

# RACISM IN MEDICINE



PHYSICIANS FOR HUMAN RIGHTS  
دוכאים أطباء لحقوق الإنسان  
ISRAELI HUMAN RIGHTS  
إسرائيل لحقوق الإنسان

# RACISM IN MEDICINE

## The Politics of Segregation in Health

**Segregation** means division, discrimination, or a process of separation. The concept of segregation, or the yardstick at the two ends of which are the pair of opposite terms integration and segregation, describes the distribution of a particular parameter or aspect in the population in relation to the concept of equality. It describes discrimination between different population groups.

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**“I think a doctor is his patients’ advocate, social worker and defender.”**

**Dr. Ido Lurie**

## Introduction

Medicine is assumed by its very nature to be free of ulterior motives and to treat people regardless of their social status or ethnicity. The intrusion of politics into medicine is perceived as a violation of the basic values of medical ethics: nonmaleficence, beneficence, respect for the patient's autonomy, and distributive justice. However, the working assumption of this paper is that the medical arena is by definition a construct of political forces and that the various medical institutions were constituted by and operate in a political and even partisan environment that affects the applicability of Israel's National Health Insurance Law, one's entitlement to medical services, and the ways those entitlements are realized and prioritized.

Social discourse uses the term segregation to denote an unequal social construct that excludes certain groups and is thereby directly and indirectly responsible for their positioning on the margins of the social array, their sense of deprivation in relation to it, and their inability to integrate and participate in it. In the medical realm, the term helps us better understand the way social constructs are brought to bear, so that medicine becomes a means that perpetuates and exacerbates exclusion and disparities in society.

Recognition of the presence of a society's power structures in its health institutions frees medicine from the neutrality trap and enables it to reject those institutions and structures that facilitate discrimination in health. This perception takes into account the barriers that face patients and actively opposes any stipulation of medical services on ability to pay, civil status, or ethnicity. That is the role of the associations and trade unions that organize medical and healthcare professionals.

**“Medicine is one of the most concrete ways to do politics. What we do here is actually what I would define as the real medicine. It’s social medicine.”**

**Dr. Daniel Solomon<sup>1</sup>**

We perceive hospitals and HMOs as places where any person should and is entitled to be protected as a patient, as someone whose medical need will dictate the professional and ethical care they receive. However, both routinely, and all the more so during conflicts over identity or ideology, health institutions are a site of friction between medicine as a vocation and medicine as a tool of government. Medical establishments are sites where there is a potential for control and policing, but also for resistance in the name of interpretation of the values of the profession and medical ethics. Between those two poles is the possibility for negotiation over stretching these boundaries in an attempt to protect patients against such policing mechanisms.



US Amb. James McDonald distributing packages from the US, 1949.  
Hans Fine, Government Press Office.

## Background

Medical professionals have a special responsibility in society, as healers, to understand and relieve human suffering and promote health. International principles of medical ethics should prevent or at least significantly reduce the participation of medical professionals in human rights violations and even place them at the forefront of defending these rights and promoting social justice. However, the medical and healthcare professions have known numerous failures throughout history and in the present. Why and how does that process occur?

Consider, for example, the role of the healthcare system in South Africa during apartheid, especially its failure to protect its black patients. A number of elements are identifiable, some of which are relevant to the analysis of any healthcare system that is not equal and that has built-in barriers for communities that are distinguished by their ethnicity, life circumstances and/or social status:<sup>2</sup>

1. The restriction of the access to healthcare<sup>3</sup> has severe effects on the excluded community;
2. The presence of a deliberate construction for exclusion from the healthcare system, and, as a result, the provision of inferior medical services to the excluded group;
3. The culture of exclusion taints the integrity of medical and healthcare personnel so that they do not experience a conflict between instructions or regulations of exclusion and medicine's commitment to equality. In the worst case, they are active participants in violations of the ethical code.

When these defects do not pertain to a particular individual but rather are systemic, they reflect a culture and social array that maintain discrimination in the environmental, social, and political aspects of health.<sup>4</sup> Systematic moral failings therefore require an examination

