provided participants with a way to express their perspective and explain their experience as a Syrian person in Israel.

Participant observation. I collected observational notes throughout the entire duration of the research project in each hospital setting, including during my follow-up trip in July 2015 (Patton, 2002). I recorded notes each day for seven weeks. Notes consisted of my own thoughts, reflections, and ideas as well as detailed observational recordings of setting, time, place, and context. Each day I was in the hospital, I sat in different areas (i.e., café, waiting rooms, emergency rooms, departmental break rooms, cafeteria, etc.) and recorded notes on the context,

the mood, and the people. I also took notes on the political environment and how people were reacting to the news and current events.

Photography. During many days in Israel and some days in the hospital, I wore an automatic camera on my shirt or backpack called a Narrative Clip and sold by a company called Narrative©. This small camera automatically took 5 megapixel photos every 30 seconds, and I downloaded all photos to my computer each night. Photos were not intentionally taken of healthcare providers' or patients' faces, and photos with any hint of someone's face were promptly deleted. Thus, photos were taken randomly to capture true, candid moments throughout my time in Israel. I incorporated these photos into my analysis due to their contextual nature regarding hospital settings as well as the overall ethnographic experience of life in Israel (Glesne, 2010). Photos are considered observational data to accompany my daily notes. Approximately 23 photographs were included for analysis (see Appendix O).

Data Management

I entered qualitative and quantitative data throughout the data collection periods in 2014 and 2015. Each day, I entered quantitative survey data using password-protected technology on my personal computer, which was locked in my dorm room at the University of Haifa. Likewise, at the end of each day, I typed qualitative observation and interview notes according to written notes taken throughout the day onto the same computer. No identification was linked to participants who completed the surveys; they were completely anonymous. Interviews were only linked to participants in my memory due to their face-to-face nature, but names or other primary forms of identification that may have been noted during the interviews have been deleted. Photos were taken to record details of the hospital setting; importantly, recognizable shots of people were not included in photographs related to this project.

Data protection. Since I returned to the U.S., three secondary researchers have also had access to the data to aid with in-depth analyses. All data will continue to be stored on my protected computer and external hard-drive. All data related to this project will be destroyed no later than December 2016, or sooner if I feel such action is necessary to protect the participants or anyone related to the study.

Data Analysis

The analysis of mixed-methods data included equally rigorous qualitative and quantitative procedures (Greene, 2007). The goal was to best understand the story represented through the data (Greene, 2007). The following describes the steps I took to analyze the data:

Qualitative data. Preliminary qualitative analysis was conducted on healthcare provider interviews using tenets of heuristic phenomenological methodology and including 5 major phases: *immersion, incubation, illumination, explication,* and *creative synthesis* (Patton, 2002; Vagle, 2014). Following a preliminary state of immersion with the data, I followed this period of time with incubation which was followed by an illumination phase. Illumination involves "expanding [one's] awareness and deepening meaning [to] bring clarity of knowing" (Patton, 2002, p. 486). The explication process involved combining the other dimensions of this research and continual self-reflection and focus as I mixed across the data sources (Patton, 2002). Finally, following the analysis and explication of all sets of data, creative synthesis occurred as I wrote subsequent research reports (Chapters 2 – 4) (Patton, 2002).

I classified transcripts by assigning labels and codes into individual, anonymous responses, I labeled themes from individual transcripts in a standardized manner (Patton, 2002). A co-researcher coded the transcripts separately, after which time we compared and discussed our separate analyses to identify the clear, emerging themes. Codes and categories can be seen in

Appendices M and N. Syrian interviews were analyzed in a similar manner, and they were considered part of the bidirectional perspective of the healthcare process.

In addition, I coded and categorized photos for analysis using Atlas.ti© according to Glesne's suggestion for visual data analysis (2010). They were integrated into the narrative qualitative data to become a type of "mind map" for use during integration and the joint display phase (Glesne, 2010, p. 82). The process of mapping out the photographs and adding them to purposeful sections of my analysis was part of the interpretivist epistemology and stimulated my memory and reflections on the story of the research (Glesne, 2010). No image that identifies an individual will be used in any publication.

The research team categorized qualitative data by identifying patterns and trends across interviews and observations, seeking convergence and regularities within the data as well as divergent areas where we find meaningful differences (Glesne, 2010; Patton, 2002). After the entire set of qualitative data was coded and organized, but before interpretation, I invited members of the research team to review the system and method of analysis. Following qualitative analysis, quantitative data was analyzed and mixed with qualitative findings due to the need to carry out dialogue with data sources throughout the analysis process (Greene, 2007).

Quantitative data. A co-researcher and expert in quantitative research aided in the quantitative data analysis. This analysis included organizing and entering the survey data into advanced analytical programs (SPSS, MPLUS). Using SPSS and MPLUSS, I performed exploratory factor analytical procedures to discover factors emerging from quantitative survey data (Brown, 2006). Next, I performed confirmatory factor analytical procedures to confirm three factors supported by my theoretical framework (Brown, 2006). Throughout analysis of quantitative data, I engaged the qualitative data in dialogue and mixed analyses and inferences

(Greene, 2007). I created and presented a joint display for co-researchers, which informed subsequent interpretation and meta-inferences. Finally, I considered both quantitative and qualitative data to form meta-inferences and warranted assertions (Greene, 2007).

Assessing Data Quality

Four researchers had access to the data and contribute to the analysis. Throughout analysis, I engaged in dialogue with my research team regarding the process to ensure inter-rater reliability. Generalizability of the data was difficult to determine due to the novel nature of this study, though it will become more possible to assume transferability of qualitative findings as more studies are published on this topic. I reached saturation of qualitative data with healthcare providers through the 20 interviews (Glesne, 2010). However, because only three Syrian caregivers were available for participation in this study during the period of data collection, their sample was unsaturated and this data was treated as a bound case study. In line with the dialectic stance, I conducted data collection procedures under the assumptions of each paradigm. I maximized my survey data collection under a quantitative paradigm, and I adhered to extensive qualitative procedures of in-depth interviews and prolonged participant observation (Greene, 2007).

Trustworthiness of the research was established by sharing all of my notes, observations, photos, experiences, and thoughts with my research team. Additionally, in line with interpretivism, my knowledge of the topic was warranted by my "closeness, engagement, and sufficient time on site to understand the inside or emic perspective" (Greene, 2007, p. 166). I was candid with my research team regarding my position and subjectivity, which facilitated their ability to encourage focus on the research topic at hand. In addition, co-researchers challenged

my theoretical viewpoints, inferences, and connections of the data as we carefully moved through the analysis.

Inference quality refers to the interpretive agreement among researchers regarding the meta-messages drawn from the multiple types of data within a study (Greene, 2007; Teddlie & Tashakkori, 2003). As noted by Greene (2007), inferences are persuasive in nature, and my research team was aware of the argumentative nature of making inferences and warranted assertions throughout the research. Importantly, inferences associated with this research were represented by and anchored in both qualitative and quantitative data (Greene, 2007).

Limitations

Limitations of this study included issues related to power dynamics associated with cross-cultural research, political stakeholders, and vulnerable character of the sample. Regarding cross-cultural limitations, differences in power were apparent due to my presence within the government-supported hospital setting. My own qualities as well as those attributes of translators and stakeholders added certain power dimensions to this research. I was considered powerful in some roles (as interviewer of Syrian fathers) and as having very little power in other roles (as interviewer of some healthcare providers, or when interacting with hospital administration).In addition, language differences also became a limitation when conducting interviews in broken English without a translator. Translators were used with some participants at varying degrees of translation. This study was conducted under the auspices of several stakeholders including hospital administration and two universities. These stakeholders influenced access to and within research sites. Finally, the sample of participants in this study was vulnerable because of their status either as a healthcare provider in a politically controversial country or as a Syrian refugee. Finally, I conducted member checking procedures during my follow-up visit to the two sites in

July 2015, where I presented the preliminary analysis of qualitative data to healthcare providers who provided extensive feedback regarding my data and inferences.

Chapter Sequence

The following three chapters (Chapters Two – Four) are presented in manuscript format. Chapter two details the importance and relevance of conducting this research as an ethnic and religious outsider. In this first manuscript, I candidly accept and explain how my subjective experiences interacted with this research and influenced the process of collecting and analyzing data. This manuscript has been accepted by Sage Methods Research Cases – Health as an article meant to be read by fellow doctoral students and emerging scholars conducting health research.

Chapter three presents the analysis of qualitative data from this mixed methods study. Because of the depth of insight garnered from the qualitative data, I chose to write a second manuscript to highlight the experiences of healthcare providers and Syrian patient-caregivers. This empirical paper was politically complex and charged, and I relied heavily on my theories, philosophical frameworks, as well as the insight of my co-authors to gracefully execute the analysis and findings. I plan to submit this paper to the journal, Qualitative Health Research.

The fourth and final manuscript is presented in Chapter four. This paper presents the mixed methods, analysis, and findings. I present tables and figures from quantitative, qualitative, and mixed analyses to integrate the aggregate of data and present warranted assertions. Finally, Chapter five summarizes this study, presenting key findings and major points from this dissertation research.

CHAPTER 2

THE INTERLOPING RESEARCHER: CONDUCTING MIXED-METHODS RESEARCH IN ISRAELI HOSPITALS[3]

[3] Spivey, S. E. and Lewis, D. C. Accepted by *Sage Research Methods Cases – Health*. Reprinted here with permission of the publisher

Abstract

This case study will describe Savannah's personal and academic growth based on research she developed with Denise and conducted in Israel in 2014. Savannah focused on healthcare providers working in two Israeli hospitals mandated to treat Syrian patients since February 2013. Israel and Syria have been political enemies for many years, and complicated ethnic demographics and political boundaries have been areas of constant division within and between the two nations. The two hospitals where Savannah conducted this research are located in an ethnically diverse region of Israel near the Golan Heights. As a female and ethnic/religious outsider, she was uniquely fit to conduct this research with healthcare providers and Syrian guests in the hospitals. This article will explicate upon her experience conducting this controversial research. Her observational notes will highlight experiences and authors will reflect upon lessons learned conducting controversial international research.

Keywords: Cross-cultural, Mixed methods, Healthcare, Language barrier, Refugees

Project Overview and Context: Navigating a Controversial Research Path

In my second year of graduate school, with aspirational naiveté strong in my grasp, I (Savannah Spivey) set out to answer some of society's most complex social questions about human interactions, refugees, identity, and healthcare. After establishing a strong knowledge base and gaining hands-on experience with refugee resettlement in the United States, I decided an interdisciplinary approach combining human development, family studies, and global health would be necessary if I wanted to truly understand complexities of refugees' lives before, during, and following resettlement or displacement. I began a certificate program in Global Health through our university's School of Public Health where I specialized in refugee health. Discussions in class began to evolve, incorporating news of the Arab Spring, which was rapidly developing in many Middle Eastern nations including Syria. The Syrian Civil War's relentlessness and complexity challenged me to participate in the class dialogue surrounding the effects of this war. At the same time, violent coups taking place in nearby Middle Eastern nations moved my advisor (Dr. Denise Lewis) and me further to understand the deep humanitarian consequences of the relentless political instability in this region.

On January 29, 2014—halfway through my second year of graduate school—the director of the Global Heath program sent me an article published by the New York Times titled, "Despite Decades of Enmity, Israel Quietly Aids Syrian Civilians" written by Isabel Kershner (2014). While brief, the personal story it told about two young boys receiving care in an Israeli hospital was fascinating. However, what was most striking were the stories it *did not* tell about Syrians receiving healthcare by their historical enemies in Israel. This newspaper article and similar pieces that followed inspired my plan for dissertation research: I would study the interaction of healthcare providers and Syrian patients and their families in Israeli hospitals.

To make this research dream a reality, I spent almost 6 months writing, revising, and expanding upon the proposal with the assistance of Dr. Denise Lewis. We submitted the proposal to our university's Institutional Review Board (IRB) and were called to defend our proposal to the ethics committee *twice* before the board was satisfied that aspects of both my own safety and the participants' safety were sufficiently addressed. Many stakeholders were engaged in developing this research in order to meet strict standards set by multiple entities. In all, two research universities, two hospitals, three ethics committees, and seven academic advisors provided their expertise, support, and consent for this research. The proposal and ethics reviews were demanding, but those steps were insignificant when compared to the rigor of the research process, which began in June 2014, approximately 1.5 years after the first Syrian casualty was admitted to an Israeli hospital for treatment (S. Sheleg, personal communication, July 29, 2015; Zarka et al., 2014).

Research Practicalities

Since it began in March 2011, the Syrian civil war has gained mass media attention due to the international or internal displacement of over seven million Syrians (The Carter Center, 2014; UNHCR, 2015). While several of Syria's neighboring countries (Lebanon, Jordan, Turkey) have aided Syrian refugees by allowing them to cross their borders and seek refuge, one country bordering Syria—Israel—has provided a different type of humanitarian assistance.

Although Israel's staunch security measures do not allow Syrian refugees to resettle in the country, one late night in February 2013, the Israeli Defense Forces (IDF) carried the first Syrian casualty to an Israeli hospital to receive urgent healthcare (Sidner, Khadder, & Levs, 2013). Since then, the IDF has continued to carry severely injured Syrian men, women, and children across the border between the Golan Heights and Syria to one of two primary regional

hospitals treating these patients. Following their initial recovery by IDF forces before arriving at a hospital, injured Syrians are triaged in an emergency setting and sometimes taken to a field hospital before traveling in an Israeli military ambulance to a receiving hospital located in the northern region of Israel (see Figure 2.1).

Figure 2.1. Map of northern Israel showing the Golan Heights which sits between Israel and Syria, and two cities where Syrians were treated: Nahariya and Safed (North Israel Map 500, 2015).

This research story began in June 2014 when I traveled to Haifa, Israel, and spent 8 weeks conducting mixed-methods research in two Israeli hospitals. Because of the unique historical context and lack of precedent, I was open to a creative research approach in which an explicit goal was to weave my personal ethnographic journey throughout the project. Through intense reflection, as well as collecting observations, interviews, and survey data from healthcare

providers and Syrians in the hospitals, my goal was to understand the psychological and human processes of interaction between and among Israeli healthcare providers and Syrian patients and their family members acting as caregivers in the hospitals. The following year in July 2015, I returned to conduct member-checking procedures with participants. In this case, we explain data collection procedures and share reflections of personal and academic growth. We will conclude by highlighting the most salient lessons we learned throughout this research—both about conducting research as a graduate student and about my role as a member of the global humanitarian society.

Why Mixed Methods?

Although quantitative and qualitative research traditions are not typically used together in one research study, when the two paradigms *are* mixed purposefully, it is called dialectic mixed methods, meaning the researcher engages both qualitative and quantitative methods to answer certain questions (Greene & Hall, 2010). This was the case in our research, as our complex research questions called for using both quantitative and qualitative methods. In order to understand how we would mix the two paradigms of qualitative and quantitative research, we mapped out the philosophical assumptions guiding our research from several levels of understanding (see Figure 2) (Greene, 2007). As is shown in Figure 2.2, our mixed-methods research was informed by hierarchical assumptions such as the dialectic paradigmatic stance, and it was grounded in a combination of two epistemologies: interpretivism and critical realism. Mixed methods is considered a methodology in itself, distinct from qualitative or quantitative paradigms, and we integrated various methods including surveys, observations, interviews, and photos to answer our research questions (Greene, 2007).

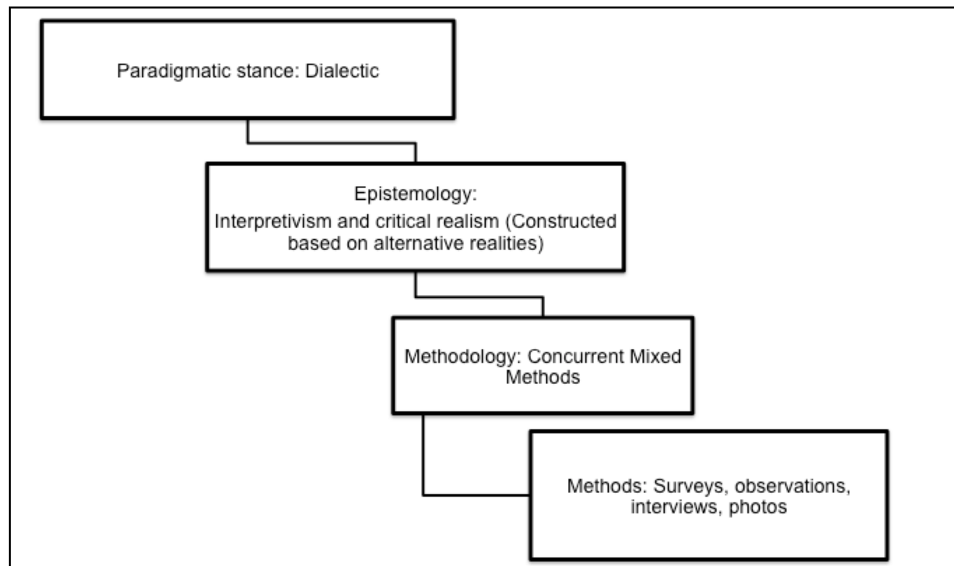


Figure 2.2. Visual presentation of philosophical framework and methods showing the levels of the philosophical framework guiding this study.

Researcher Reflections

First author voice. I must express my position within this project as an "interloping" researcher in the two hospital settings. As I apply interpretive and critical realism epistemologies to my research, I am challenged to consider how my position as a graduate student from the Southern United States who is neither Arab nor Jewish fit into this project as a whole. My unique perspectives from my life and educational training influenced the way in which I processed information and acted upon it throughout the development of this research both in the United States and in Israel. In this case, I chose to use the term "interloping" to describe how I sometimes felt perceived by others, and how I consistently perceived myself while in the hospital setting. It is essential to recognize all explanations and inferences drawn from this project were grounded in the research context (Maxwell & Mittapalli, 2010). This research context not only

included Israeli hospitals, but we also considered international geopolitics as refugees continued to cross borders fleeing persecution in Syria and other countries.

Second author voice. As a researcher who has worked with multiple culture groups in the United States and Cambodia, one of the least developed nations in the world, I recognized it was critical I provide Savannah with guidance and freedom to develop her skills as a researcher and scholar. I also recognized the need to mentor her through the process of gaining the depth of knowledge needed to address unexpected events and the patience to deal with ambiguities associated with conducting research in an unfamiliar setting.

Language and Culture in Israel

The two official languages of Israel are Hebrew and Arabic; however, English is spoken by many as well. Multiple nuances across languages can influence how verbal and nonverbal communications are interpreted. Although I was extremely limited in my knowledge of both Hebrew and Arabic (although I did study Arabic for one year following data collection), I recognized and attempted to address the cultural nuances represented by language. I felt prepared to conduct culturally responsive[4] research with participants according to their first language and had research materials translated accordingly. Interestingly, during the first week of data collection, I was prohibited from distributing Arabic-language materials at either hospital because the “official” language used in the hospitals was Hebrew. Although I was informed all staff members were fully literate in Hebrew, as a culturally responsive researcher, I was frustrated by this restriction.

[4] Researchers who are culturally responsive consider and respond to the research context and culture(s) present, as well as participants’ “power, needs, and beliefs” (Seponski, Bermudez, & Lewis, 2013).

Most Arabs who live in Israel, especially those working in hospitals, are fluent in Hebrew and learned it from a young age through school and interactions outside of their homes and Arab villages. Since receiving healthcare in a public Israeli health facility is a necessity for most citizens, understanding and speaking the Hebrew language is—by consequence—also essential. If one does not speak Hebrew, some facets of life in Israel are difficult to navigate.

We ask that you, as readers, engage in an applied thought experiment. Imagine you live comfortably in your hometown, speaking your native Arabic language at the local bakery, grocery store, bank, and clinic. Then, one day at the local clinic, you are diagnosed with a serious condition and need to consult with doctors at the large state hospital. This scenario is a normal experience for most citizens in countries like the United States; however, in Israel, the primary language spoken at the state hospital is Hebrew. Hebrew may be completely foreign to someone who is a native Arabic speaker. Continuing your applied thought experiment, consider how you might react, interact, interpret, and understand instructions when you and your healthcare providers speak different languages. This is often the condition encountered by Arabic speakers. While the Israeli government has adopted Hebrew and Arabic as official languages, Hebrew is the dominant language spoken by Jewish Israeli citizens. Although most Arab citizens are able to speak at least some Hebrew when outside of their villages due to convenience and necessity, non-Arab Israelis rarely speak Arabic under any circumstances.

Within large socio-cultural systems in which social interactions occur, there are also more distinct *cultural systems* (Archer, 1998). Both organizational levels (socio-cultural and cultural) interact, influencing the other according to people's experiences and interactions. In Israel, the socio-cultural context is overwhelmingly complex. In 1948, the United Nations established Israel's political boundaries and resettled millions of displaced Jewish survivors of

the Holocaust and diaspora, which consequently changed the societal structure for those living in the region at the time (General Assembly Resolution 181, 1947). Since then, Israel has become a predominately Jewish state with a majority ethnically Jewish-run government. That transition has created a distinct cultural system of Jewish religious beliefs, culture, and ethnicity in Israel.

The two hospitals where data were collected for my dissertation are located in the northern region of Israel. Similar to other countries in the world, Israel is diverse with certain regions representing unique characteristics of Israel's overall socio-cultural system. Northern Israel is known for being an ethnically diverse region, with many Arab Christian, Arab Druze, and Arab Muslim Israeli citizens living, working, shopping, and attending school among Jewish religious and ethnically Jewish citizens. The two hospitals referenced in this research were public institutions, and they received funding from the government to serve their patients. The staffs of each hospital represented many unique cultural groups, with Muslims, Christians, Jews, and "Secular"[5] believers of various ethnic backgrounds (i.e., Jewish, Russian, Arabic, Spanish, English, American, Indian, Mexican, and others) working together within the hospital cultural system. Despite the inherent complexity and potential controversy surrounding this research, the hospitals maintained a very collegial social setting. Even during a time of intense ethnic violence between Israel and Gaza in the summer of 2014 when these data were collected, healthcare providers worked together to provide state-of-the-art care, saving the lives of strangers whose mere presence from across the border was controversial.

