

ISSN : 2309-3234

DOI : 10.62948

TMSS Medical College Journal (TMCJ)

Volume 25, Issue 02, July 2026

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An Official Publication of TMSS Medical College



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July 2026

An Official Publication
of
TMSS Medical College, Bogura, Bangladesh

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Printed by: TMSS Printing Press, Bogura, Bangladesh. e-mail: tmssprintingpress@gmail.com

TMSS Medical College Journal (TMCJ)

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Editorial

Medical Care in War and Armed Conflict: When Humanity Must Remain above the Battlefield

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Medical Care in War: A Humanitarian Imperative

War can transform a regular functioning hospital into a mass-casualty centre within hours. Trauma due to conflicts surges in war while childbirth, sepsis, diabetes, dialysis, cardiovascular emergencies and cancer continue. Damage to power, water, oxygen, blood supply, laboratories, pharmacies, transport and communications therefore produces deaths far beyond the immediate battlefield. International humanitarian law requires protection not only of the wounded and sick, but also of medical personnel, irrespective of nationality, religion, ethnicity, political identity or combatant status.¹

When the Health System Becomes a Casualty

Health systems fail as networks. An operation theatre cannot function without electricity, oxygen, sterilization, anaesthesia, blood and trained staff. Threats, barricades and attacks delay ambulances, displace health workers and deter patients from seeking care. WHO has verified thousands of attacks on health care in Ukraine, while the occupied Palestinian territory has experienced severe degradation of essential services. Each damaged facility represents interrupted surgery, missed dialysis, unsafe childbirth and delayed treatment for infection and chronic disease.¹⁻³

Regional Realities

Gaza illustrates the agony of mass casualties, repeated displacement, damaged hospitals and shortages of food, water, fuel, medicines and consumables. In May 2025, WHO reported that only 19 of 36 hospitals remained operational, including one providing only basic care.³ Aggression has affected renal, maternal,

neonatal, cancer, laboratory, mental-health and rehabilitation services; delayed evacuation can trap patients needing advanced reconstructive, cardiac, oncological or neurosurgical care.⁴ A 2025 BMJ survey of 78 international healthcare workers deployed to Gaza documented 23,726 trauma-related injuries, with burns and limb injuries prominent and explosive mechanisms accounting for most weapon-related trauma, underscoring the need for sustained surgical, rehabilitation and clinical-surveillance capacity.^{4,5}

In the West Bank, checkpoints, road closures, insecurity of medical personnel and restriction of ambulance movements turn a short journey in inpatient into a long, critical outcome for obstructed labour, acute coronary syndrome, sepsis, dialysis or chemotherapy. These access challenges have continued in 2026. According to WHO data reported by OCHA, 53 attacks on health care were documented between January and June 2026, affecting four health facilities and 44 ambulances; obstruction of access was the most frequently reported form of interference. Gaza and the West Bank therefore demonstrate complementary failures-loss of capacity and restriction of access.³⁻⁵ Iraq demonstrates the cumulative history of repeated conflict, displacement, underinvestment and workforce loss. The Mosul experience showed that survival depends on the entire trauma pathway, from first aid and safe transport to referral surgery and rehabilitation; persistent gaps may remain long after active fighting.⁵ Iran's 2026 regional escalation showed how rapidly specialist services can be threatened. WHO reported 18 verified attacks on health care between 28 February and 11 March 2026. Conflict interrupted dialysis, insulin supply, cancer

therapy, transplantation follow-up, blood transfusion services and emergency cardiac care. Transport disruption can affect humanitarian supply chains beyond national borders, as it happened in Ukraine.²⁻⁵ Lebanon entered recent hostilities with economic crisis, workforce emigration and medicine shortages already weakening the system. By 16 October 2024, WHO had verified 23 attacks on health care after the September escalation, and 100 of 207 primary-care centres and dispensaries in conflict-affected areas were closed. Subsequent reports emphasized deaths and injuries among health workers, reduced hospital function and prolonged rehabilitation needs.²⁻⁵