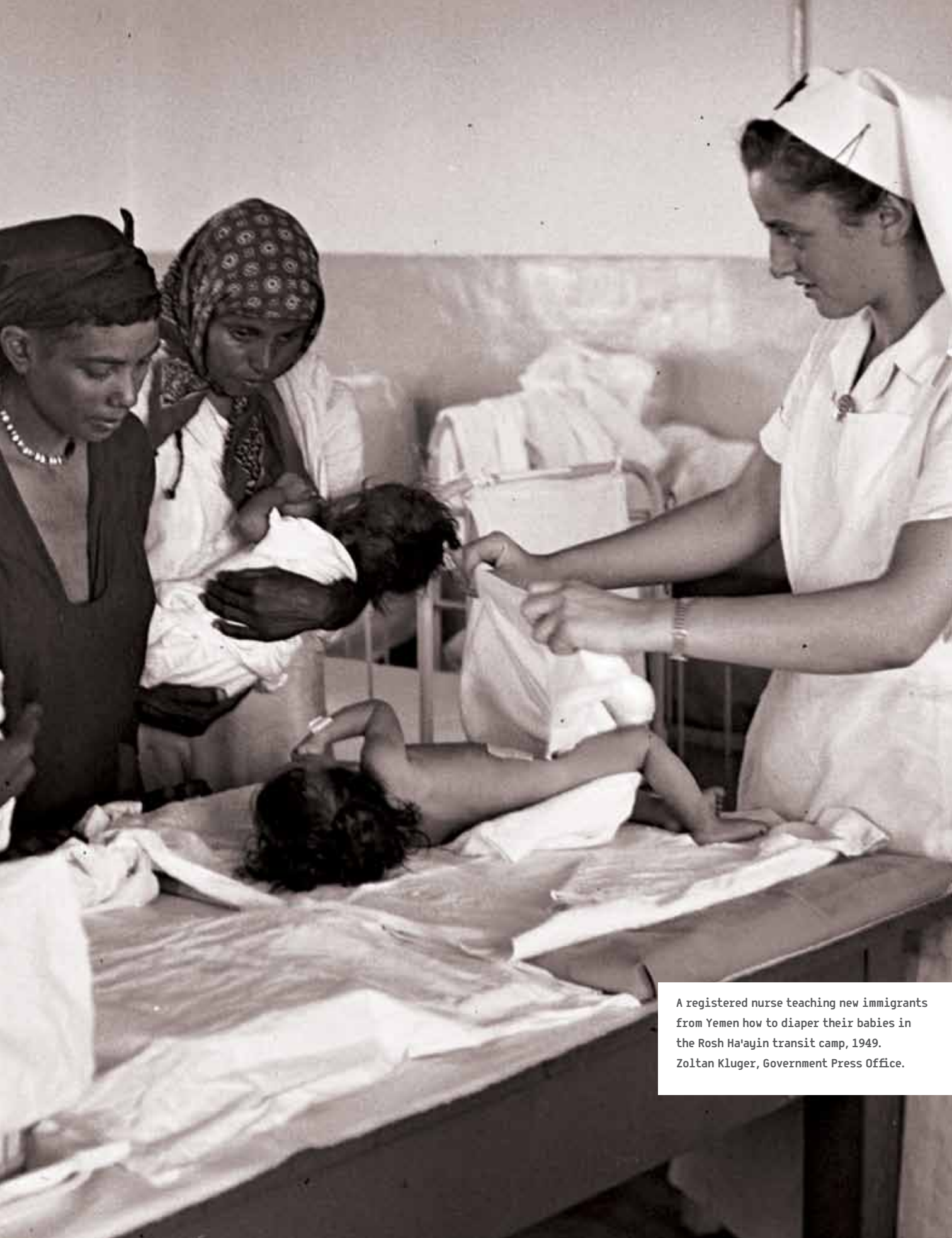


of the healthcare system, including its professional and educational institutions, as part of the social-political array that creates and preserves discrimination.

In light of the above, this paper examines the Israeli health system through a number of cases addressed by the ethics committee of Physicians for Human Rights - Israel (PHRI).<sup>5</sup> It will present factors that caused harm to the community while examining whether the situation was a unique momentary failure or rather a systemic and structural one. An examination and analysis of the reactions of the medical system and the results for those who were harmed by its conduct will then enable the identification of the exclusion mechanisms and barriers that impact the various communities in Israel. Finally, based on that analysis, this paper will recommend actions and specify the means that should be exercised in order to guarantee protection for patients and suggest what must be done to prompt medical personnel to stand at the forefront of the struggle for social justice, or, at the very least, to support such a struggle.

There are several main ideologies and mechanisms at the base of the barriers experienced by different communities: the effect of the ongoing state of war in which Israeli society lives is evident in the seepage of policing and militarism into its civilian systems, including medicine; capitalist discourse has led trends of commodification of health; and finally, racism that exists in society towards different groups who, by their very existence, challenge the Israeli national project, sometimes rises to the level of obliterating the legitimacy of those groups and their aspirations. Some of the cases discussed in this and subsequent papers will illustrate how harm and exclusion within the healthcare system are the results of these factors and their combination. Indeed, at the end of this project, we will try to connect these different mechanisms and outline their entire structure while addressing the degree of vulnerability of each community vis-à-vis the system. Clearly, the effect on each community worsens the further it stands from the center of the wealthy Jewish-Ashkenazi consensus.

In fact, most of the offenses against communities excluded from that hegemonic center are the result of a combination of several of these mechanisms. In many cases, there is an overlap of interests and power-driven structures that leads to the offense, but in this paper they will be analyzed according to the mechanism that was identified as the main cause of the offense. The subject of racism will be first and the other mechanisms will be examined subsequently.



A registered nurse teaching new immigrants from Yemen how to diaper their babies in the Rosh Ha'ayin transit camp, 1949.  
Zoltan Kluger, Government Press Office.