[5] Many participants referred to themselves as "secular" members of either Jewish or Muslim religious traditions, meaning they participated in some cultural traditions associated with the religion, but they were not active religious believers.

Research Design

Multiple conversations with partners at the data collection sites informed the research design, including partners at two large hospitals in Northern Israel affiliated with a prominent medical school in the region. This conversation began by engaging with mutual acquaintances of the director of the Global Health Certificate at University of Georgia (UGA). By the time the proposal was sent to the IRB for review, two hospital ethics committees, five hospital administrators, and physicians at both Israeli hospitals, as well as my advisor, Dr. Denise Lewis, and multiple other faculty members had reviewed and given their support for the project. The concurrent collection design allowed me to collect the bulk of the data in-person in the summer of 2014; data which included daily observations, 23 in-depth interviews, and 204 surveys from two sites.

Sampling

Sampling was conducted using snowball methods at both hospitals. During the first week of research, I introduced myself to members of the hospital staff in all departments by visiting each department's head nurse and physicians or surgeons. The hospital administrations provided letters of support written in Hebrew to distribute along with surveys, and I distributed these letters to leaders of each department to assure them of the legitimacy of this research. It was common for many healthcare providers to be skeptical at first because media outlets had bombarded them with requests for interviews over the past year. However, I was the first *researcher* who entered the scene to conduct an anonymous and ethically approved project.

At times, it was clear participants were unsure about the potential outcomes or motivations associated with this project. In an interview with a male healthcare provider who works with children, he defensively discussed his interactions with Syrian patients compared to

Israeli patients and said, “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 are all handling this just like we handle other patients.” There were others who expressed similar sentiments during interviews. It is important to understand this perception is rooted in the excessive media attention these hospitals had recently received. At the time of data collection, both hospitals had been exposed to 12 months of reporters trolling the hallways of their departments asking personal, evocative questions about their treatment of Syrian patients. Although I continued to assert I was there as an academic researcher with unbiased intentions, it is unclear how I was perceived by the majority of participants.

Interviews

Interviews were designed to be open-ended, allowing the participant adequate time and space to answer complex personal questions such as “Tell me about your personal experience as a care provider since war broke out in Syria,” “Tell me about the influence of war on your job, and on your attitude and life outside of the hospital,” “Tell me about how you have coped with your position as a healthcare provider to Syrian patients,” and “How do you feel about being Israeli?” Questions were difficult to answer, and they were meant to encourage participants to explain their perspective of treating Syrian patients in Israel due to the humanitarian crisis in Syria. Due to language barriers, Arabic-speaking social workers volunteered their time to confidentially translate interviews with Syrian family members and during my interactions with Syrian patients. Most healthcare providers I interviewed (16 of 20) spoke fluent English; as for those who were not fluent in English, a Jewish bi-lingual hospital employee provided confidential translation when requested during four interviews.

I introduced myself to healthcare providers in the hospital setting or was introduced by a healthcare provider who then suggested others speak with me (snowball effect). Inclusion criteria specified all participants must have interacted in some way with Syrian patients. Due to the complexity of Syrians' injuries and need to be transferred across departments within the hospital, it quickly became evident almost all hospital employees had—at some point and to some degree—interacted with Syrian patients. My observational notes explain how some interviews were established:

> June 30, 2014: Head nurse of Pediatrics was very open and supportive of the project after seeing the support letter, and she took 30 surveys to distribute within the department. Then, she brought in a lady for me to interview who is a nurse aid. She sat down with me in a private office and I interviewed her.

Interviews were conducted with 20 healthcare providers who had a range of interactions and spent varying amounts of time with Syrian patients. For example, two Arabic-speaking hospital social workers were interviewed, and they were the vanguard of communication with all Syrians due to their role as social workers and their Arabic language and ethnicity. Also interviewed were administrators, volunteers, teachers in the hospital, psychiatrists, surgeons, nutritionists, and nursing staff, whose interactions with Syrian patients was sometimes only minimal or occurred when the patients were unconscious.

In addition to interviews with healthcare providers who worked with Syrian patients, formal interviews were also conducted with three Syrian family members of child patients in the hospitals. However, the hospitals' ethics review committees prohibited formal interviews with Syrian patients. Instead, I was allowed to speak with willing family members of Syrian patients who were staying in the hospital with their injured relative. This restriction, while implemented for security purposes, prohibited a saturated sample of Syrians because of the limited population

present. Therefore, Syrian participants were recruited only through convenience according to who was present in the hospital at the time of data collection. Most Syrian patients were either dropped off near the Israeli border or they traveled to Israel alone, without family to accompany them. Family members of Syrian children were contacted secretly and brought in to be with their injured children. During the time of my data collection, only three family members had traveled with or met their children who had been taken across the Syria/Israel border for treatment in one of the hospitals. All Syrians interviewed were fathers of injured young boys.

Surveys

Distributing and collecting surveys was challenging due to the lack of control possible inside a hospital setting. The quantitative tradition would typically suggest a controlled and completely anonymous environment in which participants answer survey questions. However, due to constraints associated with an extremely busy and interactive hospital environment, participants in this study may have completed s in pairs or groups, potentially commenting on questions and meanings of their answers with peers. Lower level staff may have felt pressure to complete or not to complete a survey according to their supervisor's opinion of the project. For example, in one department, a disenchanted head nurse expressed her distrust because she believed there were ill-found motivations for this research by administration and government. When I visited this nurse's department 2 weeks after delivering 35 surveys for completion by employees from all shifts, the head nurse only returned five surveys to me. Although I continued to interact with staff of this particular department during the entire 8-week research period, I only collected a few more surveys from those departmental employees who delivered them to me privately. I learned that while hospitals are amazingly rich settings in which to conduct social science research, they also are complex societies of hierarchy and structured relationships. In all,

204 surveys were anonymously completed by healthcare providers and returned for analysis. These data were integrated with the qualitative interviews and observational data to inform meta-inferences.

Methods in Action

In this section, we provide a few practical examples of my experiences based on observational notes. All names and other identifiers have been removed or changed for anonymity and protection of participants.

Methods of Self

For this project, I quickly learned how important it was to remember to *have courage*. Israel entered into an official violent conflict with Gaza during the time I lived in Haifa (Summer 2014). I traveled to and from the hospitals each day by public transportation alone or with a colleague. I shopped and visited the city center regularly to buy groceries and supplies. Although I lived on top of Mount Carmel on a military-guarded university campus, I was also independently traveling around Israel for my research without speaking Hebrew or Arabic. Despite these risks, I felt most emotionally insecure while inside the secure hospitals collecting data. Many days were busy and filled with lengthy interviews or visits across the hospitals to distribute and collect surveys. However, there were also times when I encountered resistance from within the hospital settings as well as reluctance from myself. The following quote is from my personal notes written while sitting in one hospital's open lobby area:

> June 26, 2014: Today has been a very slow day, overall. This morning, I was extremely tired from bad dreams last night and have not felt "awake" yet. I stopped by the administration office to check in, and I learned the latest numbers of Syrians in hospitals in Israel. As of today, there have been 773 unique cases . . . On Sunday: Go to the Social Work departmental meeting to introduce myself, the research project, and ask for interviews. Sunday and Monday: visit surgical

> department, ER, and pediatrics to deliver and explain surveys to HCPs (healthcare providers).
> Be confident. THIS IS IMPORTANT.

As this quote suggests, there were days when I struggled due to logistical tasks, intimidation, and doubt in myself and the topic as a whole. Fortunately, these days were few due to the nature of a demanding schedule traveling from one hospital to the other. In any case, the above quote provides insight into the practical challenges associated with collecting data in an unfamiliar setting. Complex research projects such as this should not be taken lightly; confidence should be rooted in sound research questions, a thorough understanding of and strong skills in methodology, and personal and professional preparation.

The hospital setting was a place for compassion and empathy as I witnessed amputated limbs, half-naked bodies on stretchers smeared with blood and shrapnel, and children with external devices joined to multiple limbs at once as doctors hoped their bones would regenerate and grow back after being mutilated by bombs or bullet wounds. As a researcher, I was extremely aware of myself as an outsider whose compassion extended to both injured Syrians as well as the Israeli healthcare providers treating them. A slow bond developed between myself, a Syrian father, and his son who was an orthopedic patient. The father was at the hospital to care for his young son who had been receiving treatment in Israel for 41 days. I bonded with the young boy, whose 3-year-old charm was irresistible. Toward the end of my time at this site, I said goodbye to the child and his father and detailed it in my notes that day:

> July 16, 2014: I said a final goodbye to Mohammed, gave him a big hug and told him and his father that I would always remember them. Mohammed had taken my watch a few days earlier to play with, and I did not have it in me to ask him to give it back, but his father gave it to me before I left even though it broke my heart to see Mohammed cry when he took the watch from him.

Methodological Concerns

In addition to self-observations, I also documented detailed criticisms or concerns from participants regarding the research methods. For example, some participants expressed concern for a few survey questions as explained in the following observational entries recorded after long days in the hospital:

> June 29, 2014: As far as the survey, I am getting a lot of pushback about "ethnicity" as well as confusion regarding #6 (a question about being comfortable treating adult Syrian patients of the survey) . . . Another survey problem with the wording and meaning of responses for #13 and #14 (both questions about having positive or negative beliefs about Syrians after treating them), which is understandable now that I read them again. In all, there should be about 125 surveys distributed and not received.
>
> June 30, 2014: I expected to have only two interviews today, but I actually ended up with five after snowballing through different participants . . . I talked with many new people around the hospital and I was well-received by most, but not all. The main doctor of [certain department] was very resistant; he made no eye-contact and refused to speak with me. He did, however, allow me to go back into the department and contact the head nurse about surveys and interviews.

Site Practicalities

Each hospital site was intricate in layout and context. Although both sites were located in the Northern Israel region of the Galilee, they were markedly unique in their geopolitical context. The hospitals were located in Nahariya and Safed (see Figure 2.1). The city of Nahariya is located only 6 miles from the Lebanese border and, in 2006 this city experienced violent warfare between Israel and Lebanon resulting in damage to the hospital by rocket fire. Safed is located in the Eastern area of the Galilee in a mountainous region. Safed is approximately 10 miles from the border of the Golan Heights region between Israel and Syria, which is the area where injured Syrians are picked up by IDF and taken to receive healthcare in Israel. These two hospitals received the majority of Syrian patients treated in Israel due to their capacity to treat the severe

war-related injuries, which differ from Israeli patient injuries, as one surgeon described to me in detail:

> July 22, 2014: They come into the hospital dirty after being dragged through the dirt across the country to get to ambulances . . . It could be up to five days before they actually get to a vehicle that will take them to the border with Israel, at which point they are triaged in a field hospital, and if they survive they are taken to hospital in Israel. By this time, they may have an infection and sepsis, which delays treatment . . . Their bodies are in a totally different condition than those of even poor Israeli patients . . . They are the resilient ones; they are the survivors.

International, Controversial Research: Practical Lessons Learned

So far, we have provided context, explained the research design, and offered detailed examples from written observations. In this section, we will offer advice based on our experiences conducting international, controversial research as a doctoral student and supervisor of a doctoral student.

1. *Understand the context of your research site as thoroughly as possible*. Whether conducting research in a social arena such as a hospital or clinic, or in a rainforest seeking new biomedical techniques from local villagers, establish understanding of the people by reading and immersing yourself in the culture as much as possible. Expose yourself to multiple sources of media covering your location and those with whom you may interact. The immense amount of thought and research dedicated to learning about the current political situation as well as the socio-geopolitical history of the Middle East as a whole gave me a deeper understanding of the participants' nonverbal and verbal communication.

2. *Be flexible*. International research is never as clear-cut and succinct as our well-polished proposals lead us to believe. Without doubt, participants or stakeholders will expect researchers to either alter or re-focus aspects of the study. Your study may change so significantly, you are obliged to resubmit to your university's ethical review board. Be as prepared to conduct your

study as possible, but do not lose heart if you are asked to alter your purposes or questions upon arrival to your sites. It is vital that you and your supervisor remain open to change and flexible in the conduct of the research while adhering to ethical standards set forth by the various human protection guidelines.

3. *Be reflective and keep a daily journal*. Not everyone is a long-winded writer, and not everyone spends ample time reflecting on social interactions. Nonetheless, it is important to keep a daily journal of your personal thoughts and processes both as a researcher and as an individual. International work asks us to cross social, cultural, physical, and psychological boundaries most of us frequently live within and do not cross. Journaling your thoughts and experiences will help you untangle complicated and delicate aspects of your work later. Active journaling will help you understand your role within your research.

4. *Nourish relationships*. Due to the nature of controversial, politically charged research, there will be people who will not appreciate your work and make it difficult to execute. However, you will likely also find those who support your desire for understanding. Nourish those relationships with kindness, reciprocal support, and respect. In my study, translators and nurses were often gatekeepers to participants; as a researcher, you must work hard to maintain respect and kindness for those who will help you conduct your research.

5. *Have courage*. Your research questions will likely be difficult to answer because international work is rarely without controversy. Your project will challenge you to step outside of all your established zones of comfort. When your participant breaches an unprompted topic that makes you uncomfortable, have the courage to redirect or, in some cases, listen intently and then process your own discomfort and courage. If your project encounters unexpected resistance, have the courage to persist with flexibility and determination. Rest on the knowledge you have

established before crossing international borders, and have the courage to allow your knowledge to shift and change according to your experiences.

Conclusion

This case detailed my journey as a doctoral student who conducted controversial international research, describing myself as “interloping” in my research sites. Research should never be taken lightly because the results can broadly impact policy and education. More importantly, the process of planning, conducting, and drawing inferences from the research has immeasurable effects upon all involved, including the researcher(s) and participants. As investigators, we must remember our research is not conducted in isolation; our ethical reflection of our work extends not only to our participants but also to our own development.

CHAPTER 3

CONFLICT AND CARE: ISRAELI HEALTHCARE PROVIDERS AND SYRIAN PATIENTS AND CAREGIVERS IN ISRAEL[6]

[6] Spivey-Young, S., Lewis, D. C., Gilbey, P., Eisenman, A., Schuster, R. To be submitted to *Qualitative Health Research*.

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 conducted this phenomenological research 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 experience of healthcare providers who treated wounded Syrians in Israeli hospitals. Findings indicate healthcare providers and Syrian caregivers adjusted their beliefs to allow for a positive healthcare experience. Thorough qualitative analysis yielded themes of supportive and hindering systemic elements contributing to the healthcare provider-patient-caregiver relationship. Humanization of *the other* within the relationship was influenced by internal psychological developments, contextual factors, and relational processes. This study illuminates unique ethical and humanitarian demands relevant for healthcare workers and those with whom they interact.

Keywords: healthcare, conflict, healthcare providers, Israel, Syria

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 refugees[7] who have fled to camps in neighboring countries for safety (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, 2014). Many other hundreds of thousands have fled to Europe as asylum seekers. However, on Syria's western border, the nation of Israel has been 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 (see Figure 3.1), Israel's hospitals have

[7] 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.

quietly provided healthcare 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 have also fled to temporary field hospitals along the border territory in the Golan Heights 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, this research was needed to illuminate issues facing Syrians and healthcare providers.

Figure 3.1: Map showing the Golan Heights area between Israel and Syria. This map also shows three primary cities where Syrian patients have been treated in Israel: Nahariya, Safed, and Tiberias (Reed, 2013).

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 share of discrimination in Israel. Regardless of personal background or beliefs, Israeli healthcare providers are ethically bound to provide treatment to all wounded persons, including Syrians (Israeli Medical Association, 2009b). Among the wounded Syrians seeking healthcare were women and children civilians as well as nationalist and sectarian fighters. Upon entering Israel, Syrians received treatment for grave injuries inflicted as a result of the uprising in their home country (Eisenberg & Benbenishty, 2013). Syrian family members who accompanied severely wounded victims participated in this study along with Israeli healthcare providers who treated Syrian patients. This research examined the perspectives of healthcare providers who treated Syrians as well as the perspective of Syrians who were caregivers of wounded family members in the hospital.

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 paper will illuminate one phase of refugees' plight around the world: seeking and receiving immediate healthcare. This research is important because it introduces the inclusion of social, political, and historical context into the broader conversation of healthcare provision. Also, this study illuminates broader societal issues and questions surrounding providing healthcare to people considered 'enemies.' Implications of this research 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 Doctors Without Borders, Jesuit Refugee Services, the United Nations High Commissioner for Refugees, or the International Committee of the Red Cross) (UNHCR, 2014b). Neighboring countries aiding the fleeing masses of refugees may have a 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. Both the 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 (see Eisenberg & Benbenishty, 2013). Though no known empirical research has been published on this particular situation, studies have found barriers faced by healthcare providers when treating unfamiliar, foreign minority groups (Ahsan Ullah, 2011; Burchill & Pevalin, 2014; Campbell, Klei, Hodges, Fisman, & Kitto, 2014; Joseph et al., 2004; Sandhu et al., 2013). While Israelis did not consider Syrian patients in Israel to be 'refugees' according to the 1951 United Nations Convention on Refugees (see footnote 1 on page 5), 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 immediate refuge upon release from the Israeli healthcare setting. Therefore, research with and about healthcare providers 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. Addressed most often in the literature 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 healthcare providers, difficulty establishing trust with patients, and systematic/procedural barriers that are beyond the healthcare providers' control (Kelley, Kraft-Todd, Schapira, Kosowsky, & Riess, 2014). While past research has described issues of 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.

Conceptual Framework: Cognitive Dissonance and Infrahumanization

This research was guided by two interacting theoretical perspectives: cognitive dissonance and infrahumanization. Cognitive dissonance is a feeling one experiences when former beliefs contradict with newly formed beliefs, causing the person to employ strategies to reduce the uncomfortable dissonance of the 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 other beliefs that support and, thus, outweigh the intrusive dissonance beliefs (Festinger, 1957, 1964). Another strategy is to reduce the importance of the newer, dissonant beliefs; while the dissonance is still present, the 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 the strategies they employ 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 impact 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 the hospital setting 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 healthcare providers, 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 tenants of infrahumanization theory with cognitive dissonance by exploring ingroup dissonance as individuals' beliefs

collided with the actions of the group to which they ascribed or belong. Participants employed strategies to reduce their dissonance by consciously dis-identifying with their ingroup as well as reinforcing their own beliefs to combat the dissonant actions of their ingroup. Authors suggest employing such strategies may eventually lead to disintegration or weakening of the larger ingroup, as individuals spontaneously or consciously form subgroups with more similar goals in order to reduce their dissonant experience.

Hippocratic Oath

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, Tannsjo, Hansson, & Lynoe, 2013; Walton & Kerridge, 2014). In order to reconcile dissonant beliefs and avoid cultural clashes in the healthcare setting, most practitioners follow a universal ethical standard of healthcare adapted from the ancient Hippocratic Oath written by Hippocrates in the fourth century, BC (Edelstein, 1943). 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 the intruding, dissonant belief (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, the set of values

established within the Hippocratic Oath outweigh dissonant beliefs healthcare providers may experience, thus lessening any discomfort.

Methods

Methodological Approach

A heuristic, 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; Patton, 2002). 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 (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 healthcare providers and Syrian family members with patients. Follow up observational data was 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 the country (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 rigorously reviewed by the full board and approved by The University of Georgia Internal Review Board (IRB) as well as the Helsinki 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, authors chose to employ anonymous consent letters due to potential repercussions for both HCPs and Syrian participants. Consent letters detailed the purpose of the research and emphasized participation and interviews would be confidential and anonymous, and all data would return to the United States with the first author. Furthermore, the consent letter explained the primary topics covered in the interview and emphasized the participant was allowed to quit at any time for any reason. Due to hospital administrative requests, all HCPs received Hebrew consent letters prior to being interviewed. 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 transcribed 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. Hospital administrations required researchers to distribute only Hebrew consent letters to healthcare providers; Arabic consent letters were

provided to Syrian participants. Although the interviewer was not fluent in Hebrew or Arabic, only six participants requested translation during interviews. Three 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, the first author conducted in-depth, semi-structured interviews with 20 Israeli healthcare providers (HCPs) and three Syrian fathers of child patients. Criteria for participation were to be healthcare providers who worked in the hospitals and had interacted with Syrian patients, as well as family members of Syrian patients receiving healthcare in either hospital. While Syrian mothers would have been welcome in this study, only three men were available during the period of data collection who fit this study's criteria. To include participants from all shift rotations, the first author 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 3.1 presents the demographic characteristics of the healthcare providers who were interviewed. HCPs' ages ranged from 20-66 years. We chose to present HCPs' ethnicity as Jewish or Arabic, according to their description of themselves. For example, some participants

self-described as "Israeli," "Ashkenazi," "Sephardic," "Russian," "Ukrainian," "English," "American Jewish," and others. All participants who did *not* self-describe as "Arabic," confirmed their ethnicity as a subgroup of Jewish ethnicity. The Druze were also a recognized ethnic group, who reported themselves as religiously Druze and ethnically Arabic or Druze. We chose to categorize the Druze as Arab ethnicity following in-depth qualitative data analysis. Table 3.1 also presents participants' self-described religion according to their described religiosity. Participants were categorized as "secular" or "non-secular" depending on how participants explained their religious practice. Several (n = 6) participants intentionally described themselves as 'secular,' meaning they explained they were non-believers/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 ethnicity, religion, nationality are relevant 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 own children who were patients in the hospitals; the fathers' ages ranged from 25-54. These three Syrian fathers were the only available Syrian participants who met the criteria for this study during the data collection period. The first author, along with an Arabic social worker of each hospital, approached the fathers and asked if they would like to participate in this research. Arabic social workers (HCP14 and HCP15) were gate-keepers for speaking with the Syrian family caregivers. Furthermore, these two social workers were integral to the healthcare experiences of all Syrian patients treated in either hospital. They were the trusted points of contact between the hospital staff and the Syrian patients; without their cooperation, this study would not have been possible. To begin the conversation with the Syrian participants, an Arabic

consent letter was provided and read aloud by the social worker who also translated during the interviews when necessary.

