Journal of Law and Conflict Resolution Vol. 2(8), pp. 129-132, October, 2010
Available online at http://www.academicjournals.org/JLCR ISSN 2006-9804


*Full length Research*

# Conflict situations in emergency medical care provision

**K. G. Gurevich[1]*, E. G. Fabrikant[1] and I. A. Yakirevich[2]**

[1]Moscow State University of Medicine and Density, Moscow, Russia.
[2]State Central Airmobile Rescue Squad of the Russian Ministry of Emergencies (Tsentrospas),Russia.

Accepted 26 August, 2010

**There is an increasing number of emergencies both globally and in Russia particularly. Emergencies are likely to bring about complex situations that will influence the process of medical care arrangement and provision. Officers of the ministry of emergencies working abroad quite often get into conflict situations related to cultural differences. The majority of officers of the ministry of emergencies had to face various conflict situations. This being the case, the number of such situations in 2009 has remained nearly the same as in 2006. Most frequent challenges in local population outreach have been conditioned by the absence of interpreters or ignorance of a local language. Countries most frequently reported as examples of such conflicts were: Turkey, Indonesia, Iran, Algeria, Pakistan (2006), and RF, Israel, Nigeria, India, Taiwan (2009).**

**Key words:** Ministry of Emergencies, medical care, conflict situations, emergencies.

## INTRODUCTION

Currently, there is an increasing number of emergencies both globally and particularly in Russia. There is also an increasing number of man-made disasters. Table 1 provides statistics related to emergencies in the Russian federation over the recent years.

Emergencies are likely to bring about complex situations that will influence the process of medical care arrangement and provision (Zavyalov and Meditsina, 1989). From our point of view, an additional factor that produces certain influence on arrangement of emergency medical care includes religious opinions of individual persons and cultural peculiarities of their countries. Indeed, formation of patients' consciousness is largely affected by their religious and cultural environment (Shearer and Davidhizar, 2003). Preservation of patient's or injured person's health and life cannot be separated from observance of personal liberty principles and, consequently, a principle of respect for this person's beliefs. It is quite obvious that medical care cannot be adequately provided without awareness of cultural customs, especially in such multiconfessional country as Russia and in other parts of the world (Mikhailova and Bartko, 1995).

Providing medical care without due regard to religious and cultural individual customs may entail extremely ad verse consequences (Kirmayer, 2004). For example, a Muslim's visit to a dentist during Ramadan may result in patient's faintness, as the Muslims keep a strict fast during this religious holiday. Blood transfusion without the consent of a patient or his/her relatives, even to save his/her life, is considered to be a crime in a number of Islamic states and some African countries. Failure to ob serve these rules may result in criminal liability. In Muslim countries, a male doctor cannot see a woman's body in the absence of nearest relatives (Mikhtlova, 2000).

Ignorance of such cultural, ethnical and religious traditions may sometimes result in a tragedy. In the US, some patients have won multiple suits against their attending physicians for violation of patients' religious rights. It is common knowledge that in the early period of their activity, UN doctors went flop when implementing the vaccination program in Asia, as the vaccine had been prepared based on European donors' blood. This issue was settled only by using blood of the local population, honorable people, mainly elders (Gurevich et al., 2008).

We have previously proved (Gurevich et al., 2008), that in many instances when proving humanitarian and medical aid, officers of the ministry of emergencies working abroad quite often get into conflict situations related to cultural differences. That is why we have elaborated recommendations for rescuers so that they could consider cultural differences in providing medical care (Gurevich et al., 2007). The objective of our study was to compare the reporting frequency of conflict situations before and after elaboration of materials for rescuers.

*Corresponding author. E-mail: kgurevich@mail.ru.