## Racism

In its public reference to expressions of racism in the medical system, the medical establishment usually denies the dimension of racism or claims that the cases in question are individual and self-contained. However, a historic review of the attitude of the healthcare system towards disempowered populations shows that not only are expressions of racism not limited to individual healthcare workers, but systemic expressions recur again and again in the history of medicine in Israel. This paper will shed light into the dark corners of Israel's medical history, those usually concealed by the establishment, by examining four prominent events from different historic periods.

### The Yemenite, Mizrahi, and Balkan Children

In Israel's first years, there were several severe affairs in which the medical community was involved that left a residue of mistrust and pain among the injured communities. Perhaps the most famous of those is the affair of the Yemenite, Mizrahi, and Balkan children.<sup>6</sup>

Between 1948 and 1954, more than 50,000 Jews immigrated to Israel from Yemen and were sent to transit camps. Numerous testimonies have accumulated from those years of the abduction of infants and babies from their community, with one out of every eight Yemenite babies<sup>7</sup> being taken away from their parents without the parents knowing what happened to them. The parents were told their child had died, but in many cases the children were given up for adoption or transferred to institutions. The healthcare system, and arguments based on medical principles, played a key role in the abduction of these children.

The numerous testimonies of family members of the abductees, and the similarity between them, indicate a pattern: young parents residing in transit camps were asked to take their young children out of their

**Almost every day one or two children disappeared. The children were usually healthy... When I finished my shift they were healthy, when I came back the next day children were missing from their beds... I asked the next day why the children were not in their beds and I was told the children had developed a fever and been transferred to Rambam Hospital in Haifa. And anyone who went to Haifa never came back.”**  
**A nurse at the Ein Shemer transit camp**





Immigrant children from Yemen at the Atlit transit camp, 1943.  
Zoltan Kluger, Government Press Office.

tents and transfer them to children's homes to maintain these children's health. Sometimes they were even told their children were sick and had to be evacuated to a hospital. These parents were allowed to visit their children in the children's homes, and the mothers were asked to come and nurse their infants. However, in many cases – thousands, according to the testimonies – the parents came to visit their babies and were told that the baby's condition had deteriorated and it had died. In only a handful of cases were the parents shown the baby's body or allowed to bury it. In a few cases, after the parents protested fiercely, the baby was miraculously found and returned to them. In other cases, the children were found alive and well many years later in the bosom of other families.

The few testimonies that were revealed<sup>8</sup> by the commission of inquiry headed by Judge Kedmi (its conclusions were submitted in 2001) portray a pattern of action by doctors, nurses, and social workers. For example, Dr. Yosef Yisraeli, the doctor in charge of the southern district, said a policy was established to transfer dozens and hundreds of children from hospitals to children's homes far away from their parents, and from there to adoption.<sup>9</sup>

Hanna Gibori, the chief welfare officer from 1948 to 1954, who was in charge of adoptions in the northern district, testified to the Kedmi Commission:

**"Doctors from the hospitals transferred children for adoption directly from the hospitals in a nonstandard way and without the official adoption authorities being involved."**

Gibori added in her testimony that if a child was under her care and no one showed interest in it, it was given to a family without an adoption process.

Similar statements were made by H. Leibowitz, who was in charge of adoption for the Welfare Ministry, at a meeting of the public services committee in early July, 1959:

**"There is also de facto adoption, and that must be taken into consideration as well. There are children who are transferred by the Welfare Service and there are children who are transferred by the mediation of a third party, and there are children – and that is the smallest part – who are transferred by their parents."**

Member of Knesset Ben Zion Harel said explicitly at a Knesset hearing that year:

"A sizable portion of children are received for adoption directly from the hospitals, directly from the maternity ward. Sometimes it is done unlawfully, bordering on commerce..."<sup>10</sup>

At the official commission of inquiry, nurses and social workers testified that they transferred healthy children themselves in ambulances from children's homes to hospitals. In a nurse's testimony about the children's home in the transit camp at Ein Shemer, the abduction of children is associated with a visit of a mission from abroad:

"A foreign group, speaking English or French, stayed at Ein Shemer for about two weeks, during which many children disappeared. Almost every day one or two children disappeared. The children were usually healthy... When I finished my shift they were healthy, when I came back the next day children were missing from their beds... I asked the next day why the children were not in their beds and I was told the children had developed a fever and been transferred to Rambam Hospital in Haifa. And anyone who went to Haifa never came back."<sup>11</sup>

Real-time written testimony can be found in a letter sent by Dr. Lichtig, head of the Department of Hospitals in the Ministry of Health, to the government hospitals in Haifa, Pardes Katz, Sarafand, and Dajani, from April 21, 1950. Its title is "returning six children received from the camps":

"There have been cases that children left the hospitals without returning to their parents. There were apparently quick-moving people who were interested in adopting children. The 'bereaved' parents looked for their children and they were gone. There is no need to explain and emphasize that we must make every effort to prevent the recurrence of such cases [...] The camp administration will be responsible for the return of the children to their parents since it is also responsible for sending them to the hospital..."<sup>12</sup>

For the attention of  
The Health Minister  
Jerusalem.