Table 3.1
Profiles of Participants

		Syrian Caregivers		
ID	*Relationship to Patient*	*Gender*	*Age*	
S1	Father	M	n/a	
S2	Father	M	25	
S3	Father	M	54	
		Healthcare Providers		
ID	*Occupation*	*Gender*	*Religion*	*Religiosity*
HCP1	Physician	M	Jewish	Secular
HCP2	Physician	M	Jewish	Secular
HCP3	Physician	M	Jewish	Non-secular
HCP4	Physician	M	Jewish	Non-secular
HCP5	Physician	M	Jewish	Non-secular
HCP6	Physician	M	Jewish	Non-secular
HCP7	Physician	M	Jewish	Non-secular
HCP8	Nurse	F	Jewish	Secular
HCP9	Nurse	F	Jewish	Non-secular
HCP10	Nurse	M	Muslim	Secular
HCP11	Nurse	F	Jewish	Secular
HCP12	Nurse	F	Jewish	Non-secular
HCP13	Nurse	M	Muslim	Secular
HCP14	Social Worker	F	Muslim	Non-secular
HCP15	Social Worker	M	Christian	Religious
HCP16	Occupational Therapist	F	Christian	Non-secular
HCP17	Clown	M	Jewish	Non-secular
HCP18	Nutritionist	F	Jewish	Non-secular
HCP19	Staff	F	Jewish	Non-secular
HCP20	Volunteer	F	Jewish	Religious

Notes. Religion is reported here as each participant self-identified during the interview. Age and Ethnicity were removed for anonymity.

Healthcare Provider Interviews

The first author conducted 20 individual, in-depth, semi-structured interviews with healthcare providers who treated Syrian patients. Each interview was conducted in a private or semi-private setting (i.e., office or break room) in the hospitals and lasted 30 – 90 minutes. When a translator was not needed, the interviews were conducted in English only. Sometimes participants struggled to find the words they wished to use; in such cases, the interviewer engaged with participants to clarify any confusing language by repeating back what she heard them say – a technique suggested by Creswell (2003). The 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.

The first author aimed to earn the trust of participants in order 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) in order to establish a pattern of respect and trust throughout the conversation. She emphasized her goal to understand each participant's unique stories and personal experiences.

Syrian Caregiver Interviews

In addition to HCP interviews, the first author 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 – 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

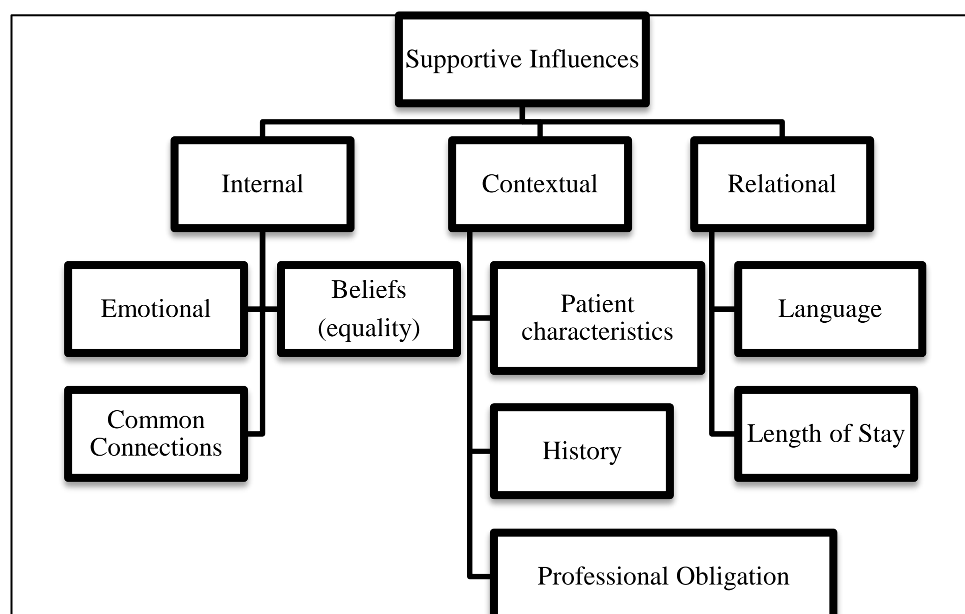
For eight weeks in 2014 and for two weeks in 2015, the first author recorded daily observational notes in each hospital setting. Observations consisted of her thoughts, reflections, and ideas as well as recordings of setting, time, place, and context. Each day in either hospital, she sat in different 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.

Data Analysis

The goal of this qualitative analysis was to best understand the story represented through the data (Greene, 2007). The interviews and observational notes were analyzed using tenets of heuristic phenomenological methodology including 5 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. The first and second authors 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 3.2). 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 HCP interviews. Syrian participants' interview data were integrated and presented with HCP data to inform the warranted assertions as supplementary evidence. To illustrate each subtheme, we present direct quotations, maintaining the integrity of participants' complex experiences in this study.



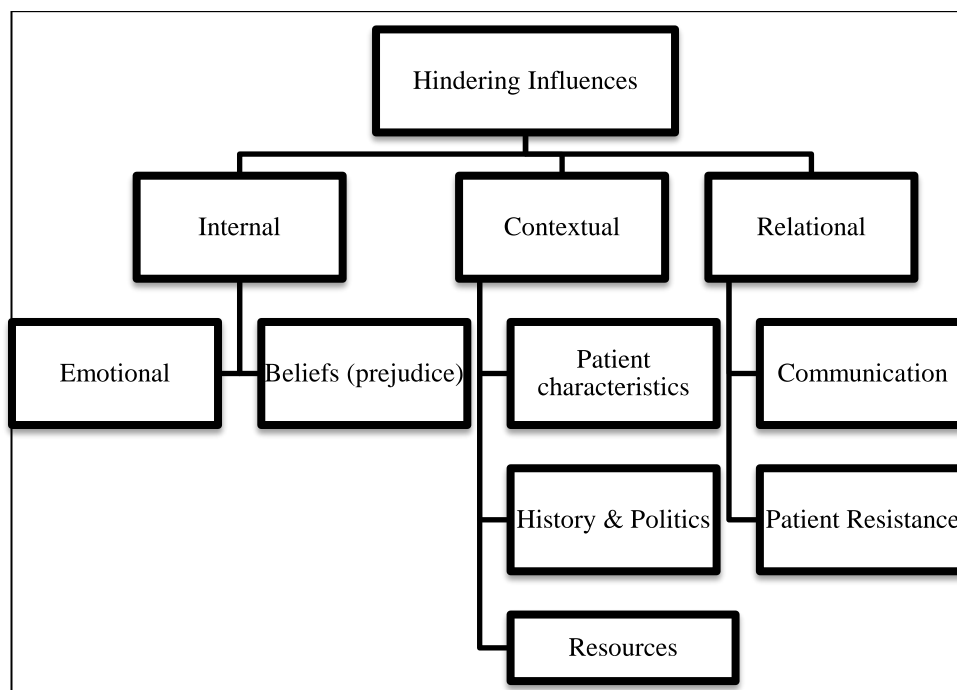


Figure 3.2: Theme maps showing the hierarchy of thematic analysis, including primary themes (Supportive and Hindering Influences), secondary themes, and associated factors

Supportive Influences

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

Internal processes. HCPs discussed internal processes including emotions, beliefs in equality, and perceived common connections which 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 HCPs also described feeling frustration, detachment, optimism, pride, and compassion as they reflected upon treating Syrian patients. For example, one young participant (HCP20) 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.”

HCP11 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, and she tells a story of how she tried to help one young Syrian patient beyond the confines of the hospital. She also described the staff’s reaction to the Syrians as shocked about how poor they were. She continued, “They 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. She told her own children what Israel was doing for the Syrians and about her experience. However, the military did not allow her to bring him home for the weekend to “show him something other than the hospital; something normal for a weekend.” She said it was very sad for everyone when he could not visit. Finally, 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 they focused on maintaining as they treated Syrian patients: “When they are stripped from their clothes and bear only wounds, healthcare crosses boundaries, religions, and cultures to treat the wounds” (HCP9). One participant (HCP8) exemplified how HCPs explained their belief in equality for all patients. She believed everyone in the hospital deserved treatment, regardless of their background or reason

for being there. She believed the whole hospital was receptive and treated [Syrians] equally by giving them the most expensive treatments, surgeries and equipment. She said 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 Arabic physician refused to be interviewed, telling the first author he had “nothing to say” about the situation of Syrians in the hospital; they were “just like any other patient.” Furthermore, in an interview with HCP17, he said, “What happened, happened.” He continued, “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. Now, we all are handling this just like we handle other patients.”

Syrian participants also expressed their belief in equal treatment from Israeli HCPs for their injured sons, which helped them trust the HCPs decisions for their children’s treatment. All three Syrian fathers said they believe their sons were receiving equal, if not better than equal, treatment as Israeli patients. Notes from S1’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 to lessen any potential cognitive discomfort as a result of treating their historical enemy. For example, two Arab HCPs discussed watching Syrian

television to understand Syrian culture and how Syrians perceive Israelis. HCP10 told the first author 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. HCP10 also discussed how he knows about mourning in Syrian culture and takes it upon himself to explain the difference to the staff. 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.” HCP14 also explained how she connected with Syrian patients through this outlet:

> 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.

Some participants made extremely personal connections to their Syrian patients who reminded them of their own family or personal struggles. In her interview, HCP9 illustrated such powerful connections. She 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 (HCP2) also described how he related to one of his Syrian patients, in particular, “[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 young woman (HCP20) made with Syrian patients:

> The Torah[8] 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.

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[8] 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 (Encyclopædia Britannica, 2014).

In addition to feeling connected to the Syrian patients and reducing cognitive dissonance, HCPs and community members made physical manifestations of common connections by donating items for Syrian patients to the hospitals. Donations included clothes, hygiene items, and toys for Syrian patients – mostly for women and children. Observational notes and photos also described designated closets or hallway corners with donations for the Syrian patients and their family members (see Figure 3.3). Because the staff knew how little the Syrians had and would have when they returned to Syria, they provided more assistance to Syrian families. One participant (HCP19) 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.” They wanted to bring hand-me-downs for Syrian children. HCP19 said, “We feel a kinship with the children and the mothers.”

Figure 3.3: Donation closet one hospital’s social worker set aside in the hospital to hold the donations for Syrian patients and their families.

Contextual processes. Contextual influences were factors over which participants had less cognitive control and helped HCPs and patients reduce their dissonance. These secondary factors included Syrian patient characteristics, the HCPs awareness of and adherence to

professional obligation, and personal history of the HCP or patient within the greater historical time frame of this project[9].

Patient characteristics. Depending on the Syrian patients' qualities 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 the 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 the heartbreak they experienced treating injured Syrian women and children they believed were innocent civilian victims of violence within Syria. One participant said, "I see women and children...they are innocent...wounded so terribly... They are all so helpless, miserable, and afraid of war" (HCP14). She perceived her patients as victims of the violent conflict in Syria, and she recognized their physical injuries as well as their psychological pain of surviving such "miserable" circumstances. Another participant (HCP18) described similar feelings regarding women and child patients, 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, some severely wounded children found alone at the Israeli-Syria border are taken to an Israeli hospital via military ambulance; as the

[9] 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.

following quote explains, they are alone in the hospital indefinitely until family members can be found and brought in:

> It is more difficult when they (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. (HCP18)

This participant did not know what happens to Syrians when they leave the hospital; she said 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 (HCP2) 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 Israeli Defense Force 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 partially 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 (HCP14) 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 life history and professional history supported their ability to reduce potential cognitive dissonance. For example, one young woman (HCP20) described the personal connection she made with the Syrian people 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. Her parents were originally from Iraq and the Ukraine. Furthermore, a Syrian father's (S3) personal history included finding out about Israeli healthcare by neighbors in Syria, which lessened his fear to come to Israel, "I am not afraid because I have neighbors who have come and returned to Syria and speak well of Israel."

Other HCPs discussed their professional history as healthcare providers during wartimes in Israel, specifically referencing the 2006 war with Lebanon. HCP9 explained she experienced the attack on the hospital in 2006 during Lebanon and Israel's conflict. She 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." Here, she said HCPs have to be the "voice of the patient" because there is no other advocate for them. She said when Syrians wake up in ICU, they are treated "like any other injured young person." She said HCPs may, in fact, 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."

In addition to personal life history and experiences, 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. The first author 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 HCP4 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. Sentiments of professional obligations were essential for many HCPs, who believed it is not their job to judge patients but only to treat them with the best care available. HCP16 simply explained, "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. One participant (HCP18) explained how she 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 participants were professionally obligated to the healthcare system and the military as reserve members of the Israeli Defense

Force. HCP5 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 (HCP7) 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 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 whoever 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 to treating Israeli patients, including working with a team of doctors across the hospital. One American-Israeli dual citizen elaborated on the 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 (HCP3) 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 eighty percent have other trauma needs as well. Another physician (HCP4) described how diverse 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.'"

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

Language. While 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 also expressed how much more they trusted doctors and nurses to whom they could communicate effectively. One nurse (HCP11) said, "It was easier for the Arabic speaking nurses and doctors to communicate with Syrian families because of language. Language helps with communication." Not only did participants speak of the *ease* of communication when HCPs could speak Arabic, they also described how sharing language facilitated more empathy from HCP to patients. HCP12 said, "The Arabic speakers relate and have more empathy with Syrian patients because they can speak to them." A male Arab nurse elaborated on this point:

> 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 fifteen HCPs who did not speak Arabic before the Syrian patients began arriving for care, nine described learning Arabic in order to interact and provide better care, which led to humanization of their Syrian patients. One nurse (HCP8) 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. S2 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 (S3) expressed his satisfaction with the treatment his son was receiving. S3 expressed he was very happy to be in Israel. According to S3, his son was receiving "excellent treatment, better than excellent." He described how his son's doctor and nurses treated them very well and with respect. He appreciated this so much. 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 HCP and Syrian patients was also influenced by the patients' length of stay in the hospitals. Two nurses explained the supportive influence of length of stay on the provider-patient relationship. HCP8 said, "After they have been here a few days, they begin talking to the Arab nurses." HCP12 also commented, "It takes a few days to

gain trust." It took time, but some Syrian patients and HCPs developed a bond. HCP12 describes how one patient's trust developed slowly into a friendship with his healthcare team. She recalled one 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, S3 explained while he was in the hospital for 13 days, he had time to consider his family's future. He actually hoped to move into Israel after his son was released from the hospital. Through a translator S3 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. We categorized these hindering factors using parallel structure of the supportive factors: internal, contextual, and relational processes.

Internal Processes. Sometimes, emotions and prejudice beliefs of Syrians or of Israelis made it difficult to employ cognitive strategies to reduce dissonance and humanize when interacting with either Syrians (for Israeli participants) or Israeli HCPs (for Syrian participants and/or patients).

Emotional. Anger, fear, and hurt were the most common hindering emotions expressed by both HCPs and Syrians. HCP12 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 HCP5 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?” Additionally, a male social worker (HCP15) who worked closely with Syrian patients expressed his frustration with one young Syrian patient’s father, who the social worker believed 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.” HCP15 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 also discussed emotional difficulty they experienced with the healthcare process early in their injured sons’ arrival to the hospital. According to a social worker at one hospital, one of the Syrian fathers (S3) 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 four-year-old Syrian boy was badly burned in a car accident 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, a social worker tried to comfort the boy with an electronic tablet she found at the pediatric ICU’s nurses’ station. The cartoon playing on the tablet only comforted the boy for about five minutes. She said the tablets were either purchased or donated specifically for the Syrian children by the hospital and

local community. As the boy listened to the social worker talk to his uncle, he began sobbing and talking. Even his uncle could not understand what he was saying. 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 a different car accident in Syria. She said this boy did not trust anyone at the hospital.

Prejudice beliefs. Some HCPs expressed their own prejudice beliefs of Syrians or prejudice they perceived from Syrians towards them, both of which hindered humanization and increased cognitive dissonance. Referring to Syrians, HCP4 said, "They are infected with a venomous hatred for Jews ... as people, but not necessarily for Israel or Israelis." Another physician (HCP5) 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?" He said, "They are animals!" Most HCPs discussed their ability to reduce dissonance by changing their beliefs over time and as they developed relationships with Syrian patients. Others honestly expressed their difficulty treating Syrians due to their beliefs and past experiences.

Contextual Processes. Certain contextual factors beyond HCPs' physical or cognitive 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 HCPs' perception of Syrian patients. Several HCPs attributed their fear of male Syrian patients with beards because this signified their strict allegiance to the Muslim religion, which they assumed meant disdain for

Israelis. For example, when HCP18 worked with men ages 18-22 and saw their beards, she "knew they were religious and [I] was nervous to be around them." She said she 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 said she worked in orthopedics with Syrian men, and she "could tell they were rebel fighters." She continued, "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 how to feel about these patients, wondering if they were fighters or civilian victims. When asked if she was uncomfortable treating young male Syrians, HCP18 said she does not ask her patients how they were injured because she does not want to know, "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, HCP20 expressed how it became difficult for her to treat Arab patients. She said after the three Israeli boys were kidnapped the violence increased. She was absolutely "shocked, we were all just shocked that they were dead. We were so sure they were alive." After this event, she said "it became very hard for me to take care of the Arab people in the rehabilitation department."

For some HCPs, it was difficult to reduce dissonance when treating Syrian patients due to the historical tension and past events between the Israel and Syria. Referring to long-term historical tension, HCP7 said, “Nobody remembers history [between Israel and Syria], and nobody cares.” Another HCP (HCP5) 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 among HCPs and Israeli patients. Treating Syrian patients was a costly decision from the Israeli perspective. High material expenses due to the extent of Syrian’s war-ravaged bodies and need for multi-departmental treatments included prostheses, extensive recovery time, and providing basic necessities for patients and their families (i.e., food, facilities, beds, etc.). Human resources were also extensive as HCPs prioritized injured Syrian patients before Israeli patients according to the urgency of their injuries. HCP3 explained his dissonance due to 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, live-saving care. Internal resistance from HCPs was also due to lack of adequate resources to treat both Israelis and Syrians without causing tension. HCP4 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 is crowded with Syrians. 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, HCP18 discussed the resentment she has experienced 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 also expenses for Syrians' initial care and transportation by the Israeli Defense Force (IDF), Israel's military unit. Members of the IDF not only brought Syrians to the hospitals in Israeli military ambulances, they also guarded the 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 and humanizing each other including communication and patient resistance. Communication was difficult due to language differences and nonverbal cues expressed from HCPs or from Syrian patients who refused treatment.

Communication. Language barriers persisted as the primary hindrance to reducing cognitive dissonance while treating patients. While Arabic HCPs were asked to provide care to Syrian patients whenever possible, non-Arabic physicians, nurses, surgeons, and other providers treated Syrians as well. In fact, depending on HCPs' schedules and the type of procedures needed, non-Arabic speakers were sometimes the only HCPs available to treat them. A non-

Arabic speaking nurse (HCP9) 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. An Arabic male nurse (HCP10) answered with the following explanation when asked "if he relates to them in any other way besides just Arabic language maybe culturally or religiously."

> 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.

The 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" (Author, in press). Recorded notes from observation of HCP14 helping a Syrian patient and his family illustrate the frightening realization patients encounter when they wake up from unconsciousness in Israel, where the language is unfamiliar:

> [HCP14] 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 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 –HCP14] 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. While rare, when Syrian patients resisted care with nonverbal cues HCPs struggled to create a trusting patient-provider relationship. HCPs 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. One nurse (HCP8) 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 experienced nurse (HCP12) described how despite efforts to help one teenage male patient, he would not allow HCPs to treat him and was returned to Syria after only three days:

> 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 said she 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

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 healthcare providers and Syrian. For example, one 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, including treatment of war-related traumas, repair and replacement of entire limbs through private donations, and the accompaniment of a family member from Syria prior to returning home.

Further prominent issues mentioned in news media include Syrian children born in Israel (Ben, 2013; “Israeli hospital delivers Syrian baby,” 2013; The Associated Press, 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 (Sela Eyal, personal communication, June 25, 2014) . Not only do ethical medical issues exist regarding Syrians, but they also extend to healthcare providers who have been charged by the Israeli government for whom they work with treating Syrians as their patients despite potential personal hindrances (Eisenberg & Benbenishty, 2013; Gilbey & Spivey, 2015). One Jewish Israeli nurse wrote candidly about her experience treating a Syrian patient on the eve of Eid al-Fitr (the end of Ramadan):

> The complexity of life in the Middle East has brought us together. While the distances are small, we have grown up worlds apart. Now his loneliness and the tragedy of his diagnosis have connected us. The connection is a sincere one. We care about him, and we want him to mend and heal. Our concern is professional and compassionate, and we are dedicated to his care. However, we are fond of him, too, and we worry for him, as we worry for the other Syrians (Eisenberg & Benbenishty, 2013, p. 543).