**Table 1.** Statistics of emergencies within the Russian territory (According to data posted at the official site of the RF Ministry of Emergencies - http://www.mchs.gov.ru).

| Year | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 1-6 months of 2010 |
|---|---|---|---|---|---|---|---|---|
| Total number of emergencies, including: | 838 | 1,134 | 2,720 | 2,847 | 2,693 | 2,146 | 424 | 160 |
| Man-made | 518 | 863 | 2,464 | 2,541 | 2,248 | 1,596 | 270 | 87 |
| Natural | 286 | 231 | 198 | 261 | 402 | 161 | 133 | 46 |
| Biological and social | 15 | 28 | 48 | 44 | 43 | 37 | 21 | 15 |
| Major terrorist attacks | 19 | 12 | 10 | 1 | ND | ND | ND | 12 |
| Deaths, persons | 1,161 | 2,459 | 5,637 | 6,043 | 5,199 | 4,441 | 734 | 361 |
| Injuries, persons | 15,631 | 23,182 | 4,945,523 | 8,150 | 27,335 | 7,484 | 2,428 | 1,105 |

ND - no data

**Table 2.** Respondents' profile.

| Parameter | 2006 | 2009 |
|---|---|---|
| Number of respondents | 36 | 22 |
| Average age (years) | 36±8 | 38±5 |
| Length of work in the Ministry of Emergencies | 11±4 | 13±4 |
| Number of trips abroad to handle emergencies | 5±4 | 7±5 |

All data to be processed have been provided in percentage terms.

## MATERIALS AND METHODS

We performed the questionnaire survey of employees of Tsentrospas airmobile squad, Russian Federation Ministry of Emergency, in 2006 and 2009 (Table 2). Questioned employees are male rescuers or doctors. Employees questioned in 2009 were previously questioned in 2006. The questionnaire contained 12 open- and close-end questions related to conflict situations in providing humanitarian and medical care.

## STUDY RESULTS

According to data provided in Table 3, majority of respondents had to face various conflict situations. This being the case, the number of such situations in 2009 has remained nearly the same as in 2006. Rescuers having more flights abroad have faced similar conflicts more frequently. One may assume that currently, conflicts between rescuers and local inhabitants are inevitable due to ignorance of relevant national, cultural and religious peculiarities.

Most frequent challenges in local population outreach have been conditioned by the absence of interpreters or ignorance of a local language. Correspondingly, rescuers could not explain themselves and substantiate the necessity to perform medical or antiepidemic activities. However, respondents had to face instances of acute national antagonism. It is interesting to note that similar cases have been reported in Israel and ex-Yugoslavian countries. Some respondents have reported that in India, they witnessed such national disfavor with regard to US rescuers.

Quite often, rescuers of the RF Ministry of Emergencies have had to face challenges caused by race differences with local inhabitants. Local inhabitants do not have much confidence in white doctors. Respondents have also faced frequent religion-based conflicts. We cannot say for sure if race-based conflicts are related to religious conflicts or not. Normally, religion-related issues have been typical of Muslim countries (Iran, Algeria, Pakistan). However, they have also been reported in Indonesia, India and Taiwan. These conflict situations have resulted in less efficient work of rescuers of the RF Ministry of Emergencies and have even hampered it. Instances of refusal to get medical care have been recorded. In some cases, local inhabitants refused to undergo medical examination putting up all possible kinds of interference, while in other instances they refused to get any assistance except for emergency care. Some representatives of local inhabitants refused to undergo medical examination, get anesthesia, therapeutic treatment in the absence of relatives or their consent or without approval of local spiritual or religious leaders and elders.

As compared to 2006, 2009 has seen a reduced number of nation- and religion-based conflicts. However, this has been accompanied by an increased number of refusals to get medical care. Unfortunately, there have also been an increased number of complete refusals to get medical care. Frequency of refusals to get medical care due to sex differences, in the absence of relatives or religious (spiritual) leaders has decreased a little.

Rescuers have searched for different ways to resolve

**Table 3.** Conflict situations when providing care after emergencies.

| Situation | Reporting frequency of conflict situations by respondents (%) | |
|---|---|---|
| | 2006 | 2009 |
| Different challenges in local community outreach | 55.6 | 50.0 |
| Nation-based conflicts | 50.0 | 22.7 |
| acute national antagonism | 2.8 | 4.5 |
| language barrier | 44.4 | 18.0 |
| domestic issues | 2.8 | 13.6 |
| Race-based conflicts | 19.4 | 9.0 |
| Religion-based conflicts | 41.7 | 4.5 |
| Instances of patients' refusal to get care due to conflicts | 13.9 | 22.7 |
| complete refusal to get care | 8.3 | 13.6 |
| refusal to get care, except for emergency care | 5.6 | 4.5 |
| refusal to get care due to sex difference | 11.1 | 9.0 |
| refusal to get care in the absence of relatives | 5.6 | 4.5 |
| refusal to get care in the absence of religious (spiritual) leaders | 11.1 | 9.0 |
| Search of ways to resolve conflict situations | 52.7 | 63.5 |
| work with injured persons | 19.4 | 40.9 |
| work with injured persons' relatives | 30.6 | 13.6 |
| work with religious (spiritual) leaders | 2.7 | 9.0 |
| Conflict resolution found | | |
| correct | 19.4 | 4.5 |
| incorrect | 2.7 | 4.5 |
| questionable | 33.3 | 18.0 |
| Countries most frequently reported as examples of conflicts | Turkey, Indonesia, Iran, Algeria, Pakistan | RF, Israel, Nigeria, India, Taiwan |