Dear Sir,  
Re: The medical service in the transit camps

On September 29, 1950 a column appeared in the Davar newspaper about the disappearance of an infant in one of the immigrant camps. I ordered an investigation into the matter and enclosed is a detailed report by one of my skilled officers. This report indicates a serious defect in the medical services in the immigration camps that requires rectification. The infant has not been found to this day.

Sincerely,  
Y. Sahar  
Commissioner General  
CC: The Minister of Police.<sup>13</sup>



Original letter from the Israel Police Commissioner General to the Health Minister. Nov. 3rd 1950

This grave and painful affair came up again when parents received draft orders for their children, the very children that the state had claimed died many years ago. However, the various commissions that were assembled in the wake of public pressure all acted in service of the state's attempt to bury the affair as one for which no factual basis had been found, and which was not the result of a systemic failure,<sup>14</sup> even though testimonies indicate the personal involvement of medical professionals and a systemic atmosphere that supported such actions.

**"An analysis of the report indicates that the commission's attitude toward the severe acts of commission and omission, some of them enumerated in its pages, is forgiving in the extreme. Thus, for example, even the destruction of archives under its very nose, while the commission was at work in recent years, does not set off an alarm for its members and does not give rise to discussion of suspicion."<sup>15</sup>**

The establishment's racism and paternalism towards poor and different population groups are not a phenomenon unique to Israel in those years. Similar affairs have been exposed in the Western world of babies and children being taken away from their parents and handed to "more desirable" adoptive families or institutions.<sup>16</sup> In many cases, the revelation of these deeds reverberated widely in the media and drew heavy public pressure that ultimately led to processes of inquiry, acknowledgment, and the taking of responsibility by the state.<sup>17</sup>

But, whereas in other countries these misdeeds received exposure, admission, and public recognition of the victims, in Israel the denial and silencing continue. Israel still denies that the abduction of children happened altogether. Given the central role played by doctors, nurses, and social workers in the affair, one could have expected that their professional associations would act for recognition of the injustice and its reparation in order to prevent a continuation of the anguish and emotional distress of the victims, and so that medical professionals and heads of the system would learn from past wrongdoings and take measures to prevent them in the future. Their silence conveys disinterest in the subject. It is what allows the silence of various witnesses who were involved, and the state's silence and silencing of its part in the crime: after all, the sState possesses the testimonies and chose to hide them away from the public until 2066. Only then, when members of the nuclear families of stolen children are no longer alive, is the information supposed to become open to the public.<sup>18</sup> Through their silence, involved medical personnel refuse to accede to the request of the parents, for whom it is important for their abducted children to know that they did not give them up, and that "it is the fault of those who were in charge and not, as they were told, that they were not interested in the children."<sup>19</sup>



Amram and PHRI have approached the medical establishment several times to request its involvement in exposing the subject, but these requests have all been denied or ignored completely. The denial of the involvement of medical personnel is surprising, considering that they were key to taking the children out of the transit camps and responsible for them in the various hospitals.

[Newspaper clip 1]

The Yemenite children's affair: Stash of pre-signed birth and death certificates found

[Newspaper clip 2]

October 21, 1995

Einat Berkowitz | Photograph: Ayal Yitzhar

Witness Sonja Milstein: I saw the corpses taken away by ambulance.

Attorney Nachman: Where were corpses taken from?

Judge Yehuda Cohen: What are corpses? Cadavers?

Milstein: I mean the corpses taken away by ambulance.

Judge Cohen: By corpses does she mean dead children?

Milstein: Taken by ambulance, who could still be saved.

Judge Cohen: Does she mean live children? Is she calling sick children corpses?

Prosecutor Nachmani: Are you referring to living children who were taken away?

Witness Milstein: Yes.







Immigrants from Ethiopia on their way from Addis Ababa to Israel on an Air Force Boeing jet, 1991  
Albert Nathan, Government Press Office.