This nurse's experience is unique, but the most interesting aspect of this anecdote is the candor and introspective humility with which she reflected on her complex position. Pursuing research in this area will add to medical ethical research literature as well as illuminating the voices of both healthcare providers and Syrians patients.

For purposes of this paper, two ingroups were considered: Israeli healthcare providers 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 healthcare providers were asked to treat them with the best care possible within the scope of their ethical mandate as healthcare providers. 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.

Limitations

Primary limitations of this study included issues of power, language differences, and a small Syrian caregiver sample. While I consider my positionality as a religious and ethnic outsider to be a strength of this research, my demographic qualities also contributed to power-related weaknesses in some situations due to not being taken seriously, or because participants assumed I would prefer them to answer a certain way. Language limitations made conducting this research more challenging, and I depended heavily on translators to collect survey and some interview data. Finally, our Syrian patient caregiver sample was small and homogenous (three

Syrian male fathers of child patients) due to a limited population of available participants at the hospital sites during the data collection period. We were not permitted to collect data from Syrian patients 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 around the globe and implications for medical ethics and practice.

Conclusion

This research provides detailed insight into the relationships and healthcare process between patients, their caregivers, and healthcare providers. While 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. Though it was sometimes a personal struggle to overcome and cope with the dissonant professional and personal beliefs, cognitive strategies allowed healthcare providers 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. Perhaps there is more than academic knowledge to be gained from their experiences.

CHAPTER 4

EFFORTS TOWARD HUMANITARIAN HEALTHCARE IN ISRAEL: HEALING THE WOUNDS OF SYRIAN PATIENTS[10]

[10] Spivey-Young, S., Lewis, D. C., Gilbey, P., Eisenman, A., Schuster, R., Oshri, A., Seponski, D. M. To be submitted to the *International Journal for Quality in Healthcare*.

Abstract

We present research conducted in two Israeli hospitals treating Syrian patients. Our objective was to understand cognitive processes and interpersonal relationships of Israeli healthcare providers and Syrian patients and caregivers. We applied a parallel mixed-methods design using data from observations, interviews, and surveys. Twenty healthcare providers and three Syrian patient-caregivers provided interview data. Quantitative data consisted of 204 surveys completed by healthcare providers. Results from mixed analyses support a three-factor model representing healthcare providers' experiences treating Syrian patients. Factors were predicted by religious and occupational differences and included Professional Baseline, Humanitarian Insecurity, and Medical Humanitarianism. As the fearful, injured, and sick continue to flee violence and cross geopolitical borders, the healthcare community will be called upon to treat migrants and refugees according to ethical healthcare principles. Critical examinations of healthcare providers' experiences will propel humanitarian healthcare in the face of a global migrant crisis.

Keywords: Professional-Patient Relations, Cognitive Dissonance, Humanitarianism, Israel, Syria

Introduction

Since 2011, millions of Syrians have fled Syria due to extreme violence caused by interminable factious conflicts. Whether unable to escape due to political restrictions, travel difficulties, or fear of the risky journey, almost eight million Syrians are unable to return to their homes due to constant danger of being kidnapped, tortured, or killed (UNHCR, 2014). Of the internally displaced Syrians remaining in the country, some of the wounded have fled to Israel, their neighboring nation and historical adversary, to receive urgent healthcare.

In February 2013, the first injured Syrian arrived in one of Israel's northern hospitals via Israeli military ambulance ("Israel may set up hospital for Syrians," 2013; T. Sheleg, personal communication, July 29, 2015). This event was controversial due to the two nations' political discord as well as uncertainty of Syrian patients' possible affiliations. In addition to treating civilians for grave injuries sustained in Syria, fighters from various groups have also received healthcare in Israel (Eisenberg & Benbenishty, 2013). Healthcare providers (HCPs) in northern Israel treating Syrians identify with various ethnic and religious groups, including Jewish, Arab, Druze, Christian, and others, and their experiences add unique perspectives to treating Syrian patients. Despite political, religious, or ethnic beliefs and differences, HCPs have treated these patients, abiding by their ethical code of healthcare to treat all sick people equally (Edelstein, 1943; Israeli Medical Association, 2009a).

Unfortunately, empirical research has yet to be published exploring this phenomenon (anecdotal evidence from Eisenberg & Benbenishty, 2013 and Gilbey & Spivey, 2015; studies in progress include Lane, 2016 and Spivey-Young, 2016). In response to the lack of data on this patient-provider experience, we examined this issue for two principal reasons: (1) its empirical

value to all healthcare providers treating patients with politically antagonistic history, and (2) because there is a lack of empirical data illuminating Syrians' experiences during this conflict, particularly those involving healthcare. To present a comprehensive narrative, we examined perspectives of Israeli healthcare providers as well as Syrian patient caregivers (SCGs) in two hospitals using mixed methods to answer our primary research question: "How do Israeli healthcare providers and Syrians in the hospitals experience the healthcare process?" Sub-questions included, "How can HCPs experiences treating Syrian patients be categorized and understood?" and "How do HCPs explain their experiences treating Syrian patients considering their personal beliefs?"

Literature Review

Call to Action

Humanitarian medical ethics in times of warfare has become an issue for researchers, policy-makers, and clinicians alike. In his call to practitioners for action and attention on this topic, R. Asgary (2015) cites the United Nations, which has reinforced International Humanitarian Law (IHL) and called for more preemptive, global recognition and enforcement of IHL especially in war-torn regions. Asgary asserts the IHL has lost global legitimacy due to a geopolitical system that wrongfully blends politics with humanitarian aid.

Patient-Provider Relationship

In healthcare literature, the patient-provider relationship has a broad, yet unrefined empirical base. Patient-HCP communication has been studied among researchers and is decidedly one of the most important aspects of the interdependent relationship (Hertz, 2015; Jefferson, Bloor, Birks, Hewitt, & Bland, 2013; Turcotte et al., 2015; Zolnierek & DiMatteo, 2009). Researchers have found many influences on patient-provider communication, including

gender (Jefferson et al., 2013), perceived understanding and respect throughout the interaction (Hertz, 2015), and provider transparency (Stambolovic, Duric, Donic, Kelecevic, & Rakocevic, 2006).

Most communication issues between healthcare providers and patients involve power issues. According to Hertz (2015), healthcare providers can reduce negative patient outcomes with more effective communication practices. Hertz (2015) offered broad, applicable communication suggestions for providers to empower patients and ultimately improve health outcomes, including training staff and empowering patients with explanations and validation of their concerns. Furthermore, patients feel empowered when providers engage in a partnership with them and do not impose a hierarchal, intimidating presence (Jefferson et al., 2013). When patients feel insecure about their care based on perceived disrespect or discrimination, they do not engage with healthcare providers (Jefferson et al., 2013; Stambolovic et al., 2006). A meta-analysis by Zolnierek and DiMatteo (2009) found poor patient-provider communication resulted in negative patient outcomes and noncompliance to treatment plans. Healthcare providers are encouraged to empower their patients by respecting them and being transparent about conditions, treatment plans, and prognoses (Hertz, 2015; Jefferson et al., 2013; Stambolovic et al., 2006; Zolnierek & DiMatteo, 2009).

Certain tools have been developed to encourage and assess healthy patient-physician relationship, especially for potentially uncomfortable interactions. In their research with physicians and patients following the war in former Yugoslavia, Stambolovic et al. (2006) found most patients were uninformed about their human rights and could not communicate with physicians regarding their conditions due to perceived relational barriers including arrogance, discrimination, and non-transparency in care. Based on their research, Stambolovic and

colleagues (2006) distributed a patient-physician relationship manual to the Serbian Anthropological Society with detailed relationship standards. Furthermore, in their development of the Decisional Conflict Scale to measure personal dissonant feelings experienced when one must make choices that oppose personal life values, Turcotte et al., (2015) argue patients and their health providers balance a careful relationship of shared, interdependent decision making. Although authors recognized patients and providers are independent actors, they emphasized the interdependent relationship both parties share. Both patients and healthcare providers are involved in the care process physically and mentally; they influence each other's thoughts, judgments, and emotions, which subsequently influence behavior. Patients' responses to physicians' questions are influenced by perceptions of support and beliefs that physicians are confident and/or compassionate of their situation and health. Turcotte and colleagues (2015) call for researchers to study both patients *and* providers to fully understand how they make decisions and influence each other.

Power in healthcare

Researchers have discussed the nature of power involved in the physician-patient relationship (Hertz, 2015; Stambolovic, Duric, Donic, Kelecevic, & Rakocevic, 2006; Asgary, 2015; Zolnierek & DiMatteo, 2009). Physicians and other HCPs are perceived as more powerful within this relationship due to patients' vulnerability, and physicians' resources and medical expertise; this power is exponentially increased in humanitarian aid situations (Asgary, 2015). Patient-provider conflict can arise when patients are vulnerable and distressed (Hertz, 2015). Such power issues may intensify patients' sense of fear and discomfort, and it is physicians' jobs to 'help them work through that' (David A. Fleming quoted in Hertz, 2015, p. 32).

Healthcare Providers

Patients are not the only party affected within the provider-patient relationship. Though some HCPs are trained on coping with traumatic cases, treating patients during times of warfare or violent conflict can affect HCPs stress levels and coping mechanisms can be tested (Kudler, 2014). Therapists who treated U.S. war veterans exposed to trauma reported increased stress levels and inability to separate home-life from work stressors. Researchers suggest the need for both communication training and support systems for clinicians who work with patients who have experienced trauma to encourage and share stories of compassion, fatigue, and professionalism involved with working with difficult cases (Kudler, 2014; Zolnierek & DiMatteo, 2009).

Theoretical Framework

We depended on two major psychological theories to guide this study: cognitive dissonance (CD) and infrahumanization. Cognitive dissonance is an established theory explaining how people cope with internal conflict they experience when faced with ethical or moral dilemmas that contradict their prior beliefs (Festinger, 1957, 1964). Discomfort stems from the irrational balance of one's previously held belief in a situation that challenges them to alter, mitigate, or change beliefs. Secondly, infrahumization theory is an interpretation of dehumanization theory from the field of social psychology (Leyens et al., 2001). Contrary to the dichotomy of classifying someone as human or inhuman found in dehumanization theory, infrahumanization considers how people attribute characteristics which endorse or deny others as *more* or *less* human (Haslam & Loughnan, 2014; Leyens et al., 2001). Characteristics which endorse humanization have been termed "human essence" and refer to ingroup qualities

(advanced mental capacities, language, reasoning); contrarily, outgroup members lack such advanced human qualities and are thus *less* human (Leyens et al., 2001, p. 407).

To our knowledge, infrahumanization and cognitive dissonance have never been combined to study healthcare, though elements of each were applied to a recent study by Glasford, Pratto, and Dovidio (2008). The interaction of both theoretical perspectives allowed us to understand the patient-provider relationship mixing qualitative and quantitative findings based on decision-making, coping strategies, and patient-provider relationship dynamics. In this study, we considered two primary ingroups: (1) Israeli healthcare providers, (2) Syrians in the hospital (patients and caregivers). As healthcare providers and Syrians interacted with one another, they may have experienced cognitive dissonance related to humanizing the other group. This paper will describe this patient-provider relationship and how participants experienced their patient-provider relationship with “outgroup” members.

Significance of Study

Unfortunately, global conflict is not subsiding with regard to ethnic, religious, and racial differences. Healthcare providers will likely be called upon to treat individuals from various presumed outgroups. As the Israeli health community is obliged to treat all patients regardless of personal, political, or religious differences, our global society faces an extraordinary migration of diverse asylum seekers who some believe threaten their lifestyle and peace of mind (Noack, 2015). This study explores the nature of one part of this global forced migration phenomenon as we consider the provision of healthcare by Israelis to historically incompatible Syrians.

Methodology

We developed our research questions after critically orientating ourselves to the phenomenon of providing or receiving healthcare to or from a historical enemy, specifically

Israeli healthcare providers and Syrian patients (Van Manen, 1990). Due to the complexity of the multiple perspectives we wanted to consider, we used an interpretive, phenomenological epistemology to develop our research questions. (Freeman & Vagle, 2013; Moustakas, 1990; Vagle, 2014). We applied a partially-mixed concurrent, equal status design, wherein qualitative and quantitative data were collected separately but simultaneously, and both methods were relied upon equally to develop warranted assertions (Leech & Onwuegbuzie, 2009; Natasi, Hitchcock, & Brown, 2010). A visual diagram of our methodology is depicted in Figure 4.1. See Table 4.1 for a description of key topics covered by each data collection method. Phenomenological mixed methodology was the most fitting because of multiple viewpoints involved in understanding a shared phenomenon (Mayoh & Onwuegbuzie, 2015), and we engaged our qualitative and quantitative data dialogically throughout analysis and interpretation (Greene, 2007).Adapted from Cooper and Hall (2016), Figure 4.2 depicts the paradigm and methods we used to answer our research questions.

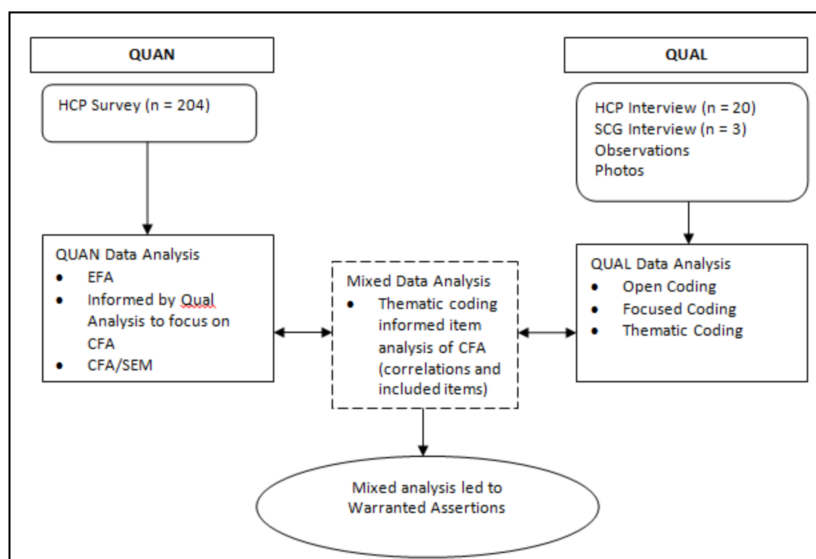

Figure 4.1. Graphical representation of partially-mixed concurrent equal status mixed methods design.

	Research Question	Paradigmatic Emphasis	Methods*
1.	How do Israeli healthcare providers and Syrians in the hospitals experience the healthcare process?	QUAL + QUAN	• 23 HCP/SCG Interviews • Observations • Photos
2.	How do HCPs explain their experiences treating Syrian patients considering their personal beliefs?	QUAL	• 20 HCP • 3 SCG Interviews • Observations
3.	How can HCPs experiences treating Syrian patients be categorized and understood?	QUAN	• 204 HCP Surveys

Figure 4.2. Research questions with paradigmatic emphasis and methods.
*Methods are listed in order of importance as it pertains to each question.

Data were collected during eight weeks in 2014 and two weeks in 2015 in two government-funded hospitals in the ethnically diverse Galilee region in northern Israel. The University of Georgia Internal Review Board and Helsinki ethics committees of both hospital sites approved this study. These were the two largest hospitals treating Syrian patients in Israel. Due to the potentially controversial nature of our research, we used Hebrew language letters to obtain participant consent from HCPs and Arabic language letters for SCGs. In addition to interview and survey data, the first author recorded daily, detailed observational notes paying special attention to current events and interactions within the hospital sites. Data collection tools will be described in detail in later sections.

Table 4.1
Data Collection Methods and Key Topics Covered

Method	Key Topics Covered
Surveys	Professionalism regarding patient care
6 Demographic items	Personal feelings regarding general patient care
14 Likert-Scale items	Personal feelings regarding Syrian patient care
	Israel-Syria geopolitics
HCP Interviews	Demographics
In-depth	Professional experience in hospital
Semistructured	Personal effect of Syrian Conflict
20 Predetermined questions	Balance of professional and personal beliefs
Probing	Personal feelings of life in Israel
SCG Interviews	Demographics
In-depth	Experience in Israeli hospital
Semistructured	Balance of personal beliefs with health needs
24 Predetermined questions	Life in Syria
Probing	Personal effect of Syrian Conflict
Observations	Patient-provider interactions
Daily notes	Anecdotal HCP/SCG stories
2 Hospital sites	Syrian patient interaction
	HCP interaction
	Intersection of historical context and current events
	Personal experiences as researcher
Photos	Hospital setting
	Israel setting and diversity

Note: HCP = Healthcare provider; SCG = Syrian caregiver

Sampling

Participation criteria included HCPs who worked at either hospital site and had interacted with Syrian patients. Though we were not permitted to interview Syrian patients, Syrian caregivers (SCGs) were interviewed if they were with a family member being treated in one of the two hospitals. All participants were recruited using snowball sampling procedures (Patton, 2002). A total of 20 HCPs and three Syrian patient-caregivers were interviewed; HCPs also completed 204 surveys. While it is possible interviewed participants also completed a survey, it was not a requirement or an expectation, and the interviews were conducted separately from the anonymous surveys.

Table 4.2 shows the participants' demographic and professional information, which we organized by categories used to understand our research questions for this paper. Other demographic information was also collected, including self-described ethnicity and nationality. In-depth qualitative explanations suggested we focus on the following categories for analysis of survey data to understand factors associated with treating Syrian patients: Age, Sex, Religion, and Occupation. When responses could be collapsed into a larger category, we chose to classify the response into broad categories (i.e., Pediatric nurse became "Nurse," Surgeon became "Physician," Orthodox Jewish became "Jewish," and Druze became "Muslim"[11]). For parsimony we depicted most common healthcare professions of participants: physician, nurse, and social worker. However, we do not consider these positions more or less important in the healthcare system. Other professions included nutritionist, occupational therapist, medical clown, National Service volunteer, janitorial staff, and others.

[11] To group Druze with those who self-described as Muslim was a difficult choice, but we ultimately based this decision on notions of outgroup attribution, in which Druze are considered Muslim by the majority of Jewish and Muslim people in our study due to strong historical ties, though the Druze consider themselves distinct from Muslims (Nisan, 2010).

Table 4.2
Demographic Characteristics of Participants

Participant demographics		**Quantitative Survey**	**HCP Qualitative Interview**	**SCG Qualitative Interview**
Participants (n)		204	20	3
Mean age [years] (range)		42 (19–80)	46 (20–66)	39.5 (25, 54)
Sex % (N)	Male	34 (69)	11	3
	Female	65 (132)	9	0
	Unknown	1 (3)	0	0
Religion % (N)	Jewish	50 (103)	15	0
	Muslim	15 (30)	3	3
	Christian	12(24)	2	0
	Other	23 (47)	0	0
HCP Occupation % (N)	Nurse	64 (130)	6	n/a
	Social Worker	5 (11)	2	n/a
	Physician	17 (35)	6	n/a
	Other	14 (28)	5	n/a

Interviews

Interview protocols were developed to explore and elaborate upon perceptions and experiences of providing and receiving healthcare in the hospital. The in-depth, semi-structured interview protocol for HCPs explored the following topics: demographic information, hospital environment, personal perception of conflict in Syria, balance of work ethics with personal beliefs, and life in Israel. Questions for HCPs were developed to answer the research subquestion, “How do HCPs explain their experiences treating Syrian patients considering their personal beliefs?” Similar interviews were conducted with SCGs and explored the following topics: demographic information, hospital experience, balance of need for care with personal beliefs, life in Syria, and personal effects of conflict in Syria. Questions for SCGs were developed to provide insight into their experience and help answer the overarching research question, “How do Israeli healthcare providers and Syrians in the hospitals experience the

caregiving process?" Interviewed participants were provided a detailed consent letter describing the key topics covered in the interview, and participants consented verbally with the first author (interviewer) before interviews began.

The first author conducted total of 20 HCP and three SCG interviews. All interviews lasted between 20-90 minutes and were conducted in a private (office or patient room) or semi-private (break area or shared office) setting in the hospitals. Participants read and verbally agreed to letters of consent provided in Hebrew for HCPs and Arabic for SCGs. Interviews were not recorded due to confidentiality and safety concerns. The first author carefully transcribed notes throughout the interviews, writing responses to answers and quotes. Six interviews were fully or partially translated by a hospital staff member. Two Arabic (one Muslim and one Christian) social workers fully translated for two SCG interviews; a third SCG participant used broken English to conduct his interview. One Jewish hospital employee partially translated for four HCP interviews.

Surveys

Only healthcare providers completed surveys due to a small sample of Syrian caregivers. This two-page (front and back) anonymous survey was developed by a team of researchers based on our research questions, theoretical insight, and nuanced geopolitical and social history of this phenomenon. Letters were attached to each survey explaining the purpose of this research and how data would be securely stored and analyzed if they chose to participate by answering the survey questions. This survey was translated into Hebrew and distributed to hospital departments where Syrians had been treated, along with a hospital administrative support letter and participant consent letter. Healthcare providers completed a total of 204 surveys.

Survey items included six demographic questions (binary gender and write-in options: age, occupation, ethnicity, nationality, and religion) as well as 14 Likert scale items ranging from one (indicating, “I completely disagree”) to seven (indicating, “I completely agree). The items were conceptualized by culturally diverse team of researchers in order to understand the complex phenomenon under investigation. Items were intended to explore HCPs’ personal experiences and feelings treating Syrian patients, and answer the quantitative research subquestion, “How can HCPs experiences treating Syrian patients be categorized and understood?”