conflict situations. Most of them have tried to raise awareness among relatives or injured persons themselves. This being the case, the period of study has seen an increased number of rescuers who have tried to resolve this issue in such a manner. Fewer rescuers have tried to come to terms with local religious or spiritual leaders and elders. However, since 2006, there have been an increased number of rescuers who have tried to resolve this issue in such a manner. This being the case, most of respondents doubt that they have found an adequate way to resolve the conflict situation.

## Examples of conflict situations

1) Turkey: After an earthquake, rescuers dug up a woman from under building wreckage. Her husband attempted to murder both rescuers and his wife, as unbelievers had seen her naked (her legs were exposed). According to the husband, he would rather kill his wife than let her be seen naked by a stranger. The conflict was resolved through negotiations with the community leader.
2) Indonesia: After a flood, a girl aged 10 looked totally worn-out and exhausted. Parents refused to seek doctor's advice, as the doctor is a man. They were told that an examination was necessary to make a diagnosis. The conflict was not resolved.
3) Nigeria: Relatives of injured persons were not satisfied with a tracker dog and showered stones on it. Relatives considered that the dog was profaning both the dead and the living. Search operations had to be interrupted. The conflict was resolved through negotiations with relatives.
4) Russia: Following an explosion in the marketplace, the dead were taken to the mortuary to undergo medical and forensic expertise as provided for by the applicable legislation. The expertise had to take several days. However, some relatives of the dead started to beset the mortuary requesting to get their dead bodies, as according to the Muslim tradition, the dead have to be buried on the day of their death. The conflict was resolved by muftis.
5) Israel: Refusal to have blood transfusion made according to medical indications, as it was unknown whether the blood to be transfused had belonged to a Jew or not. The conflict was resolved after involvement of a rabbi.
6) India: Refusal to have vaccination prepared based on bull blood. The conflict was resolved through negotiations

with local community leaders.

## Conclusion

According to these data, conflicts when providing care after emergencies are quite frequent. Over 3 years of observation, the reporting frequency of such conflicts has not decreased but a trend towards mitigation of these conflicts has become evident. One may assume that this is related to the use of information materials that we have elaborated for rescuers. We would also like to suggest that when handling emergencies, rescuers should engage in further local outreach with participation of community and religious leaders.

### REFERENCES

Zavyalov VI and Meditsina M (1989). Civil defense /edited.
Shearer R, Davidhizar R (2003). Using role play to develop cultural competence. J. Nurs. Educ., 42(6): 273-276.
Shearer R, Davidhizar R (2003). Using role play to develop cultural competence. J. Nurs. Educ., 42(6): 273-6.
Mikhailova EP, Bartko AN (1995). Biomedical ethics. Theory, principles and challenges. – M.: MGMSU publishing house, p. 238.
Kirmayer LJ (2004). The cultural diversity of healing: meaning, metaphor and mechanism. Br. Med. Bull., 69: 33-48.
Mikhtlova LB (2000). Islamic tradition and biomedical ethics challenges. Methodological and social problems of medicine and biology. Resp. editor E.P. Mikhalovskaya-Karlova, issue. 12. M. p. 35.
Gurevich KG, Fabrikant EG, Yakirevich IA (2008). Ethical problems of medical care provision in emergencies. Crit. Emerg. Med., 1: 23-30.
Gurevich KG, Fabrikant EG, Yakirevich IA (2008). Conflict situations in medical care provision in emergencies and risks for rescuers' health. – Crit. Emerg. Med., 1: 19-22.
Gurevich KG, Tischenko PD, Fabrikant EG, Yudin BD (2007). Ethical challenges related to medical care in emergencies – Moscow: Publishing house of the Moscow Arts University, p. 91.