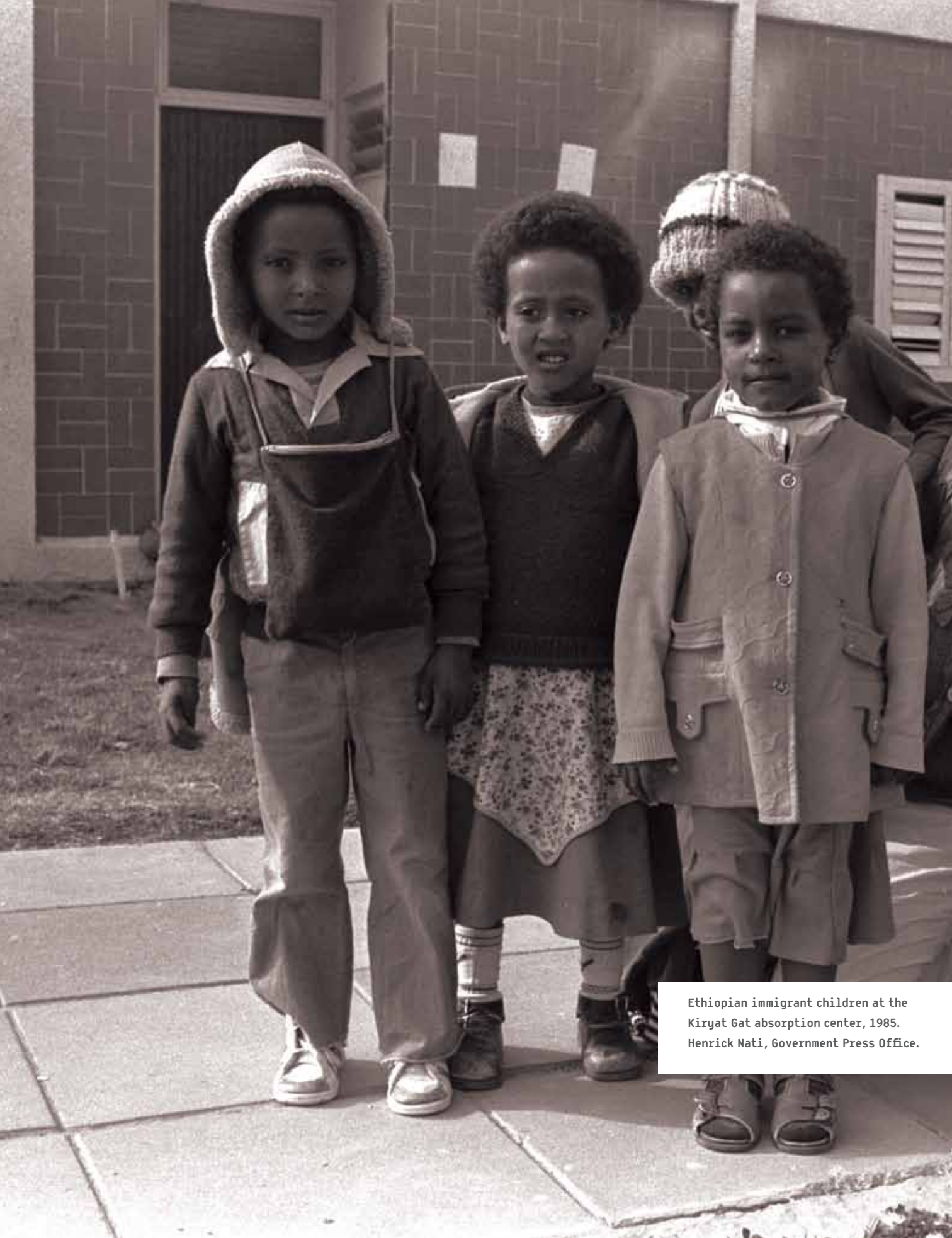
## The Depo-Provera

Taking responsibility for failures is one basis of trust between institutions and the people and communities who depend on them. Ethical violations and moral failures committed in the past cannot be brushed off with the argument that bygones are bygones, because the repetition of expressions of a paternalistic and racist approach by the medical community toward certain ethnic groups proves that lessons were not learned. The history of the Israeli healthcare system shows that when a community is treated paternalistically, as soon as it begins to suspect or protest, the medical establishment and its supporters resort to tactics of concealment or aggression. Where in the 1950s immigrants from Yemen were a central target of racist attitudes, in the 1990s and 2000s we see intense racism towards immigrants from Ethiopia.

The Depo-Provera affair, named after the contraceptive, reveals that racism or treatment "tailored" to a particular community continue to exist, are based on a distorted social perception, and are implemented in medical practice. Just like the Yemenite children's affair, here too in question is a perception of parenthood, a very paternalistic view of parental "efficacy," or what constitutes "desirable" parenting in the worldview of policymakers and their executors.

Whereas in the Yemenite children's affair, children were abducted out of the crude perception that they were being given to better parents and better lives, in this case, birth itself was prevented out of just as crude a belief that these parents ought to have fewer children. Here again, immigrant women were facing an Israeli system that was foreign to them, and they did not therefore know how to navigate their way through it and demand their rights,<sup>20</sup> surely not in the first years after coming to Israel. It should be noted that Depo-Provera is an approved contraceptive. However, it is not commonly used and is not offered to most patients.<sup>21</sup> Therefore, the thrust of the following criticism is over the way it was presented and given to Ethiopian women.

The affair was first exposed in 2008 in an article in the Yedioth Ahronoth newspaper,<sup>22</sup> describing a policy of use of the Depo-Provera contraceptive, which is administered by injection, for Ethiopian women. The report showed that after coming to Israel, there was a steep decline in the Ethiopian community's birthrate. For instance, among 57 Ethiopian families living in the Pardes Katz neighborhood of Bnei Brak, there was only one birth in three years.



Ethiopian immigrant children at the Kiryat Gat absorption center, 1985.  
Henrick Nati, Government Press Office.