Analysis

Using a dialogic technique, we allowed the data to mix and inform each other throughout analysis and interpretation (Greene, Benjamin, & Goodyear, 2001; Greene, 2007). For example, decisions regarding variables we examined with factor analyses and predictor covariates were based both in theory *and* qualitative findings. We employed multiple matrices and joint displays to present and analyze the conglomerate of data by multiple researchers (Lee & Greene, 2007; Mayoh & Onwuegbuzie, 2015) (See Table 4.3).

Interviews and observational data were analyzed using Atlas TI© version 7.5.2. Using a phenomenological lens, we immersed ourselves in the data in order to illuminate and explicate clearly our interpretations as we synthesized our qualitative findings with initial quantitative findings (i.e., open-ended demographic responses and frequencies of survey responses). We grounded our coding procedures in our theoretical framework of cognitive dissonance and infrahumanization. First, we used open coding to structure the data for further analysis. We applied over 450 codes prior to conducting focused coding procedures, in which families of related codes were categorized and analyzed for consistency by multiple researchers. We

combined and compared the analyzed data from HCPs and SCGs using a joint analysis matrix (Greene, 2007; Mayoh & Onwuegbuzie, 2015).

Upon review of qualitative data, we collapsed demographic items from the surveys according to qualitative analysis. Qualitative analysis also heavily informed our selection of ten items of the total 15 similar items for factor analysis procedures including an exploratory factor analysis (EFA) followed by a confirmatory factor analysis (CFA). First, using a maximum likelihood model estimator and an oblique geomin rotation method, we performed an EFA of 10 Likert-scale quantitative survey items to determine the factor structure. Comparing model fit indices as well as AIC/BIC criteria, we determined a three-factor solution was the best fit for our data ($\chi^2 (18) = 42.051$, $p < .01$), analysis of the eigenvalues depicted on the scree plot (see Figure 4.3), and theoretical cohesiveness upon consideration of the qualitative data analysis. We found an acceptable, not excellent, model fit for this three factor solution based on Hu and Bentler (1999) cutoff criteria [$\chi^2 (18) = 42.05$, $p < 0.01$; RMSEA = 0.081, CFI = 0.938, TLI = 0.844, and SRMR = 0.044]. We also examined solutions for one, two, four, five, and six factors using the oblique geomin rotations. However, we preferred the three factor solution based on two primary reasons: (1) theoretical and qualitative cohesion and (2) the scree plot of eigenvalues indicating support for three factors. After synthesizing qualitative themes, relationships, and insights with the information provided by the EFA, we selected nine of the original ten items to be tested in a three-factor confirmatory factor analysis (CFA) (Brown, 2006). We dropped one item (*When I provide healthcare to patients, it* helps *me if I know less about their reasons for being in the hospital.)* due to poor fit and qualitative data suggesting this was a confusing item[12].

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[12] Participants wrote comments throughout many surveys denoting their confusion with this item. They also changed their answers from one end of the Likert scale to another end, suggesting confusion on item interpretation.

Findings

Relying on insight gained from our quantitative factor analyses, qualitative analysis, and theoretical framework, we identified the following three factors from the confirmatory factor analysis: Professional Baseline, Humanitarian Insecurity, and Medical Humanitarianism. The tested three-factor model is depicted in Figure 4.4. The sample variance-covariance matrix was analyzed using MPLUS, and a maximum likelihood estimation (Table 4.4 presents *correlations*, *means*, and *SDs*). According to Hu and Bentler (1999), cutoff values for fit indicators of maximum likelihood estimation include the following: CFI/TLI scores should be .95 or above, SRMR should be .08 or less, RMSEA should be .06 or less. We found a good fit for this model, which we determined using standardized goodness of fit measures as well as theoretical cohesiveness [χ^2 (71) = 83.468, $p < 0.05$; RMSEA = 0.029, CFI = 0.968, TLI = 0.951, and SRMR = 0.047] (Hu & Bentler, 1999). According to the conservative combination of these model-fit indices, the data was a good fit for this three-factor model. The final model was over-identified with 71 degrees of freedom. Completely standardized parameter estimates are presented in Table 4.5. Factor loading estimates revealed a range of support for relationship to their latent factor (R^2s = .10 – .85), which further underscores the complex nature of this study. We also analyzed frequencies of responses in agreement with each item statement and presented the percentage of participants who responded with answers ranging from five to seven on a seven-point Likert scale (indicating they “somewhat agree” or “completely agree” with the statement) (see Table 4.5).

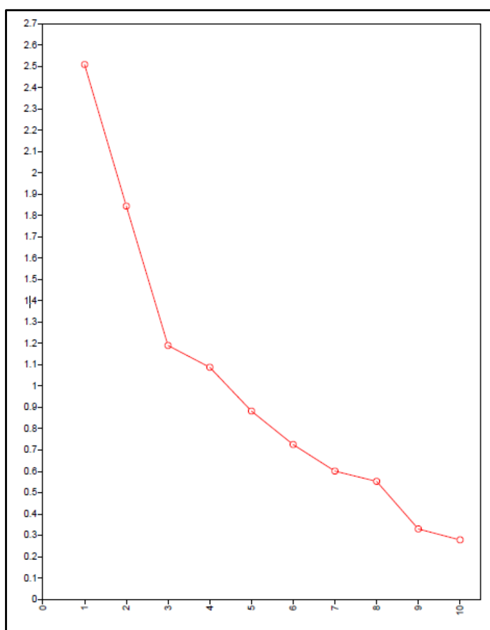

Figure 4.3: Scree plot showing eigenvalues for the three-factor solution of our EFA extraction of data obtained from our 10 item survey (N = 204).

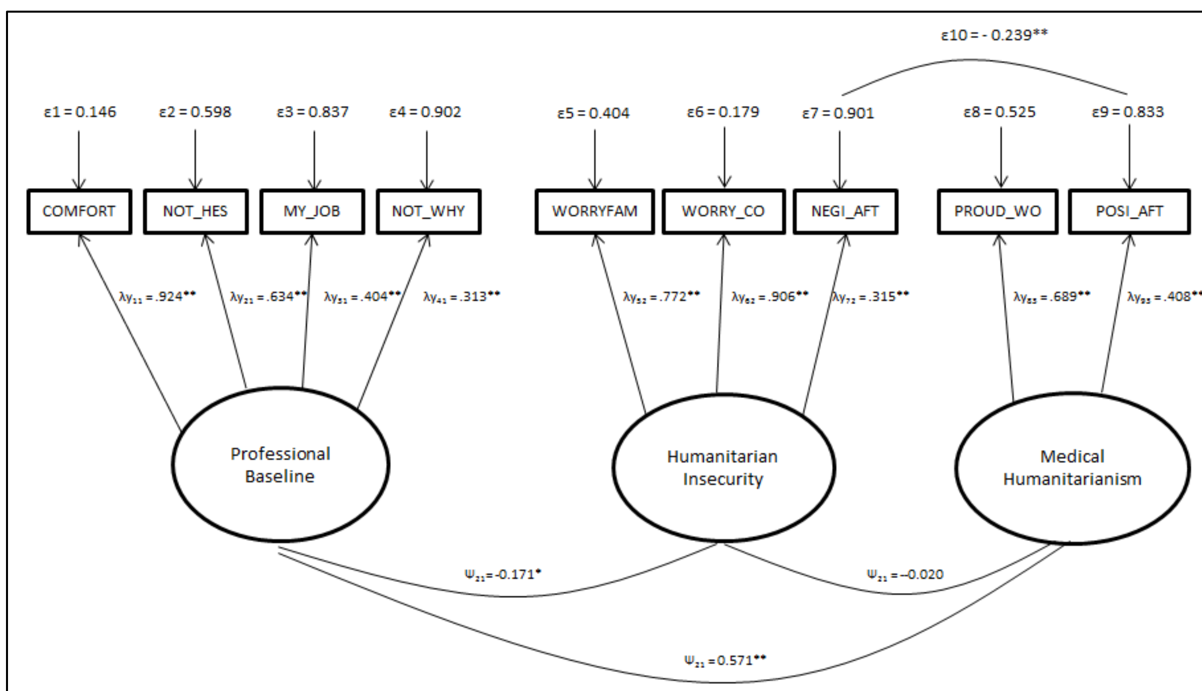

Figure 4.4: Structural model with three latent factors and related items. Definitions of items are provided in Table 4.5.

Table 4.4

Bivariate Correlations, Means, and Standard Deviations (N = 204)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Comfort	—																		
2. Not_Hes	**.59****	—																	
3. My_Job	**.36****	**.30****	—																
4. Not_Why	.30**	.12	.13	—															
5. Worryfam	-.11	-.12	**-.21***	.04	—														
6. Worry_Co	-.13	**-.15***	**-.19***	.03	.70	—													
7. Negi_Aft	-.21**	-.08	-.13	-.17	**.22****	**.26****	—												
8. Proud_Wo	**.40****	**.26****	.12	.16	-.03	-.05	-.10	—											
9. Posi_Aft	**.20****	-.02	.02	.17	.08	.10	**-.22****	**.30****	—										
10. Jewish	.56	.06	.06	.00	-.13	-.08	-.08	-.02	-.02	—									
11. Islam	.07	.11	-.05	.01	-.00	.06	-.04	**.19****	.24	**.41****	—								
12. Christian	.02	-.01	.08	.04	-.03	-.05	-.01	.08	.02	**-.37****	**-.15***	—							
13. Other Reli.	**-.14***	**-.16***	-.09	-.03	**.18****	.09	.11	**-.21****	**-.17***	**-.55****	**-.22****	**-.20****	—						
14. Age	.06	.02	.03	.06	.10	**.18***	.02	.03	.02	**.26****	-.13	-.08	-.13	—					
15. Gender	.07	-.02	.02	-.04	-.12	**-.17***	-.01	-.03	.04	**.17***	-.12	.01	-.09	.12	—				
16. Nurse	.06	.06	.04	-.05	.08	.03	**.17***	.02	.01	.11	-.04	-.07	-.05	.03	-.02	—			
17. Soc. Work	.03	.07	.07	-.09	-.05	.04	-.02	.07	.08	**-.21****	**.50****	-.09	-.09	.01	-.08	**-.33****	—		
18. Physician	.04	.02	-.05	.02	.01	.03	-.12	-.06	-.05	-.12	**-.15***	**.28****	.06	-.07	-.04	**-.60****	-.11	—	
19. Other Occ.	.06	**-.16***	-.06	.11	-.09	-.10	-.10	-.01	-.02	-.12	-.12	**-.14***	.06	.03	.13	-.52	-.10	**-.18***	—
Mean	6.55	6.60	6.85	5.93	1.39	1.51	2.78	5.53	3.86	.5	.14	.12	.23	42.28	1.66	.64	.64	.17	.13
SD	1.01	1.10	.51	1.66	1.21	1.39	1.80	1.84	1.86	.50	.35	.32	.42	11.80	.48	.48	.48	.38	.34
Range	6	6	3	6	6	6	6	6	6	1	1	1	1	61	1	1	1	1	1

Note 1. All variables were used in the quantitative factor analysis and were chosen based on exploratory factor analysis and qualitative insight.
Note 2. P-values were two-tailed, * $p < .05$; ** $p < .01$

Four items loaded onto a latent factor we identified as HCPs' Professional Baseline. This factor represented HCPs' sentiments of professionalism regarding healthcare, specifically their obligation to provide care to all people simply because doing so is their job. Three items identified a second factor, Humanitarian Insecurity. These indicators considered HCPs insecurity concerning changes in their personal and professional relationships due to their treatment of Syrian patients. A third indicator suggested HCPs' negative feelings toward Syrians as a whole following treating Syrian patients. As a whole, these three items represent a sense of insecurity HCPs experience due to this phenomenon. Finally, two items indicated a third factor, Medical Humanitarianism. These indicators represented sentiments of proactive humanitarianism, including feeling proud of their work and positive changes in their beliefs about Syrians as a whole.

We tested the model further according to qualitative and theoretical suggestions concerning participant religion and occupation (see Figure 4.4). We controlled for age and gender due to poor demographic heterogeneity and distribution. We examined Occupation (Nurse, Social Worker, Physician, and Occupation-other) and Religion (Jewish, Islam, Christian, and Nonaffiliated-Religion) as predictive indicators for each factor. Nonaffiliated-Religion significantly predicted all three latent factors (Professional baseline, $\beta = -0.167$, $p = 0.04$; Humanitarian insecurity, $\beta = 0.200$, $p = 0.02$; Medical humanitarianism, $\beta = -0.218$, $p = 0.04$). Other significant predictions included Religion-Islam on Medical humanitarianism ($\beta = 0.304$, $p = 0.01$), and Occupation-Physician on Professional Baseline ($\beta = 0.245$, $p = 0.01$).

Estimates from this three-factor solution represent interesting intra-latent factor relationships as well. Professional Baseline was significantly negatively related to Humanitarian insecurity ($\Psi = -0.171$, $p = 0.04$), and significantly positively related to Medical

Humanitarianism (Ψ = 0.571, p = 0.00). There was an insignificant, but conceptually noteworthy negative relationship between Humanitarian Insecurity and Medical Humanitarianism (Ψ = -0.020, p = 0.87).

Table 4.5

Standardized Parameter Estimates, Confidence Intervals, and Percent of HCP Respondents who Agreed with Item Statements from Each Factor

Latent Factor	**Observed Variable (Item)**	**Factor loadings**	**Standard Error**	**95% CI**	**% (% neutral choice 4)**
Professional Baseline	Comfort: “I am comfortable providing healthcare to all patients in my care.”	.924	.058	[.83 – 1.02]	93.6 (96.0)
	Not_hes: “I do not hesitate to provide healthcare to anyone in my care.”	.634	.058	[.54 – .70]	96.2 (99.1)
	My_job: “It is my job to treat all patients in the hospital, regardless of the reason for their injury.”	.404	.068	[.29 – .52]	98.5 (100)
	Not_why: “When I provide healthcare, I do not think about *why* patients are in the hospital.”	.313	.068	[.20 – .43]	88.3 (93.7)
Humanitarian Insecurity	Worry_fam: “I worry about what my friends and/or family will think about me if I help Syrian people in the hospital.”	.772	.060	[67 – .87]	13.4 (13.9)
	Worry_co: “I worry about what my colleagues will think about me if I treat Syrian people.”	.906	.064	[.80 – 1.01]	6.3 (7.3)
	Negi_aft: “All in all, after treating Syrian patients, I have more negative beliefs about Syrian people.”	.315	.069	[.20 – .43]	14.6 (35.6)
Medical Humanitarianism	Proud_wo: “I am proud of my work treating and helping Syrian patients.”	.689	.110	[.51 – .87]	70.2 (81.9)
	Posi_aft: “All in all, after treating Syrian patients, I have more positive beliefs about Syrian people.”	.408	.088	[.26 – .55]	32.3 (61.2)

Note 1. All p-values were significant at the 0.000 level of significance

Note 2. Respondents who answered 5 or greater on 7-point Likert scale were categorized as “agreeing” with item indicator statement

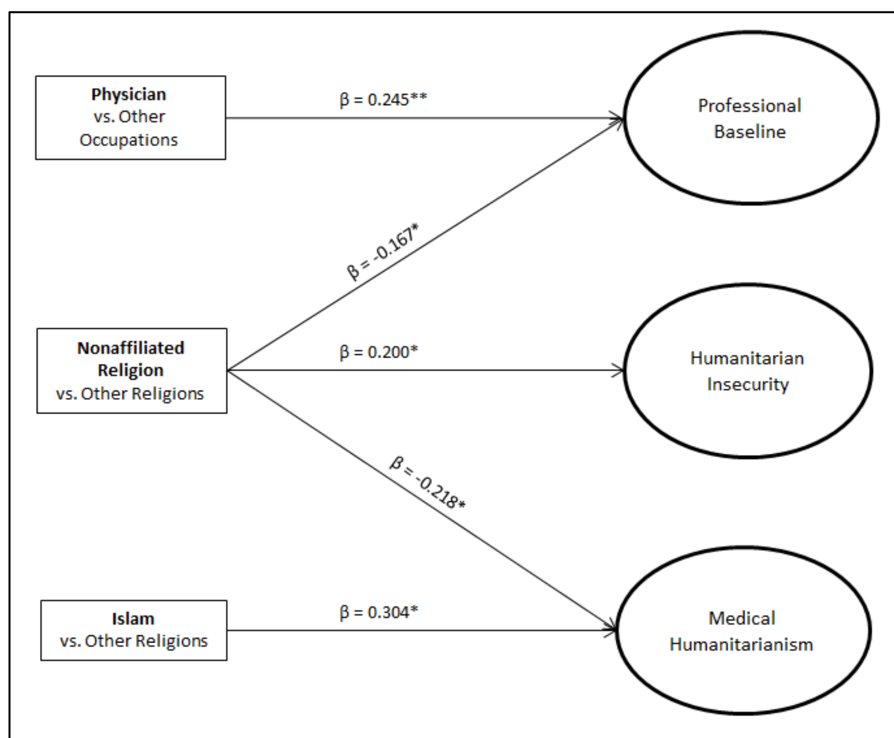

Figure 4.4: Standardized regression of Physician, Nonaffiliated Religion, and Islam on latent factors.

Mixed Findings

A mixed analysis of qualitative and quantitative findings revealed four major domains of HCPs experience treating Syrian patients and is presented in Table 4.3. Specifically, Healthcare providers discussed elements of professionalism, personal experiences, Israel-Syria geopolitics, and their balance of professional and personal beliefs. Additionally, analysis of SCG interview data is also presented in Table 4.3 according to three major domains: their Israeli hospital experience, their balance of personal beliefs with their child's need for healthcare, and their life in Syria.

Domains were explained by themes of supportive and hindering influences HCPs experienced as they provided healthcare to Syrian patients as well as support from our quantitative factor analysis. An in-depth analysis of qualitative data from this study was conducted and provides further support of qualitative domains and themes (see Chapter 3).

The Professionalism domain is explained by data related to providing care to all patients and the overall hospital environment. Primary hindrances to reducing dissonance related to treating Syrian patients included a lack of financial and material resources as well as uncooperative HCP colleagues who did not like to treat HCPs. It was much more common for HCPs to discuss professionalism including following ethical medical codes and working together as a diverse team to provide the best care possible to all patients. Quantitative findings further reinforce the HCPs high regard for professionalism.

The domain of Personal Experiences is illuminated by HCPs' experiences treating Syrian patients, how the Syrian conflict has affected their lives, and their overall life in Israel relative to the Syrian conflict. Some HCPs described connecting with patients in a personal way and feeling sad for their Syrian patients who they believed were suffering in Syria. Their empathy allowed them to humanize Syrian patients and reduce their uncomfortable dissonant feelings regarding providing healthcare. In addition, HCPs recognized the diversity and complexity of Israeli life, and some were able to speak Arabic with their patients, which facilitated a more understanding patient-provider relationship. Overall, few HCPs were insecure regarding how they were perceived by loved ones or colleagues because of treating Syrians. Very few reported harboring negative feelings toward Syrian people following this experience. Hindrances to treatment included Syrian patient resistance and HCP present involvement in military missions against Syrians in the Golan Heights.

Geopolitical history of Israel and Syria was discussed by HCPs to explain the context of their feelings in interviews. Observational data also contributed to understanding this domain, especially as Israel entered into a violent military operation against the Gaza Strip at the time of data collection in 2014. HCPs explained their fear of Syrians, stating how Syrians may one day return to hurt Israelis despite HCPs efforts to help them. Additionally, the survey data revealed the diversity of religions and claims of nationality and ethnicity. HCPs self-identified into over 22 distinct ethnic groups, 19 nationalities, and 7 religious preferences. Members of the Druze ethnic group explained their complicated political affiliation with both Israel and Syria, as many of their families were separated when national borderlines were drawn in 1942 between the two countries.

Healthcare providers also discussed their professional and personal perspectives on treating Syrian patients, specifically how they balanced their professional obligations with their personal beliefs regarding geopolitics, religious differences, and historical discord with Syria. Quantitative analysis of survey items suggested a factor we labeled Medical Humanitarianism because of the compassionate effort HCPs devoted to treating Syrian patients. This factor encompasses more than fair and equal treatment, but emphasizes *compassionate* treatment of patients from a historically enemy country for a humanitarian purpose. After treating Syrian patients, some respondents (32%) reported positive changes in their beliefs of Syrian people as a whole.

Qualitative data suggested treating small children or patients who were in the hospital for extended lengths of time challenged HCPs practice of separating personal and professional aspects of their lives, and they attributed human qualities as they developed relationships with patients and their families. Although HCPs built relationships with some patients, especially

children and their families, many patients were adult males who had been injured during their participation in the war efforts. Additionally, many HCPs may not have been able to communicate with unconscious Syrian patients at all during treatment. HCPs described their personal conflict treating Syrian male fighters, and many explained how they focused on their professional ethical duties, which they separated from their personal conflicting beliefs.

Syrian Caregivers

Qualitative data from Syrian caregivers was divided into three domains: Israeli hospital experience, balance of personal beliefs with need for care, and life in Syria. All three participants were fathers of children who were being treated for war-related injuries (i.e., bomb explosions, targeted shootings). Overall, SCGs described their positive experiences in the Israeli hospitals, and they explained how the word had spread in Syria about the kindness of Israelis and they were less afraid to come to Israel with their children. They described their lives in Syria as "hopeless" and hoped for peace to eventually come between Israel and Syria.

Because their children had been badly injured and needed multiple operations, they were also long-term patients who had been in the hospital as long as 50 days. They were not allowed to leave the hospital, and donations of hygiene items and clothes from local community members and some HCPs helped them be more comfortable during their stay. SCGs described how comforting it was to communicate in Arabic with some HCPs, and they were surprised by how many people could speak their language. They felt respected by their children's doctors, with whom they interacted the most.