The Ethical Compass of the Physician

Conflict does not suspend medical ethics. Humanity, impartiality, confidentiality, dignity and professional independence remain essential. In mass-casualty triage, priority should reflect physiological urgency, time sensitivity, likelihood of benefit and available resources—not social worth, rank, wealth, nationality, ethnicity, religion or political affiliation. Decisions should be transparent, consistent and repeatedly reassessed. When curative treatment is impossible, analgesia, symptom control, communication, psychological support and palliative care remain obligations.^{1,4, 5}

Beyond Trauma: Preserve Essential Services

Conflict medicine must extend beyond blast and penetrating injuries. Pregnant women still need safe delivery; premature infants need warmth, oxygen and nutrition; patients with diabetes need insulin; kidney failure requires dialysis; and tuberculosis, HIV, epilepsy, asthma, COPD, cardiovascular disease and malignancy require continuity of therapy. Humanitarian planning should protect a minimum package of essential services, referral routes and stocks of priority medicines.^{3,4,5} Displacement increases overcrowding, unsafe water, poor sanitation, food insecurity and interrupted vaccination, raising communicable-disease and malnutrition risks. Effective response therefore requires primary care, maternal and child health, infection prevention, surveillance, rehabilitation and palliative care alongside emergency surgery.^{4,5}

Mental Health and the Health Workforce

War produces bereavement, displacement, family separation and prolonged insecurity. WHO estimates that about one in five people exposed to war or conflict in the preceding decade lives with a mental disorder such as depression, anxiety or post-traumatic stress disorder.⁶ Recent studies show the particular burden on healthcare workers. In a 2025 cross-sectional study of Palestinian and international healthcare workers who had worked in Gaza, approximately 90% of respondents experienced severe depression, severe anxiety and severe stress, alongside displacement, prolonged work without adequate rest, food insecurity, workplace aggression and loss of colleagues.⁷ Evidence from the southern West Bank likewise demonstrates substantial psychological strain among nurses working during the Gaza war, including symptoms consistent with post-traumatic stress disorder, increased workload, burnout and shortages of staff and medical supplies.⁸ Health workers therefore face not only burnout and grief but also moral distress and moral injury when they know what patients need but cannot provide it. Staff protection should include reasonable rotation, peer support, confidential mental-health care, adequate staffing and clear leadership.

Protecting Medical Neutrality and Building Resilience

Protection must cover the entire chain of care: patients, first responders, ambulances, hospitals, laboratories, pharmacies, blood banks and humanitarian supply routes. Violence, threats, detention, obstruction and interference with impartial care weaken every link. Medical neutrality preserves the professional space to treat every wounded or sick person according to need; it safeguards patients, trust and the integrity of medicine.^{1,8} Hospitals should map dependencies on power, water, oxygen, blood, medicines, information systems and supply routes; establish redundancies; and train staff in triage, haemorrhage control, trauma resuscitation, burns, emergency anaesthesia, infection prevention, evacuation, psychological first aid and ethical allocation. Recent conflict-focused literature emphasizes protection of essential infrastructure, physical hospital preparedness and alternative sources

of water and electricity, while broader evidence from fragile and conflict-affected settings frames resilience as the capacity to absorb shocks, adapt services and, where necessary, transform health-system operations.⁹ Portable ultrasound, point-of-care testing, telemedicine, offline records, decentralized stocks and distributed referral pathways may help maintain continuity when centralized systems are disrupted, but resilience ultimately depends on trained people, simple protocols, local supply capacity and trusted coordination.^{4,5,9}

A Responsibility Beyond Borders

Professional bodies, universities, journals and humanitarian agencies should document attacks, study direct and indirect mortality, strengthen trauma and referral systems, and develop practical approaches to rehabilitation and continuity of chronic-disease care. Data collection must be accurate and ethical and must not expose patients or health workers to additional danger. Medical journals should create space for clinicians working in conflict-affected settings while preserving scientific independence, transparent attribution and acknowledgement of uncertainty.^{1,10}

Conclusion

War is one of the greatest tests of medical ethics. Hospitals should remain places of healing, ambulances vehicles of rescue and healthcare workers free to treat without fear. From Yemen to Gaza and the West Bank, Iraq, Iran, Lebanon, Ukraine and every conflict-affected region, medicine has a duty that transcends geography and politics: to preserve life, relieve suffering, protect dignity and defend the humanitarian space in which care can exist. When societies are divided by conflict, medicine must refuse to divide humanity.

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