Following the report, a study was conducted by Hedva Eyal<sup>23</sup> for the Isha L'Isha organization, and was later described in a report by Gal Gabbay.<sup>24</sup> These and other sources paint a picture of widespread use of this contraceptive for Ethiopian women in such a way that did not allow them to make an informed choice out of the variety of contraceptives available in Israel. A number of gynecologists in various HMOs who were asked by non-Ethiopian patients about Depo-Provera replied that it is not a recommended contraceptive except for in exceptional cases. Similar responses were received from both the Ministry of Health and Clalit Health Services.<sup>25</sup> Later, Dr. Adatto, a former Member of Knesset and a gynecologist by profession, explained that Depo-Provera is the last contraceptive she recommends to women, and that it is usually used by women who suffer from developmental disabilities, women in custodial institutions, and women who cannot be trusted to take the pill.<sup>26</sup>

Then Health Minister Shlomo Benizri insisted there was no separate policy for Ethiopian women, and the use of the injection was their own cultural choice.<sup>27</sup> This position was later backed up by Deputy Health Minister Litzman.<sup>28</sup> This statement contradicts figures presented in Isha L'Isha's study, according to which most of the women in Ethiopia who chose to use contraceptives used pills. The report also presents the data provided by Clalit Health Services, indicating that in the years preceding the writing of the report there was a sharp rise in the number of users of Depo-Provera in Israel, with 57% of the injection's consumers being of African origin, and another segment of the women who received the injection being women who suffered from cognitive disabilities and resided in various custodial homes and institutions.<sup>29</sup>

These data indicate that these women were not adequately given a choice. For instance, an Ethiopian physician reported that during his work at immigration centers, he saw that women were not receiving information about other contraceptives or informed about Depo-Provera's side effects so that they could make an informed decision. When they did receive an explanation, it was given with insufficient or inaccurate translation. That impression was reinforced by a TV report years after the initial exposé.<sup>30</sup>

This TV program revealed that the sweeping use of the Depo-Provera contraceptive for Ethiopian women continued after it was exposed. Some of the women interviewed for the report said they had begun to receive injections when they were still in transit camps in Ethiopia, with some not receiving an explanation that they were contraceptives. Some even testified that their immigration to Israel was stipulated on their acquiescence to receive the injection. Some said they were told that in Israel it is hard to raise children and it would be better if they did not have too many. Some of the interviewees said that when they came

**"Ethiopian women, because they forget, and they don't know, and the explanations are difficult for them. So it's best that they get one shot every three months. And for three months they are calm, and so are we, supposedly, because actually they don't understand anything."**

**Clalit Employee**

to the immigration centers in Israel, immigration counselors made appointments for them with doctors to continue receiving the injections. Others said that they heard about the injections for the first time at the immigration centers as part of family planning workshops.



One woman was filmed by a candid camera while visiting the HMO. She was documented receiving a Depo-Provera injection from a doctor, in a way that did not allow any possibility of her making a choice, exposing prejudicial views against the Ethiopian community:

Clalit Employee: You have an appointment for next time...

This time I will take her into the doctor. To [make sure he gives her the prescription so she gets the injection on time.

Patient's Escort: It's a contraceptive, right?

Clalit Employee: Yes.

Escort: Do a lot of women come here to get it?

Clalit Employee: Uh-huh.

Escort: Yes? Ethiopian women or... only Ethiopian women?

Clalit Employee: (nods) Some, but mainly Ethiopian women, because they forget, and they don't know, and the explanations are difficult for them. So it's best that they get one shot every three months. And for three months they are calm, and so are we, supposedly, because actually they don't understand anything."<sup>31</sup>

Most of the interviewees in the Isha L'Isha report said that they first received information about Depo-Provera from the Joint Distribution Committee, at lectures they heard in Ethiopia, or during their first days in Israel as part of family planning classes by the Jewish Agency and the Ministry of Immigration and Absorption. Approaches to these various parties in the course of writing this report led to their shirking responsibility and pointing fingers at each other.<sup>32</sup>

When the affair was examined by the PHRI ethics committee, it opined that the overwhelming use of Depo-Provera among Ethiopian women raised grave concern and it reflected a policy that expressed ethnocentric arrogance, if not outright racism. Cases of the injection being administered to women at risk of osteoporosis<sup>33</sup> indicate that sometimes the ethical violation was compounded by professional malpractice. Furthermore, Ethiopian women belong to a population that should have received special attention to enable them to make an informed choice, precisely because of their language difficulties and unfamiliarity with the Israeli medical system. The ethics committee emphasized what should have been obvious, which is that a medication should not be administered based on ethnicity or any other consideration except for the patient's medical condition and personal preference, and that it is the doctor's duty to present a woman with the existing alternatives and to discuss their pros and cons with her. It was also stressed that no choice whatsoever should be demanded,<sup>34</sup> patients should not be pressured, and the situation should be periodically evaluated to allow for a change of choice of medication.