One of the most difficult aspects of their experience was the inability to communicate with family members in Syria. Though this policy was meant to protect all involved, including family members in Syria, the SCGs described having to make difficult medical decisions about

their children without consulting their wives or other family members. In addition, for those who had been in the hospital for many weeks, they were unsure how to find their family once they returned to Syria. They feared their family may have been killed or fled during the time they had been in Israel. Following returning to Syria, they explained that they would not talk to many people about being in Israel because it could endanger their families and be considered treasonous.

Table 4.3
Mixed Findings from Qualitative and Quantitative Inquiry on Major Research Domains

Israeli Healthcare Providers

Domains	Qualitative Investigation	Quantitative Investigation
Professionalism Patient care (all patients) Hospital environment	*Supportive influences* HCPs believe in health code of ethics and obligation to treat all patients equally Teamwork environment exists between HCPs across hospital departments Diversity among hospital staff is key to quality patient-provider communication and overall experience *Hindering influences* Resources provided to Syrian patients is a strain financially and materially HCPs know which other HCPS are resistant to treating Syrians based on informal interactions	Professional baseline latent factor • Most of HCPs believed their job is to treat all patients *(99%)* and do not hesitate to do so *(96%).* • Many HCPs *(94%)* reported feeling comfortable treating all patients in their care, regardless of why patients were in the hospital (88%).
Personal Experiences Syrian patient care Effect of Syrian Conflict Life in Israel	*Supportive influences* HCPs connected with Syrian patients emotionally, historically, or personally, which reduced cognitive dissonance and facilitated humanization Shared language facilitated relationship; some HCPs learned Arabic words purposefully HCPs expressed sadness regarding Syrian conflict and feelings of helplessness for wounded civilians and children HCPs recognized life is Israel is ethnically and politically complex, yet they feel safe relative to neighboring countries. *Hindering influences* Syrian patient resistance to treatment mired patient-provider relationship	Humanitarian insecurity latent factor • Few HCPs *(less than 14%)* worried about what others thought of them if they treated Syrian patients. • Few HCPs *(less than 15%)* experienced more negative feelings toward Syrian people after treating Syrian patients, though 20% answered neutrally on this item.
Israel-Syria Geopolitics	Israel's history with Syria has been contentious; citizens of each country do not understand each other and are fearful of each other. Members of Druze religious/ethnic group live in Israel, Syria, and some remain in Golan heights and were separated according to established political boundaries. Military involvement of Israel in Gaza Strip during time of study further complicated HCPs feelings about treating Syrian patients.	Diverse mix of religious perspectives, as well as intricate and numerous differences in ethnicity and nationality were reported.
Professional/Personal Balance	Coping mechanisms included focusing on beliefs in professional ethics and personal moral beliefs in equal treatment of all patients (cognitive dissonance strategy towards humanization) HCPs focused on professional role in the hospital, and expressed setting aside their dissonant personal views or opinions (reducing importance of conflicting belief of Syrians as enemies, cognitive dissonance strategy) Long-term patients and small children challenged HCPs separation of personal and professional beliefs because they developed relationships with these patients and their families (humanization)	Medical humanitarianism latent factor • Most *(70%)* HCPs were proud of their work treating Syrian patients • Some *(32%)* experienced a change in their beliefs regarding Syrian people as a whole

Syrian Care Givers

Domains	Qualitative Investigation
Israeli hospital experience	SCGs expressed appreciation with how well they were treated by HCPs and were surprised by how many HCPs spoke some Arabic language. All SCGs expressed they felt respected by Israeli HCPs and that their sons received excellent treatment. SCGs were unable to contact family in Syria, which was very difficult because they could not communicate about their wounded child's condition, make medical decisions with loved ones, or learn about family displacement or other events at home with other children or family members. Some SCGs remained in the hospital as long as six weeks with their wounded child. One SCG did not trust Israel was helping Syrians for humanitarian reasons, and believed Israel could and should do more to help Syrian people.
Balance Personal beliefs of Israel with need for care	SCGs heard about Israel treating Syrians wounded in the conflict and were thankful for the help for their children. SCGs were hopeful for peace to exist between the two countries, and were confident in the HCPs ability to help them.
Life in Syria	Upon returning to Syria following hospitalization, SCGs expressed they will not share with many people about their experience in Israel because it could endanger them further.

Discussion

As R. Asgary (2015) suggests, medical practitioners are ideal mobilizers of international reform for humanitarian aid due to their international relatability and ability to use their "social capital and advocacy resources" to influence political realms (p. 679). Asgary urgently calls for universal advocacy of safe healthcare provision, which could stigmatize violence in healthcare settings that violate International Humanitarian Laws. Israel may have begun to answer this call to humanitarian urgency by treating wounded Syrians from across the border. One female social worker in this study described how she believed their work contributes to a larger purpose:

> I know there are some people who are angry we are helping Syrians, because they say the Syrians will come back and kill us. But I think we are making a difference by showing them kindness, and we are moving toward peace by saving them. After one year treating Syrians in Israel, many Syrians who come now say they have heard from other people who have returned to Syria that we are peaceful, helpful and kind to them here in Israel. Those who come now are more trusting and less fearful because they have heard from previous patients. This is how we make peace, and I think one day they will remember we helped them during this time. I do not think they will come back and kill us.

Asgary (2015) challenges the humanitarian sector saying, "condemnation and advocacy are not enough," and only through acting for justice and with equality in healthcare can change truly come to pass (p. 679). Israeli healthcare providers in this study provided in-depth, personal challenges and feelings associated with treating patients from a historically enemy country. They discussed particular challenges related to religion, geopolitical history, and current events.

Non-Neutral Positions: Religion and Ethnicity

Participants' self-described religiosity varied from being completely secular and non-religious, to being active tradition-keepers of religion without *believing* in the religion truths, to holding very strongly to religious beliefs *and* traditions. The complexity of religiosity was less clear on the surveys, where participants simply wrote "Jewish" or "Muslim" or "Druze" or

"Secular" (meaning they do not hold to a belief system at all). However, qualitative data provided rich insight into the deep complexity of how politically-charged religious devotion and practice can be in Israel. Though some described themselves as religiously "secular," they would also explain how they believed in equal treatment of all people. In this way, qualitative data showed the politicization of religious identification in Israel; identifying one's self as "secular" further emphasized participants' belief in equal treatment and status for all people. Religious identification was not a neutral position or question.

Additionally, it is important to note intersections associated with ethnicity and religion in Israel. Arab ethnicity could indicate Muslim, Druze, Christian, or secular religious backgrounds. Muslim and Christian families may live together in Arab villages in Israel, though some villages are religiously homogenous. Additionally, decades of Russian/Ukrainian immigration to Israel since the late 1960s includes some Christian religious believers as well, though this is not as prominent a phenomenon (Central Bureau of Statistics, 1999). Though ethnicity is a common measure of identification in the United States (Eisenhower, Suyemoto, Lucchese, & Canenguez, 2014), this categorization presented a particular challenge to our participants who frequently translated the word, "ethnicity" to the Hebrew word, "מוצא אתני" (transliteration is "Motsa Etnee") which back-translates to "ethnic origin." Due to the very nature of Israeli nationality and geopolitics, identification with an ethnic group was also a non-neutral statement and question.

Theoretical Reflection of Latent Factors

Reflecting on the latent factor predictions based on religious identification and occupation also provides insight into the experience of Israeli healthcare providers treating Syrian patients. Nonaffiliated-Religion negatively predicted Professional Baseline and Medical Humanitarianism, but this identification positively predicted Humanitarian Insecurity. It is

possible those who identified as *Nonaffiliated-Religion* (which primarily included those who identified as “secular” or left the space blank) did not harbor salient religious beliefs that could have contributed to dissonance.

Language was a facilitator for HCPs and Syrian patients, and sharing a language allowed HCPs to create common connections with their patients. Religion-Islam positively predicted Medical Humanitarianism. Because Arab Muslims encountered fewer barriers to creating common connections with Syrian patients than others, due to language and religious-cultural similarities, they were proud of their work treating Syrians. Sharing a common language also allows HCPs to recognize and attribute human qualities to their patients more quickly and easily. HCPs who spoke Arabic with Syrian patients could listen to patients directly, learn about their lives, how they were injured, and respond to their needs without using a translator. Direct communication has been shown to increase the quality of the patient-provider relationship (Dima-Laza, 2013; Hertz, 2015; Zolnierek and DiMatteo, 2009).

Occupation-Physician positively predicted Professional Baseline latent factor. This factor reflects HCPs beliefs regarding the importance of professionalism at work, equal and fair treatment, and their comfort treating all people. Being a physician, more so than other occupations, significantly predicted the strength of one’s professional baseline. Interestingly, qualitative analysis revealed the mechanisms through which HCPs reduced dissonance they experienced treating Syrian patients: their sense of professional obligation was often merged with ethical duties to treat all wounded people.[13] Compared to participants with other health occupations (nurses, social workers, and others), physicians spent less time with Syrian patients.

[13] The Israeli Medical Association’s ethical tenants include the standard Greek Hippocratic Oath as well as The Oath of the Hebrew Physician. The Oath of the Hebrew Physician merges personal morals with and professional ethics to treat all wounded people, including enemies (Israeli Medical Association, 2009a).

Their roles were limited to brief examinations of patients and quick assessments of how to treat war-related traumas. The nature of their positions frequently limited their ability to form subjective relationships with patients. Because their roles were not as conducive to creating common connections with patients, physicians may have consciously focused on their professional and ethical duties in order to reduce dissonance.

Cognitive dissonance theory is supported by the negative relationship between Professional Baseline and Humanitarian Insecurity. Humanitarian Insecurity factor reflected HCPs' feelings of worry and negativity, dissonant feelings that could be cognitively outweighed or subdued by focusing on professional beliefs. However, Professional Baseline and Medical Humanitarianism shared a positive relationship, further supporting how the concepts of cognitive strategies and attribution of human qualities are related. Healthcare calls for fair and ethical treatment of all people. Yet, the healthcare profession has been politicized by the transparency of our globalized society. In this study, we argue professionalism and humanitarianism have become interrelated concepts healthcare providers confront, especially when they provide healthcare to political refugees whose history has been historically antagonistic toward their own. Further study should continually seek understanding of such complex humanitarian issues, especially concerning the growing refugee crisis around the globe and implications for medical ethics and practice.

Conclusion

In Israel, a country whose very political authenticity is debated, healthcare providers have challenged centuries of ethnic, religious, and political hostility by saving the lives and dignities of Syrian men, women, and children. Representing the countless threads of demographic diversity woven throughout Israel's population, healthcare providers have devoted their most

advanced surgical and prosthetic technologies to Syrian patients since the first patient arrived in February 2013 (“Israel May Set Up Hospital for Syrians,” 2013; T. Sheleg, personal communication, July 29, 2015). This study illuminated how barriers of mutual fear, distrust, and misunderstanding slowly dissolved for both Syrian patients and Israeli healthcare providers. The hospital environment is known as a uniquely safe harbor for the wounded. By understanding the dynamics of Syrian patient and Israeli healthcare provider relationships, humanitarian healthcare efforts are strengthened. The call to humanitarian healthcare action has been heard in Israel, and represents a model for the rest of the humanitarian field and society at large.

CHAPTER 5

CONCLUSION: MEDICO-HUMANITARIAN IDENTITY

Approaching this dissertation, my research question reflected a desire to explore humanity in action: "How do Israeli healthcare providers and Syrians in the hospital experience the caregiving process?" I was inspired by the seemingly paradoxical nature of Israelis saving the lives of Syrians, in spite of their countries' adversarial relationship. I chose to explore the phenomenon of human interaction experienced by Israelis and Syrians – people groups who typically do not interact face-to-face and who have developed with adversarial perspectives of each other for decades, some would argue for centuries.

To answer my question, I considered the human development of all involved, including dimensions of politics, geography, religion, ethnicity, and nationality. I considered meta-values of each group – values and characteristics groups claim as their own, as well as those attributed to each group by outsiders – as salient frameworks for the application of cognitive dissonance, cultural dissonance, and infrahumanization theories. Reflecting on the meta-messages of this research, I am inspired to propose the concept of *medico-humanitarian identity*, which I believe both Israeli healthcare providers and Syrians ascribed to during the healthcare process as they provided and received healing treatment for and by an 'enemy' person.

Medico-Humanitarian Identity

The *medico-humanitarian identity* represents the higher-order qualities participants expressed as they reduced the importance of their subjective characteristics (religion, ethnic identification, political differences) that caused dissonance when providing or receiving care, and instead they actively sought and attributed human qualities to the other. Healthcare providers'

narratives explained how they attributed human qualities to Syrian patients and their caregivers in order to reduce any feelings of dissonance related to their cultural, religious, and political differences. Some incorporated personal beliefs into their medico-humanitarian identification, prioritizing prior beliefs of equality of all people. Others reduced personal prejudices by investing in their professional duties in order to warrant their actions. Overall, healthcare providers ascribed to a medico-humanitarian identity, over and above any individual identities that set them apart as unique individuals. In the healthcare setting studied in this research, unique differences were uncharacteristically set aside for the purpose of treating wounded patients who happened to be Syrians.

Conclusion

It is likely that many Israelis and Syrians may be changed because of their experiences interacting in such a vulnerable manner as providers and receivers of life-giving healthcare. As HCP7 said, "Every single patient sticks out because they are so unique. I think about it all the time, at home and at work. It is bullshit if people say they aren't affected by the patients. No one trains you for this." Participants in this research were able to lay aside personal differences for the purpose of saving lives, even the lives of their enemies. Perhaps the greatest lesson to learn from this research is one of *purpose*. What purpose will we have in this life, individually and as a society? In a globalized society that increasingly values uniqueness, difference, and individuality, this study illustrated the value in recognizing our shared humanity. Through the voices and responses of healthcare providers providing life-saving healthcare, may we be encouraged to continue to break down the proverbial walls that separate us and instead seek the human qualities we share.

The sheer volume of individuals and families being forced from their homes and relocated to foreign communities challenges our research needs as well as our societal needs. The global exchange of people who have faced trauma, poverty, illness, and oppression necessitates thorough understanding through research, policy, and overall awareness. As I pursue a career working with refugee families and conducting research on health and resettlement, I will strive to be responsibly inclusive and critical regarding my theoretical and methodological choices. Despite philosophical challenges associated with mixing theories and methods, I clearly heard the call to study refugees' needs and disseminate the voices of those involved in this healthcare experience in Israel. I hope to continue to seek and publish their voices in the current and future dialogue of related research and policy.

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Appendix A

Interview Protocol: Healthcare Providers

Savannah E. Spivey

Syrian Refugees in Israeli Hospitals: How Cognitive Dissonance of Healthcare Providers Influences Caregiving and Affects Syrian refugee patients and their Families.

Review of Interview Process

1. Introduce the researcher
2. Explain the purpose of the study
    - Answer any questions
    - Ask if participant would like to be interviewed.
3. Explain the consent process
    - Answer any questions
4. Give consent/assent form
    - Answer any questions
5. Interview
6. Thank participant(s)
    - Answer any questions

Demographic Information

1. By what name would you like to be called for the purposes of this research?
2. What is your age?
3. Where were you born?
4. What is your ethnicity?
5. What do you consider as your nationality?
6. Can you tell me if you practice a religion and, if so, which religion you practice?

Ask Participants to Describe Their Experience in the Hospital as Care Providers

1. Tell me about your overall experiences as a care provider here at this hospital.
2. How long have you been practicing healthcare?
    a. In general/overall?
    b. In Israel?
    c. In this hospital?
    d. In this department?

3. Tell me about your experiences as a care provider here since the war broke out in Syria.
    a. Explain if and how this conflict has influenced/changed your routine as a care provider?
    b. Can you describe if and how your job has influenced/changed, overall, since the conflict began?
    c. Please tell me about any positive or negative experiences you've had regarding Syrian patients and how those experiences compare to treatment of non-Syrians.

Ask participants to describe how they have personally been affected by the conflict in Syria.

1. Please describe how you feel, personally, about the civil war in Syria?
    a. How has this conflict affected you, personally?
    b. Tell me about how this conflict has influenced your attitude about your job as a healthcare provider.
    c. Tell me about how this conflict has affected your life outside of the hospital.
        i. Please explain how it has affected your family.
        ii. Please describe how it has affected your friendships.
    d. Please explain how the conflict in Syria has affected other areas of your life.

Ask participants to describe how they balance their job with their personal beliefs.

1. Tell me about how you balance your personal life with your work life.
    a. Explain if and how this balance has been affected by the Syrian conflict.
2. Tell me about your relationships with colleagues at the hospital.
    a. Can you explain if and how your professional relationships have been affected by the Syrian conflict?
    b. Please explain how you generally feel about treating Syrian patients.
    c. Tell me about how your colleagues feel about treating Syrian patients.
        i. Tell me about why you think they feel this way.
3. Explain how the conflict influences your own attitude toward Syrian people.
    a. Tell me about how the conflict has influenced your attitude toward Syrian children, soldiers, rebels, nationals and civilians.
    b. Tell me about your beliefs regarding Syrian people, overall.
    c. Tell me about your beliefs/feelings regarding the Syrian conflict.
    d. Tell me about your relationships with Syrian patients in your care.
    e. Explain if and how treating Syrian patients is different than treating non-Syrian patients in your care.
4. Please tell me about any feelings you experience related to your job as a healthcare

provider treating Syrian patients.

    a. Please explain how it makes you feel as a healthcare provider.

5. Please explain how it makes you feel, personally.
    a. Describe how you feel about yourself as a person and as a healthcare provider during these troubling times.
    b. How do your personal beliefs or morals affect your job?
    c. Explain how you balance your personal feelings regarding the conflict in Syria with your position as a healthcare provider.
    d. Describe any anxiety you may experience regarding your job.
6. Tell me about some ways you cope with and manage the feelings you have described to me.

Ask participants to describe how they feel about their life in Israel.

1. Please explain how you feel about Israel as your country.
    a. Tell me about your personal beliefs regarding Israel's history.
2. Explain complications related to your citizenship in Israel
    a. How have you and your family been influenced by Israel's history.
    b. Describe your ethnicity and how you see yourself, specifically related to your relationship with others in Israel.
3. Tell me about your life in Israel.
    a. Tell me about how your life has been different since the conflict in Syria began.
4. Tell me about the feelings you may experience related to your personal beliefs, ethnicity, your job as a healthcare provider and the Syrian conflict.

Appendix B

Interview Protocol: Syrian Refugees

Savannah E. Spivey and Denise C. Lewis

Syrian Refugees in Israeli Hospitals: How Cognitive Dissonance of Healthcare Providers Influences Caregiving and Affects Syrian Refugee Patients and their Families.

Review of Interview Process

1. Introduce the researcher
2. Explain the purpose of the study
   - Answer any questions
   - Ask if participant would like to be interviewed.
3. Explain the consent process
   - Answer any questions
4. Give consent/assent form
   - Answer any questions
5. Interview
6. Thank participant(s)
   - Answer any questions

Demographic Information

1. What is your age?
2. Where were you born?
3. What is your ethnicity?
4. What do you consider as your nationality?
5. Can you tell me if you practice a religion and, if so, which religion you practice?

Ask participants to describe their experience in the hospital as Syrians

1. Tell me about your journey that led you to Israel.
   a. Tell me about how long you have been in Israel.
   b. Explain your overall experience in Israel.
2. Tell me about your **overall experiences** here at the hospital.
   a. How long have you been in this hospital?
      i. In general/overall?
      ii. In Israel?
      iii. In this department?
   b. Can you please tell me about your relationship with the person you came here with?

i. Tell me about him/her/them.

c. Tell me about why you came to this hospital.
d. Please describe your experience accompanying/waiting for this person/these people in the hospital.

3. Tell me about your relationship with the hospital workers.
    a. Please describe how you communicate with the caregivers.
    b. Tell me about how you stay informed about the injured friend or family member whom you are here with.
    c. Tell me about how the hospital workers talk to you.
    d. Can you tell me about your trust of people here in this hospital?
4. Can you tell me about a positive experience you have had here at this hospital?
    a. Or along your journey?
5. Can you tell me about a less positive/negative experience you have had here in the hospital?
6. Have you noticed any differences in treatment or care for you and your friend/family member compared to others here at the hospital?
    a. Tell me about how you feel about the healthcare or treatment they are receiving.
    b. In what ways do you think the treatment they receive is different than or is the same treatment other patients receive?

Ask participants to describe how they balance their need for care with their personal beliefs.

1. Tell me about how this conflict has influenced your attitude about Israel and Israelis.
    a. How has the experience of seeking healthcare in Israel affected how you feel about Israel and Israelis overall?
    b. How has your experience here in the hospital been as you expected? *(maybe they had no expectations)
        i. In what ways has it been different?
    c. Tell me about how this experience in the hospital influences how you think about Israelis.
2. Explain how the conflict influences your attitude toward Israeli people.
    a. Tell me about your beliefs regarding Israeli people, overall.
    b. Tell me about your beliefs regarding the healthcare providers treating injured Syrians.
        i. Explain how you feel about receiving help from Israel/Israeli citizens in the hospital.
3. Please explain how being in this Israeli hospital makes you feel, personally.
    a. Describe how you feel about yourself as a person being helped by Israeli citizens.

    b. Describe how your personal beliefs or morals affect how you perceive or experience the hospital setting with your injured friend/family member.
4. What will you tell your friend/family members when you leave the hospital?
    a. How might this experience with the Israeli medical staff influence what you tell people back home?
5. How will you explain this experience to your friends and family when you return home?
6. How might this experience change how you feel about Israel?
7. Tell me about any anxious feelings you may have being here in Israel.
8. Tell me about some ways you cope with and manage the feelings you have described to me.

Ask participants to describe how they feel about their life in Syria.