The response of the medical community was diverse. While certain doctors noted it was not a common method even though it is legitimate, the heads of the system refused to acknowledge there was a problem of severely inappropriate administration and gave excuses based on the women's own cultural variables. The exception was the response received from the Director General of the Ministry of Health (January 20, 2013) to a letter sent by the coalition of organizations (January 10, 2013) on the use of Depo-Provera:<sup>35</sup>



Memorial march for Yosef Salamsa, 2015.  
Oren Ziv, Activestills.

For the attention of:

Prof. Haim Bitterman, Chief Physician, Clalit Health Services  
Dr. Yair Birenbaum, Director of Health Division, Maccabi Healthcare Services  
Dr. David Mosinzon, Vice President Medicine, Meuhedet  
Prof. Daniel Vardy, Vice President Medicine, Leumit Health Services

Dear Sirs,

Re: The use of Depo Provera as a contraceptive among women from the Ethiopian community in Israel  
Letter from Attorney Sharona Eliyahu-Chai from January 10, 2013

See enclosed

Without taking a position or establishing facts concerning the claims raised in this context, I wish from hereon to instruct all of the gynecologists working in the health fund and with the health fund not to renew Depo Provera prescriptions for women of Ethiopian descent or other women whom for any reason there is concern did not understand the consequences of the treatment, without a conversation with the patient in which the physician will seek to understand why she is using contraceptives at all and this one in particular, whether she wishes to prevent pregnancy from her own free will, and whether she understands the side effects compared to other contraceptives.

Of course this should be done with the appropriate cultural competence, using if necessary mediators from the Ethiopian community and/or medical interpretation services.

Sincerely,  
Prof. Ronni Gamzu

In his response, the director general refrained from addressing the investigation's findings, but did explicitly order staff[who?] to uphold the ethical guidelines that should have been the clear consensus of the entire medical community. However, even though the response was worded carefully, it was enough, along with then Health Minister Yael German's support for establishing a parliamentary commission of investigation,<sup>36</sup> to draw the ire of senior members of the medical community. For example, in an especially strong letter protesting the director general's memo and the idea of an investigation, Prof. Daniel Seidman, President of the Israeli Society of Contraception and Sexual Health, and Prof. Moshe



מדינת ישראל  
STATE OF ISRAEL

משרד הבריאות, ירושלים  
Ministry of Health  
Jerusalem

המנהל הכללי  
Director General

סי בשבט, התשע"ג  
20 ינואר, 2013  
סימוכין: 03359013  
(במספר: ציין סימוכין)

לכבוד  
פרופ' חיים ביטורמן, הרופא הראשי, שירותי בריאות כללית  
ד"ר יאיר בירנבאום, ראש חטיבת הבריאות, ממבני שירותי בריאות  
ד"ר דוד מוסין, סגן מנהל רמ"א, מאוחדת  
פרופ' דניאל ורדי, סגן מנהל רמ"א, מאוחדת שירותי בריאות

שלום רב,

נדון: השימוש ב-Depo Provera כאמצעי למניעת הריון כבר שנים המהוללות האתונות בשראה  
מכתבה של שידור שרונה אליהו-חי מיום 10.1.13

ראו את המצ"ב.

מבלי לנקוט עמדה או לקבוע עמדות באשר לטענות שעלו בחקשר חו, אני מבקש להורות לרופא את כל רופאי הנשים העובדים בקופות חינו ורמ"א, שלא לחדש מרשמים של דפו מרברד לנשים ממוצא אתיופיה או נשים אחרות שמכל סיבה שחש שיש להן סיכוי גבוה לא להבין את השלכות השימוש, אלא לאתר שיתח עם המסופקת בה יבקש הרופא להבין מדוע יש שימוש באמצעי מניעה בכלל ובדפו בפרט, האם היא מבקשת להמשיך מתירון מרברד החופשי והאם היא מבינה את תופעות הלוואי לפרול האמצעי מניעה אחרים.

כמובן, יש לבצע זאת בניגודות הרבותיות מתאימה, ותוך היעדרות במידת הצורך בנגשרים בני העדה האתונות וראו שירותי תרגום רפואי.

מכבוד רב  
פרופ' רוני גמזו

Original letter from the Ministry of Health Director General. Jan 20th, 2013.



Ben-Ami, Chairman of the Israeli Society of Obstetrics and Gynecology, asserted that this was unfounded libel.

"Israel's enemies are already hurling heavy accusations at the State of Israel and its doctors as a result of this libel, one that brings to mind dark times in history when Jewish doctors in Europe were subjected to similarly false accusations. The day is not far when Israeli doctors will be afraid to travel abroad lest they be charged with deliberately harming women as a result of an official racist policy by the State of Israel.