1. Please explain how you feel about Syria as your country.
    a. Tell me about your feelings of receiving help in Israel.
2. Explain any complications related to your citizenship in Syria
    a. How have you and your family been influenced by Syria and Israel's riddled history.
    b. Describe your ethnicity and how you see yourself, specifically related to your relationship with others in Syria and Israel.
3. Tell me about your life in Syria.
    a. Tell me about how your life has been different since the conflict began.
    b. Tell me about how being in Israel during the conflict in Syria affects your personal beliefs.

Ask participants to describe how they have personally been affected by the conflict in Syria.

1. Can you describe how you feel about the war in Syria?
2. How has this conflict affected you, personally?
    a. Tell me about how this conflict has affected your life.
        i. Please explain how it has affected your family.
        ii. Please describe how it has affected your friendships.
        iii. Please explain how the conflict in Syria has affected other areas of your life.

Appendix C

Survey for Healthcare Providers in Israel Treating Syrian Refugees

Thank you for taking part in this survey. Please answer the following questions as honestly as you can.

Gender: Male Female **Age**: ___________________________

Occupation: Nurse Social Worker Physician Specialist Other ___________________

Ethnicity: _______________________ **Nationality**: _____________________________

Religion: ________________________

On a scale of 1 to 7, please indicate how you agree or disagree with the following statements, with 1 meaning you "completely disagree," and 7 meaning you "completely agree."

I Completely Disagree **I Do Not Agree or Disagree** **I Completely Agree**

1. I am comfortable providing healthcare to all patients in my care.
   1 2 3 4 5 6 7

2. I do not hesitate to provide quality healthcare to anyone in my care.
   1 2 3 4 5 6 7

3. It is my job to treat all patients in the hospital, regardless of their reason for being there.
   1 2 3 4 5 6 7

4. When I provide healthcare to patients, I do not think about underlying issues related to *why* they are in the hospital.
   1 2 3 4 5 6 7

5. When I provide healthcare to patients, it *helps* me if I know less about their reasons for being in the hospital.
   1 2 3 4 5 6 7

6. Because Israel and Syria are at war, I am uncomfortable treating Syrian *adult* patients.
   1 2 3 4 5 6 7

7. Because Israel and Syria are at war, I am uncomfortable treating Syrian *child* patients.
   1 2 3 4 5 6 7

8. I feel guilty for treating injured Syrian patients in the hospital.
   1 2 3 4 5 6 7

9. I worry about what my friends and/or family will think about me if I help Syrian people in the hospital.
   1 2 3 4 5 6 7

10. When I am at work, I worry about what my colleagues will think about me if I treat Syrian people.
    1 2 3 4 5 6 7

11. I am proud of my work treating and helping Syrian patients.
    1 2 3 4 5 6 7

12. I am proud of my Israeli citizenship.
    1 2 3 4 5 6 7

13. All in all, after treating Syrian patients, I have more positive beliefs about Syrian people.
    1 2 3 4 5 6 7

14. All in all, after treating Syrian patients, I have more negative beliefs about Syrian people.
    1 2 3 4 5 6 7

Over the last <u>two weeks</u>, how often have you been bothered by the following problems?

11. Feeling nervous, anxious or on edge	0	1-6 days	More than 6 days	Nearly every day
12. Not being able to stop or control worrying	0	1-6 days	More than 6 days	Nearly every day
13. Worrying too much about different things	0	1-6 days	More than 6 days	Nearly every day
14. Trouble relaxing	0	1-6 days	More than 6 days	Nearly every day
15. Being so restless that it is hard to sit still	0	1-6 days	More than 6 days	Nearly every day
16. Becoming easily annoyed or irritable	0	1-6 days	More than 6 days	Nearly every day
17. Feeling afraid as if something awful might happen	0	1-6 days	More than 6 days	Nearly every day

Appendix D

Survey for Syrian Refugee Families or Friends in Israeli Hospitals

Thank you for taking part in this survey. Please answer the following questions as honestly as you can.

Gender: Male Female **Age:** ______________________________

Ethnicity: ______________________ **Nationality**: ________________________

Religion: _______________________

Please circle the number that shows how you agree or disagree with these sentences, with 1 meaning you "completely disagree," and 7 meaning you "completely agree."

I Completely Disagree **I Do Not Agree or Disagree** **I Completely Agree**

1. I am comfortable at this Israeli hospital as a Syrian person.
   1 2 3 4 5 6 7

2. I am pleased with the healthcare my friend or family member is receiving here at the hospital.
   1 2 3 4 5 6 7

3. I believe my friend or family member is being treated fairly by healthcare providers at this hospital.
   1 2 3 4 5 6 7

4. Because I am from Syria, I feel like I am treated badly in Israel.
   1 2 3 4 5 6 7

5. I am worried about returning to Syria after my friend or family member is released from the hospital.
   1 2 3 4 5 6 7

6. I worry about the quality of treatment my friend or family member is receiving at this hospital because we are from Syria.
   1 2 3 4 5 6 7

7. Because Syria and Israel are at war, I am worried about what our friends and family will think about us receiving healthcare in Israel.

1 2 3 4 5 6 7

8. I am proud of my Syrian nationality.

1 2 3 4 5 6 7

9. Because Syria and Israel are at war, it bothers me to rely on Israel for healthcare.

1 2 3 4 5 6 7

10. Receiving healthcare in Israel gives me a more positive attitude about Israeli citizens.

1 2 3 4 5 6 7

11. Receiving healthcare in Israel gives me a more negative attitude about Israeli citizens.

1 2 3 4 5 6 7

Over the last <u>two weeks</u>, how often have you been bothered by the following problems?

11. Feeling nervous, anxious or on edge	0	1-6 days	More than 6 days	Nearly every day
. 12. Not being able to stop or control worrying .	0	1-6 days	More than 6 days	Nearly every day
. 13. Worrying too much about different things .	0	1-6 days	More than 6 days	Nearly every day
. 14. Trouble relaxing .	0	1-6 days	More than 6 days	Nearly every day
. 15. Being so restless that it is hard to sit still .	0	1-6 days	More than 6 days	Nearly every day
. 16. Becoming easily annoyed or irritable .	0	1-6 days	More than 6 days	Nearly every day
. 17. Feeling afraid as if something awful might happen	0	1-6 days	More than 6 days	Nearly every day

Appendix E

Interview Consent Letter

Summer 2014

Dear Participant:

I am a graduate student at The University of Georgia, The United States of America. I invite you to participate in a research study entitled "Care of and for Syrian Refugees in Israeli Hospitals" that is being conducted by the University of Georgia. The purpose of this study is to examine how healthcare workers are ethically obligated to treat wounded Syrian patients and how this could potentially disagree with their beliefs about Syrians.. This research is not affiliated with this hospital in any way and all information collected will go back to the U.S. with the researcher. No data will remain here at this hospital. In addition, participating in this interview will, in no way, affect your experience as a refugee, your wounded friend or family member's experience here at this hospital, or your employment here at the hospital.

You are being asked to participate in this study because you are either a **healthcare provider or hospital staff member** who has treated Syrian patients, or you are a **visitor in Israel from Syria** and you are in the hospital with an family member or friend who has been injured in Syria.

Participating will involve a 20-90 minute interview. All information you provide will be transcribed word for word, stored securely, and only used for research purposes. Audio recordings used for this research study shall be retained for research purposes, but will then be destroyed by October 6, 2016.

You may be asked about the following topics: information about you (age, religion, gender), experience in the hospital as a refugee or as an employee, your personal experience with the Syrian conflict, your beliefs, and your experience in Israel as a citizen or as a refugee.

You can choose to speak with the researcher or not, it is up to you. You may also stop anytime during the interview if you would like. Also, if requested in a written or typed note or email, the researcher will destroy all information you have provided if this is your wish at any point during the interview. You will not be required to provide information that will violate medical ethics related to patients' injuries or diseases. If you do participate, this participation will be your consent because researchers are not asking for your signature. You may be asked to speak to the researcher up to two more times to clarify or add information.

No individually-identifiable information about you, or provided by you during the interview, will be shared with others. Translators will agree to keep everything you say strictly confidential, and your name or any other information about you, specifically, will not be able to be traced back to

you after the conclusion of this interview. In fact, the interviewer will not ask for your name, but you may provide it if you wish. You will be assigned a number and this number will be used in all of the interview transcription by the researcher. The investigator will answer any further questions about the research, now or during the course of the interview.

The results of the research study may be published, but your name or any identifying information will not be used. In fact, the published results will be presented in summary form only.

If you agree to be interviewed, you will be able to voice your concerns to the researcher about your experience as an employee or refugee. This may help you process your experience so far. This research may provide much needed information on refugees' healthcare in times of conflict by assisting countries. Refugees' needs are unique and this study will help inform how hospital staff and refugees interact so as to improve quality of care and experience for those in similar situations.

If you ever become uncomfortable, please let the researcher or translator know and they will move on to another topic or stop the interview completely.

If you have any questions about this research project, please feel free to send an e-mail to Savannah Spivey at sespivey@uga.edu. Questions or concerns about your rights as a research participant should be directed to The Chairperson, University of Georgia Institutional Review Board, 629 Boyd GSRC, Athens, Georgia 30602; telephone (706) 542-3199; email address irb@uga.edu.

Thank you for your consideration! Please keep this letter for your records.

Sincerely,

Savannah Spivey

University of Georgia

Appendix F

Survey Consent Letter

Summer 2014

Dear Participant:

I am a graduate student at The University of Georgia, The United States of America. I invite you to participate in a research study entitled “Care of and for Syrian Refugees in Israeli Hospitals” that is being conducted by the University of Georgia. The purpose of this study is to examine how healthcare workers are ethically obligated to treat wounded Syrian patients and how this could potentially disagree with their beliefs about Syrians.. This research is not affiliated with this hospital in any way and all information collected will go back to the U.S. with the researcher. No data will remain here at this hospital. In addition, participating in this interview will, in no way, affect your experience as a refugee, your wounded friend or family member’s experience here at this hospital, or your employment here at the hospital.

You are being asked to participate in this study because you are either a **healthcare provider or hospital staff member** who has treated Syrian patients, or you are a **visitor in Israel from Syria** and you are in the hospital with an family member or friend who has been injured in Syria.

Your participation will involve completion of the attached brief survey regarding your experience. You can expect to complete this survey in less than five minutes. Please try to be as truthful as you can. Your participation is completely voluntary and anonymous. There will be no way to track your responses back to you after you submit this survey. You may choose not to participate and this will, in no way, affect your job at the hospital or your experience as a refugee in the hospital. No one will be able to trace this survey back to you, including the researcher.

Questions on the survey are broadly addressing your personal feelings about your experience as an employee of the hospital or as a refugee in the hospital. Please take a look at the survey attached to this consent letter if you would like to see the questions before you answer them.

The results of the research study may be published, but your name or any identifying information will not be used. In fact, the published results will be presented in summary form only.

If you fill out this survey, you will be able to express your concerns about your experience as an employee or refugee. This may help you process your experience so far. This research may provide much needed information on refugees’ healthcare in times of conflict by assisting countries. Refugees’ needs are unique and this study will help inform how hospital staff and refugees interact so as to improve quality of care and experience for those in similar situations.

If you have any questions about this research project, please feel free to send an e-mail to Savannah Spivey at sespivey@uga.edu. Questions or concerns about your rights as a research participant should be directed to The Chairperson, University of Georgia Institutional Review Board, 629 Boyd GSRC, Athens, Georgia 30602; telephone (706) 542-3199; email address irb@uga.edu.

By completing and returning this questionnaire in the envelope provided, you are agreeing to participate in the above described research project.

Thank you for your consideration! Please keep this letter for your records.

Sincerely,

Savannah Spivey

University of Georgia

Appendix G

Hospital-1 Administration Support Letter for Employee Participation

Dear [Hospital] Employee,

Please consider participating in this research conducted by Savannah Spivey who is from the University of Georgia, USA. On behalf of [our chief administrator] and the administration of [this hospital], I encourage you to participate by completing a brief survey and/or answering Savannah's questions. This research will not only aid the hospital as a whole, bringing additional research experience to Israel's healthcare community, but it will also promote our hospital as a refuge for Syrian patients in our care. The research will be published internationally, and will be important for the future of healthcare and refugee issues. As you know, we are a teaching hospital, and research of social issues such as those surrounding Syrian patients are equally important to the future of healthcare as other areas of study we have conducted here.

[Our chief administrator] and the administration, as well as the University of Georgia's Ethics Review Board (IRB/Helsinki), have approved of and support this work.

We encourage your honest participation,

[International Relations Administration]

Appendix H

Survey Consent Letter: Hebrew

מכתב הסכמה להשתתפות בסקר

קיץ 2014

משתתף יקר:

אני סטודנטית לתואר שני באוניברסיטת ג׳ורג׳יה בארה״ב. אני מזמינה אותך להשתתף במחקר בנושא ״דאגה וטיפול בפליטים סוריים בבתי חולים בישראל״, אשר נערך על ידי אוניברסיטת ג׳ורג׳יה. מטרת המחקר הינה לבחון כיצד עובדים במערכת הבריאות מחויבים מבחינה אתית לטפל במטופלים סוריים פצועים, וכיצד הדבר עלול לגרום לאי הסכמה פוטנציאלית בהקשר לעמדותיהם כלפי הסורים. המחקר אינו קשור בשום אופן לבית החולים הנוכחי, וכל המידע שייאסף יוחזר לארה״ב ע״י החוקרים. לא יישאר מידע כלשהו כאן בבית החולים. בנוסף, ההשתתפות בסקר זה לא תשפיע בשום אופן על חווייתך כפליט, חוויית חברך הפצוע או בני משפחתך כאן בבית החולים, או העסקתך כאן בבית החולים.

הינך מתבקש להשתתף במחקר זה עקב היותך **ספק/ית שירותי בריאות או חבר/ת סגל בבית החולים** שטיפל/ה במטופלים סוריים, או **מבקר/ת בישראל מסוריה** הנמצא/ת כאן בבית החולים עם בן משפחה או חבר שנפצעו בסוריה.

כחלק מהשתתפותך תתבקש/י למלא את השאלון הקצר המצורף בנוגע לחווייתך. ניתן לסיים מילוי שאלון זה בפחות מ-5 דקות. אנא נסה/י להיות כנה בתשובותיך ככל שאת/ה יכול/ה. השתתפותך בסקר הינה בהתנדבות ואנונימית לחלוטין. לא ניתן יהיה להתחקות אחר תשובותיך לאחר מסירת שאלון הסקר המלא. את/ה יכול/ה להחליט שלא להשתתף בסקר, והדבר לא ישפיע בשום אופן על עבודתך בבית החולים או על חווייתך כפליט/ה בבית החולים. לא תהיה יכולת לאף אחד, כולל החוקר, להתחקות אחר תשובותיך.

שאלות הסקר מתייחסות בצורה רחבה לרגשותיך האישיים בנוגע לניסיונך כעובד/ת בית החולים או כפליט/ה בבית החולים. אנא עיין/י בשאלון המצורף למכתב הסכמה זה אם ברצונך לראות את שאלות הסקר לפני המענה עליהן.

ייתכן וממצאי המחקר יפורסמו, אולם לא יעשה שימוש בשמך או בכל פרט/ מידע מזהה. למעשה, ממצאים מפורסמים יוצגו בצורת סיכום בלבד.

באם תמלא/י את שאלון הסקר, תוכל/י לתת ביטוי לכל הנוגע לניסיונך כעובד/ת או כפליט/ה. דבר זה יכול לתרום לך בעיבוד חווייתך עד כה. מחקר זה יכול לספק את מרבית המידע הדרוש על שירותי בריאות לפליטים

בעתות קונפליקט צבאי באמצעות מדינות מסייעות. צרכי הפליטים הינם מיוחדים במינם, והמחקר הנוכחי יסייע לקבל מידע אודות האינטראקציה בין חברי צוות בית החולים והפליטים, זאת במטרה לשפר את איכות הטיפול וחוויותיהם של אלו הנמצאים במצבים דומים.

אם יש לך שאלות בנוגע לפרויקט המחקר הנוכחי, אנא תרגיש/י חופשי לשלוח דוא״ל לסוואנה ספיווי (Savannah Spivey) לכתובת sespivey@uga.edu. ניתן להפנות שאלות או תהיות בנוגע לזכויותיך כמשתתף במחקר ליו״ר ועדת ביקורת מוסדית באוניברסיטת ג׳ורג׳יה לכתובת: 629 Boyd GSRC, Athens, Georgia 30602; טלפון: 542-3199 (706); כתובת דוא״ל: irb@uga.edu.

מילוי ומסירת שאלון זה במעטפה המיועדת לכך, מהווים הסכמתך להשתתפות במחקר הנוכחי.

תודה לך על שיתוף הפעולה! אנא שמור מכתב זה ברישומיך.

בברכה,

סוונה ספיווי

אוניברסיטת ג׳ורג׳יה

Appendix I

Interview Consent Letter: Hebrew

מכתב הסכמה להשתתפות בראיון

קיץ 2014

משתתף יקר:

אני סטודנטית לתואר שני באוניברסיטת ג׳ורג׳יה בארה״ב. אני מזמינה אותך להשתתף במחקר בנושא ״דאגה וטיפול בפליטים סוריים בבתי חולים בישראל״, אשר נערך על ידי אוניברסיטת ג׳ורג׳יה. מטרת המחקר הינה לבחון כיצד עובדים המספקים את שירותי הבריאות מחויבים מבחינה אתית לטפל במטופלים סוריים פצועים, וכיצד הדבר עלול לגרום לאי הסכמה פוטנציאלית בהקשר לעמדותיהם כלפי הסורים. המחקר אינו קשור בשום אופן לבית החולים הנוכחי וכל המידע שייאסף יוחזר לארה״ב ע״י החוקר. לא יישאר מידע כלשהו כאן בבית החולים. בנוסף, ההשתתפות בראיון זה לא תשפיע בשום אופן על חווייתך כפליט, חוויית חברך הפצוע או בני משפחתך כאן בבית החולים, או העסקתך כאן בבית החולים.

הינך מתבקש להשתתף במחקר זה כתוצאה מהיותך **ספק/ית שירותי בריאות או חבר/ת סגל בבית החולים** שטיפל/ה במטופלים סוריים, או **מבקר/ת בישראל מסוריה** והנמצא/ת כאן בבית החולים עם בן משפחה או חבר שנפצעו בסוריה.

ההשתתפות תהיה כרוכה בראיון בן 20 – 90 דקות. כל המידע שיימסר על ידך יתורגם מילה במילה, יאוחסן בבטחה, וישמש לצרכי המחקר בלבד. הקלטות שבהן נעשה שימוש לצורך המחקר הנוכחי, ישמרו לצרכי המחקר ויושמדו עד ה-6 לאוקטובר 2016.

ייתכן ותישאל/י על הנושאים הבאים: מידע עליך (גיל, דת, מין), חוויה בבית החולים כפליט/ה או כעובד/ת, ניסיון אישי עם הקונפליקט הסורי, עמדותיך וניסיונך בישראל כאזרח/ית או כפליט/ה.

ביכולתך לבחור האם לשוחח עם המראיין או לא, זה תלוי בך. הינך רשאי/ ת להפסיק את הראיון בכל רגע שתרצה/י. כמו כן, באם נשאלת בכתב או בדפוס או באמצעות דוא״ל, החוקר ישמיד את כל המידע שסופק באם תרצה בכך בכל שלב ביצוע הראיון. לא תידרש/י למסור מידע שיפר את כללי האתיקה הרפואית בהקשר לפציעות או מחלות המטופלים. באם תבחר/י להשתתף במחקר זה, השתתפותך תהווה הסכמה, מאחר והחוקרים לא יבקשו את חתימתך. ייתכן ותתבקש/י לשוחח עם החוקר עד שתי פעמים נוספות במטרה להוסיף או להבהיר מידע שנמסר.

המידע אודותיך שניתן לזיהוי אישי או כזה שנמסר על ידיך במהלך הראיון לא יועבר לגורמים אחרים.

יוסכם עם המתרגמים כי כל דבר שייאמר על ידיך יישמר בסודיות מוחלטת, ולא ניתן יהיה להתחקות אחר שמך או כל פרט אחר אודותיך, באופן ספציפי, לאחר סיום ראיון זה. למעשה, המראיין לא יבקש לציין את שמך, אולם ביכולתך לומר אותו באם תרצה/י. יוקצה לך מספר סידורי שיעשה בו שימוש בכל תמלול הראיון ע״י החוקר. החוקר יענה על כל השאלות הנוספות אודות המחקר כעת או במהלך ביצוע הראיון.

ייתכן וממצאי המחקר יפורסמו, אולם לא יעשה שימוש בשמך או בכל פרט/ מידע מזהה. למעשה, ממצאים מפורסמים יוצגו בצורת סיכום בלבד.

באם תסכים/י להתראיין, תוכל/י להשמיע לחוקר את כל הנוגע לניסיונך כעובד/ת או כפליט/ה. דבר זה יכול לתרום לך בעיבוד חווייתך עד כה. מחקר זה יכול לספק את מרבית המידע הדרוש על שירותי בריאות לפליטים בעתות קונפליקט צבאי באמצעות מדינות מסייעות. צרכי הפליטים הינם מיוחדים במינם, והמחקר הנוכחי יסייע לקבל מידע אודות האינטראקציה בין חברי צוות בית החולים והפליטים, זאת במטרה לשפר את איכות הטיפול וחוויתם של אלה הנמצאים במצבים דומים.

אם בשלב מסוים של הראיון תרגיש/י שלא בנוח, אנא יידע/י את החוקר או את המתרגם והם יעברו לנושא אחר או יפסיקו את הראיון לאלתר.

אם יש לך שאלות בנוגע לפרויקט המחקר הנוכחי, אנא תרגיש/י חופשי לשלוח דוא״ל לסוונה ספיווי (Savannah Spivey) לכתובת sespivey@uga.edu. ניתן להפנות שאלות או תהיות בנוגע לזכויותיך כמשתתף במחקר ליו״ר ועדת ביקורת מוסדית באוניברסיטת ג׳ורג׳יה לכתובת: 629 Boyd GSRC, Athens, Georgia, 30602; טלפון: 542-3199 (706); כתובת דוא״ל: irb@uga.edu.

תודה לך על שיתוף הפעולה! אנא שמור מכתב זה ברישומיך.

בברכה,

סוונה ספיווי

אוניברסיטת ג׳ורג׳יה

Appendix J

Healthcare Provider Survey: Hebrew

<u>סקר בקרב ספקי שירותי הבריאות בישראל המטפלים בפליטים סוריים</u>

ברצוני להודות לך על השתתפותך בסקר. אנא השב/י על השאלות הבאות בכנות ככל הניתן.

מין: זכר נקבה **גיל:** ____________________

מקצוע: אח/ות מוסמך/ת עובד/ת סוציאלית רופא/ה מומחה/ית אחר ____________________

מוצא אתני: ____________________ **לאום:** ____________________

דת: ____________________

בסקאלה שבין 1 ל-7, אנא ציין באיזו מידה הינך מסכים או לא מסכים עם האמירות הבאות, כאשר 1 משמעותו "כלל אינני מסכים", ו-7 משמעותו "מסכים בהחלט".

אני מסכים בהחלט **אני לא מסכים ולא מתנגד** **כלל אינני מסכים**

1. אני מרגיש/ה בנוח לספק שירותי בריאות לכל המטופלים שבאחריותי.

7 6 5 4 3 2 1

2. אני לא מהסס/ת לספק שירותי בריאות איכותיים לכל המטופלים שבאחריותי.

7 6 5 4 3 2 1

3. תפקידי הוא לטפל בכל המטופלים בבית החולים, ללא קשר לסיבת הימצאותם בו.

7 6 5 4 3 2 1

4. כשאני מספק/ת את שירותי הבריאות למטופלים, אני לא חושב/ת על הסיבות להימצאותם בו.

7 6 5 4 3 2 1

5. כשאני מספק/ת את שירותי הבריאות למטופלים, עוזר לי לדעת פחות על סיבות הימצאותם בבית החולים.

7 6 5 4 3 2 1

6. בגלל המלחמה בין ישראל לסוריה, אני לא מרגיש/ה בנוח לטפל במבוגרים סוריים.

1 2 3 4 5 6 7

7. בגלל המלחמה בין ישראל לסוריה, אני לא מרגיש/ה בנוח לטפל בילדים סוריים.

1 2 3 4 5 6 7

8. אני מרגיש/ה אשם/ה לטפל בפצועים סוריים בבית החולים.

1 2 3 4 5 6 7

9. אני דואג/ת מה חבריי ו/או משפחתי יחשבו עליי אם אטפל באנשים סוריים בבית החולים.

1 2 3 4 5 6 7

10. כאשר אני בעבודה, אני דואג/ת מה הקולגות שלי יחשבו עליי אם אטפל באנשים סוריים.

1 2 3 4 5 6 7

11. אני גאה בתפקידי לטפל ולעזור למטופלים סוריים.

1 2 3 4 5 6 7

12. אני גאה באזרחות הישראלית שלי.

1 2 3 4 5 6 7

13. בסך הכל, לאחר טיפול במטופלים סוריים, יש לי עמדות חיוביות יותר כלפי העם הסורי.

1 2 3 4 5 6 7

14. בסך הכל, לאחר טיפול במטופלים סוריים, יש לי עמדות שליליות יותר כלפי העם הסורי.

1 2 3 4 5 6 7

במהלך השבועיים האחרונים, באיזו תדירות היית מוטרד מהבעיות/ תופעות הבאות?

11. הרגשת עצבנות, חרדה או "על קוצים"	כמעט כל יום	יותר מ-6 ימים	1-6 ימים	0
. 12. חוסר יכולת להפסיק לדאוג או לשלוט בדאגה	כמעט כל יום	יותר מ-6 ימים	1-6 ימים	0

.

13. דאגה יתר על המידה לדברים שונים.	כמעט כל יום	יותר מ-6 ימים	1-6 ימים	0
14. קושי להירגע.	כמעט כל יום	יותר מ-6 ימים	1-6 ימים	0
15. המצאות במצב של חוסר מנוחה עד כדי כך שקשה לי לשבת בשקט.	כמעט כל יום	יותר מ-6 ימים	1-6 ימים	0
16. מוטרד/ת או מתרגז/ת בקלות.	כמעט כל יום	יותר מ-6 ימים	1-6 ימים	0
17. הרגשת פחד כאילו משהו נורא עלול לקרות	כמעט כל יום	יותר מ-6 ימים	1-6 ימים	0

Appendix K

Syrian Interview Consent Letter: Arabic

رسالة موافقة المقابلة

صيف ٢,١٤

عزيزي المشارك:

أنا طالبة دراسات عليا في "جامعة جورجيا" في الولايات المتحدة الأمريكية. أدعوكم إلى المشاركة في دراسة بحثية بعنوان "رعاية اللاجئين السوريين في المستشفيات الإسرائيلية" التي من قبل جامعة جورجيا. الغرض من هذه الدراسة هو دراسة كيفية العاملين في مجال الرعاية الصحية ملزمة أخلاقيا بعلاج المرضى السوريين وكيف يحتمل أن هذا يمكن أن تختلف مع معتقداتهم حول السوريين... لا ينتمي هذا البحث مع هذه المستشفى بأي شكل من الأشكال، وجميع المعلومات التي تم جمعها سوف تعود الي الولايات المتحدة الامريكية مع الباحث. لن تبقى أية بيانات هنا في هذه المستشفى. بالإضافة إلى ذلك، المشاركة في هذه المقابلة لن، بأي حال من الأحوال، تؤثر على تجربتك كلاجئ، صديقك المجروح أو تجربة أحد من أفراد عائلتك هنا في هذه المستشفى، أو عملك في هذه المستشفى.

ويطلب منك أن تشارك في هذه الدراسة لأنك أحد مقدمي الرعاية الصحية أو موظف المستشفى الذي يعالج المرضى السوريين، أو كنت زائر في إسرائيل من سوريا وكنت في المستشفى مع أحد أفراد العائلة أو صديق أحد جرح في سوريا.

المشاركة تتضمن مقابلة عشرون إلى تسعون دقيقة. سيتم تدوين جميع المعلومات التي تقدمها كلمة كلمة، مخزنة بشكل آمن، وتستخدم فقط لأغراض البحث. التسجيلات الصوتية المستخدمة في هذه الدراسة البحثية يحتفظ بها لأغراض البحث، ولكن سيتم تدميرها في أكتوبر السادس من العام ألفين وستة عشرة.

يمكن أن تسأل عن المواضيع التالية: معلومات عنك (العمر، الدين، الجنس), والخبرة في المستشفى كلاجئ أو كموظف، تجربتك الشخصية مع الصراع السوري، معتقداتك، وتجربتك في إسرائيل كمواطن أو كلاجئ.

يمكنك اختيار التحدث مع الباحث أو لا، والأمر يرجع لك. يمكنك أيضاً الوقف في أي وقت خلال المقابلة إذا كنت ترغب. أيضاً، إذا طلب في مذكرة مكتوبة أو مطبوعة أو البريد الإلكتروني، سوف يدمر الباحث كل المعلومات التي قدمتموها أذا كانت هذه هي رغبتكم في أي لحظة خلال المقابلة. لن تكون هناك حاجة إلى تقديم معلومات من شأنها إنتهاك قواعد آداب مهنة الطب المتصلة بالمريض. اذا كنت سوف تشارك، سوف تكون هذه المشاركة موافقتك لأن الباحثين لا يطلبون التوقيع الخاص بك. قد يطلب منك التحدث الى الباحث مرتين أو أكثر للتوضيح أو إضافة معلومات.

لا معلومات شخصية منفردة عنك سوف يتم تقاسمها مع الآخرين. سوف المترجمين توافق للحفاظ على كل ما تقوله في سرية تامة، واسمك أو أي معلومات أخرى عنك، وتحديدا، لن تكون قادرة على أن ترجع لك بعد انتهاء هذه المقابلة. في الواقع، فإن المقابلة لا تسأل عن اسمك، ولكن يمكنك تقديم إسمك إذا كنت ترغب في ذلك. سيتم تعيينك عددا وسيتم استخدام هذا الرقم في جميع النسخ مقابلة من قبل الباحث. سوف يجاوب أو يرد المحقق على أية أسئلة لديك أخرى حول البحوث، الآن أو في أثناء المقابلة.

يمكن نشر نتائج الدراسة البحثية ، ولكن لن يتم استخدام اسمك أو أي معلومات محددة . وفي الواقع، ستقدم النتائج التي نشرت في شكل موجز فقط.

إذا وافقت على إجراء المقابلة ، سوف تكون قادر على التعبير عن المخاوف الخاصة بك إلى الباحث عن تجربتك كموظف أو اللاجئين. وهذا قد يساعد في معالجة تجربتك حتى الآن. قد توفر هذه البحوث على المعلومات المطلوبة كثيرا على الرعاية الصحية اللاجئين في

أوقات الصراع لمساعدة البلدان . احتياجات اللاجئين هي فريدة من نوعها و سوف تساعد هذه الدراسة إبلاغ كيفية تفاعل العاملين في المستشفى واللاجئين وذلك لتحسين نوعية الرعاية والخبرة لمن هم في حالات مماثلة .

إذا كنت في أي وقت متضايق أو غير مرتاح، أبلغ الباحث أو المترجم بذلك وأنها سوف ننتقل إلى موضوع آخر أو إيقاف المقابلة تماما.

إذا كان لديك أي أسئلة حول هذا المشروع البحثي ، فلا تتردد في إرسال رسالة بريد إلكتروني إلى سافانا سبيفي في sespivey@uga.edu . أسئلة أو استفسارات حول حقوقك كمشارك البحوث ينبغي أن تكون موجهة إلى الرئيس ، جامعة جورجيا مجلس المراجعة المؤسسية ، 629 بويد GSRC ، أثينا، جورجيا 30602 ؛ الهاتف (706) 542-3199 ؛ عنوان البريد الإلكتروني irb@uga.edu .

أشكركم على اهتمامكم ! يرجى الحفاظ بهذه الرسالة لسجلاتك .

مع خالص التقدير،

سافانا سبيفي

جامعة جورجيا

Appendix L

Translator Confidentiality Agreement
Human Development and Family Science
Syrian Refugee Healthcare in Israel Research

I, ____ understand that I must keep confidential all information from, about, or in any way relating to research participants associated with my role as ___________________________________ for the research being conducted by Savannah E. Spivey on Syrian refugees in Israeli hospitals and employees of those hospitals.

1. I agree to refrain from discussing and/or disclosing to anyone other than Savannah E. Spivey (or with other members of the research team as identified by Savannah E. Spivey) any aspect of information that contains any personally identifiable information associated with any audio, visual, written, or oral information about any research participant associated with my role in gathering, translating, reviewing, or otherwise having access to information about this research.
2. If I discuss any aspect of any personally identifiable information with Savannah E. Spivey, I agree to do so only when there is the reasonable expectation that the discussion between me, Savannah E. Spivey, and any other members of the research team, will not be heard by other parties.
3. I will not allow any person other than myself, Savannah E. Spivey, or other members of the research team as identified by Savannah E. Spivey to have access to any equipment or materials associated with my role in this research.

I fully understand the importance of confidentiality and agree to abide by the procedures set forth in this document.

____ ______________________
Signature of assistant/translator Date

____ ______________________
Savannah E. Spivey Date

Appendix M

Codes Used in Preliminary Qualitative Analysis from ATLAS.ti©

Code-Filter: All

HU: Savannah's Codes
File: [I:\Israel Data\Atlas TI Coding of Data\Coding\Coding - Savannah\Savannah's Codes.hpr7]
Edited by: Super
Date/Time: 2015-08-31 14:28:19

"Just like any other patient"
"strange"ness of Syrian patients in hospital
"the whole person"
ability to change
administrative influence
Adult ICU
advocate
'advocate'
After Work
Age
Age of Syrian patients
agreement to interview
Alliah
Alyah
American
amount of procedures
amputation
Anecdote
Anger about treating Syrians
appearance
Arab
Arab Israeli citizenship
Arab news sources
Arab patients
Arab staff
Arabic and Israeli relations
Arabic Language
army in hospital
Ashkenazi
Assistance to Syrian patients' families
Asylum in Jordan
at first
atheist
attachment
Attention to Syrian patients
'basic treatment only'
Bedouin
Belief in peace
better treatment
Big Picture
born in
busy hospital
Cafeteria
cancer
Change of perspective
Christian
citizenship
civilian war
civilians
clothes
'come back and kill us'
commitment to treatment
communication
community and hospital
community curiosity
community donations
community respect for healthcare providers
concern for child
confusion during interview
connection to holocaust
consent
context
conversations about Syria
cooperation among staff
cooperative
Coping
correction in notes
Cost of healthcare
CT
Cultural differences
Cultural responsiveness
Cultural understanding
current events
Damascus
date of interview
Date Recorded
department
desire to heal
dietician
difference in care

difference in kinship
Difference in treatment according to hospital department
Difference in treatment of Israelis and Syrians
Differences in Israelis and Arabs
Difficulty of Healthcare Provider Experience
Disagreement between healthcare providers
dissonance
Distinction of ethnicity on ID
Diversity
Diversity of ethnicity
Diversity of religion
donations
dream
Druze vs Arabs
duty according to job at the time
duty to help
Ear, Nose, and Throat (ENT)
Education level of Healthcare Provider
Emergency room
Emotional toll of war in Syria
emotions
Empathy for Syrian Patients
English
equal treatment of Syrians
equality of care
equality of sick people
equality of Syrians
Ethics
ethnic relations in Israel
Ethnicity
ethnicity confusion
exhaustion
expense of treatment
extremism
factors that help patients
family
family bond
family history
family in Syria
Fares
fear of Syrian patients
Feelings about 'being Israeli'
feelings about religion
Female
'fighters'
first impression
follow up care
follow-up
forbidden personal care
forced to fight
friend
frustration
Future implications of treating Syrians
Gender
gender differences
genuineness of participant
geography of Israel
hatred
He was very startled by my ope..
head injury
head nurse
head of department
healing process
Healthcare provider
Healthcare provider experience
healthcare provider feelings
Healthcare provider interaction with each other
Healthcare provider interaction with Syrian patients
healthcare provider objective vs Syrian patient desire
healthcare provider reaction to Syrian patients
Healthcare provider respect
Healthcare Provider roles
healthcare provider stress
healthcare system

Hebrew Language
Helpless feeling of Healthcare Provider
Helplessness of Syrians
Helsinki
historical influence
homesick
Hope for peace
hospital patients
hospital authority
hospital clinics
hospital decision-making
Hospital Diversity
Hospital environment
Hospital location
Hospital Name
Hospital priority
hospital procedure
hospital security
Hospital treatment of Syrians
how patient was injured
humanitarian
humanity
ICU
IDF
immigration
infection
influx
influence of age
influence of kidnapping on work environment
Influence of Syrians returning to Syria
influence of time since Syrians began coming on healthcare provider
innocent children
internal conflict
interview context
interviewee response to research
Interviewer interaction with Syrian participant
Interviewer interaction with Syrian patient
intimacy
intuition
IRB
ISIS
Islam
Israel and Syria relations
Israeli and Syrian treatment balance in hospital
Israeli army
Israeli children patients
Israeli citizenship
Israeli desire to help
Israeli government
Israeli insurance
Israeli patients
Israeli patients reaction to Syrian patients
Israeli politics
Israeli resources
Israel's location in Arab world
Jail
jaw surgery
Jerusalem
Jewish
Jewish and Arabic connection
Jewish and Arabic interaction
Jewish history
job department
job title
Judaism and Islam
judgment of interviewer (savannah)
June
justification
kinship
knowledge of Arab speaking staff
lack of adequate healthcare
language
Language preference during interview
leaving work at work
length of stay of Syrian patients
level of compassion

Level of Healthcare Provider Experience
level of translation
life in Syria
Lifestyle
location of interview
Male
male nurse
Married
Media influence
Medical clown
medical device
medical ethics
Medical school
medically interesting
methods
military contact with Syrian family members
Military in the hospital
money
Mood
morals
more than a patient
more than language
Mourning
MRI
Multiple departments
Muslim
Nahariya
national service
Nationality
negative experience with Syrians
negotiator
nervous
Neurosurgery department
New for healthcare provider
Non religious people
non war related injuries
Notes
Number of Syrian patients
nurse
nurse's aid
nutritionist
observation
occupational therapy
openness of participant
orthodox
orthopedics B
orthopedics department
Palestine
Palestinian
Palestinians are our neighbors..
Parental influence
Participant name
participant trust
participation in fighting in Syria
past wars
past wars with Israel and Syria
Patient kit
patient stories
patient trust
Pediatric ICU
Pediatric surgery
Pediatric Unit
Pediatrics
perception of researcher
personal care to Syrian patients
personal connection to patient
Personal feelings about war in Syria
Personal influence of war on Healthcare Provider
photograph of injuries
physical demonstration
physical depiction of religiosity
physical therapists
physician
Place of Birth
politics
prior healthcare before Israeli hospital
professional relationships
Professor
protective
Proud to be Israeli

proud to be Jewish
Providing healthcare to Syrians helps
future peace
Public awareness
public health
Quality of care
quote
rare
reason for being in hospital
rebel
reciprocity
recovery
Red Cross
reflection
refugee status of Syrians
Regional diversity
rehabilitation
relationship
Religion
religion and work
religiosity
religious differences
research stakeholder
Resilience
Respect as an Arab Israeli citizen
responsibility of healthcare provider
Returning Syrian patients
returning to Syria
Reverence for culture
riots
Russian
Russian language
as
sampling
seizure
separate two lives
severity of injuries
Sex of Syrian Patients
Sharing experience with coworkers
Sharing experience with family
shock
situation in Syria
sleep
Social workers
solution
staff donations
Status of Syrians
Sunni Shia conflict
supportive
Surgical department
survey collection
Survey confusion
survey distribution
Survey questions
survey reaction
survival
Syria helping Israel
Syrian anger
Syrian arrival
Syrian children
Syrian children in hospital
Syrian communication outside of Israel
Syrian education
Syrian family member interaction with
each other
Syrian family members
Syrian family members in hospital
Syrian father
Syrian father awareness
Syrian father knowledge
Syrian father reaction to interviewer
Syrian fear of receiving treatment in
Israel
Syrian injuries
Syrian Interview
Syrian journey to Israel
Syrian male patients
Syrian patient appearance
Syrian patient feelings
Syrian patient interaction with Arab staff
Syrian patient interaction with each
other

Syrian patient with family
Syrian perception of being in Israel
Syrian reaction to interview
Syrian soldiers as patients
Syrian time in hospital
Syrian women
Syrian's future
Syrians' previous knowledge of Israeli treatment
Syrians vs Arabs
taking work home
Talmud
team
tears
tension
terrorist
thankfulness
This is a Code
three Jewish boys
Time as Healthcare Provider
time in hospital
Timeline
torah
Traditions
transference to other hospitals
translator
translator influence
transportation to hospital
treating Arab patients
treating Syrian patients
'treating the enemy'
Treatment in Jordan
trust in God
Tsvat, Israel
two stories one person
type of injuries
type of treatment in department
Ukraine
Uncertainty upon release of patient
uncomfortable
uncooperative
uniqueness of injuries
uniqueness of this situation
unity
urgency of care
village
war related injuries
War with Lebanon 2006
warehouse
'well enough'
West Bank
what healthcare provider has learned
what patients talk about
Where healthcare provider has lived
Where healthcare provider has worked
Which side of Syrian war patient is from
who pays for healthcare of Syrians?
'why they are here'
work and war
working with other hospitals treating Syrian patients
Working with Syrian patients
Workload
Ziv Medical Cente

Appendix N

Codes and categories of demographic variables

Ethnicity	Nationality	Religion
1 = Arabic	1 = Arabic	1 = Islam
2 = Israel	2 = Israel	2 = Jewish
	3 = Jewish	
3 = Druze	4 = Druze	3 = Druze
4 = Jewish	5 = Jewish/Israel	4 = Secular
5 = Ethiopian	6 = Islam	5 = Christian
6 = Muslim	7 = Russia	6 = else
7 = Mexican	8 = caucasian	7 = religious/traditional Jewish
8 = mixed	9. Israeli/Arab	
9 = Russian	10. Chechnya	
10 = Indian	19. USA	
11 = Sephardic		
12 = Ashkenazi		
13 = Christian		
14 = Argentina		
15 = English		
16 = Lithuanian		
18 = Iraqi/Jewish/Serb		
19 = USA		
20 = Europe		
21 = Spain		
22 = Moroccan		

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Step 1 – group responses according to the following four groups

Step 2 – dichotomize Islam, Christian, Other (Jewish is reference group)

Religion – groups
1 = Islam (includes Druze)
2 = Jewish (and traditional)
3 = Christian
4 = Other (secular, Else)

Step 3 – group occupation according to following four gropus
Step 4 – Dichotomize Occupation by Social worker, Physician, Other (nurse is reference group)

Occupation – groups
1 = Nurse (includes 'specialists' who answered 1 and 4)
2 = Social Worker
3 = Physician (includes specialists)
4 = Other (Student/Staff/Volunteer, medical student, no answer)