"It is unfortunate that the Ministry of Health under your direction has joined a discussion of this baseless slander without checking the facts first. The fact that, despite our specific request, there was no representative of the Society of Obstetrics and Gynecology on behalf of the Israel Medical Association at the committee hearing, only adds to the feeling of a plot against the gynecologists."<sup>37</sup>

This behavior of automatic rejection of the charges coming from within the injured community, despite their being backed by data, while utilizing nationalist arguments, is not unusual,<sup>38</sup> and is a useful and extremely powerful instrument for hiding information and silencing dissent. Even though the community itself might at times fall silent in the face of such arguments, the fact that the establishment attempts to quell its complaints leaves the wound open:

"The rift between the Ministry of Health and members of the community is ongoing... The trust is almost irreparable for the simple reason that, if we look at the blood donation affair, [described hereunder], and then move 10 years forward from the time the first affair came to light in 1996, and then we see in 2006 the second affair, and now the Depo-Provera and the State of Israel, then there is no doubt at all... The story cannot be addressed by a committee like this. It has to be [evaluated by] a very serious committee."<sup>39</sup>

Despite attempts to do so, the report by the Knesset Research Center did not show unequivocally that the treatment was indeed forced upon women, but it did show that many of them received it and that there was a significant drop in fertility rates of women from Ethiopia in 2008–2011. However, as with the Knesset Health Committee hearing, the research center failed to identify who was responsible for the policy, and some of the relevant documents were hidden from it.

"I have the feeling there was a guiding hand at play. Where's the smoking gun? Who is the smoking gun? Who determined this conduct? We did not manage to answer

**"The day is not far when Israeli doctors will be afraid to travel abroad lest they be charged with deliberately harming women as a result of an official racist policy by the State of Israel."**

**Prof. Daniel Seidman & Prof. Moshe Ben-Ami**

**those questions. We don't know. I think it is the role of the State Comptroller, because even the Knesset Information and Research Department faced difficulty reaching certain places and exposing certain documents."**<sup>40</sup>

There were high expectations that the State Comptroller's report could find that smoking gun and expose the connection between the state and its institutions and the policy that began in Ethiopia through the Jewish Agency and the JDC and continued in Israel. But high expectations lead to great disappointments. Not only did the report not find the source of these policies, but it looked like there had not even been an attempt to look for it. Just like in the Yemenite children's affair, "without real suspicion there can be no real investigation."<sup>41</sup> Thus, for example, not one of the Ethiopian women, not even those who were interviewed for Gal Gabbay's program on camera, was invited to testify to the State Comptroller.

**"He based his investigation on directing questions to officials from the JDC, the Jewish Agency, the Ministry of Health, and physicians. Could any of those questioned, who head those organizations or departments, have been expected to testify that they themselves threatened or exerted pressure on women? The comptroller mentioned the limits of power vis-à-vis nongovernmental organizations, but preferred not to acknowledge the effect of that essential limitation on his work and on his ability to reach unequivocal conclusions. Instead of admitting he could not get to the bottom of the affair by virtue of the definition of his role, the comptroller actually chose to assert that there was no evidence of the women's claims as to administering the Depo-Provera contraceptive to women of Ethiopian origin."**<sup>42</sup>

Such a report, just like the commission of inquiry into the abducted Yemenite children, cannot close the affair for the injured community. That is because it is clear that there was no intention to uncover the truth about the involvement of institutions connected to the migration of Jews to Israel, or to revisit the picture of the "melting pot" where there are no disparities or racism. It appears that, like the ones that came before it, this report sought to silence the affair rather than discover those responsible for it. When the establishment does not take responsibility for repeatedly offending a disempowered community, does not genuinely examine its grievances, does not admit its guilt, and, most importantly, refuses to learn practical lessons - trust gradually crumbles. The medical establishment, in whose hands people place their lives, has continuously failed to build trust that the lives of some are

no different in value from the lives of others. This failure began as far back as Israel's earliest years with the state's attitude towards the "cultural level" of the immigrants as part of its discussions of public health.<sup>43</sup>

**"For us, 'eugenics'<sup>44</sup> in general, and protection against the transmission of hereditary diseases in particular, has an even higher value than for other nations! ...We have no interest in a tenth child or even a seventh child in the poor Middle Eastern families. We are interested in a fifth, fourth and third child in every Jewish home. In today's reality, we often must pray for a second child in the families that belong to the 'intelligentsia.'<sup>45</sup>**

## Segregation in Maternity Wards

Another affair reveals the extent to which the issue of childbirth - rooted in the demographic struggle waged by state institutions - continues to challenge medical personnel. Media reports indicate that hospitals in Israel acquiesce to requests by maternity patients to segregate them on ethnic and nationalist grounds. In this case, it appears that racism has joined with financial motives to allow discriminatory conduct within the confines of hospitals and by their employees. Therefore, we must examine the role of the medical community and its members in creating the hierarchy between themselves and women, and between strong groups of women - citizens, Jews - and weak groups - Palestinian citizens of Israel and asylum seekers from Eritrea. Meanwhile, we must take into account the processes that lead patients (especially from a high social class) to perceive themselves as customers who can make demands that contradict medical ethics. All of these factors are at play in a society that views itself as caught in a demographic struggle and which encourages Jewish childbirth above others.

Unlike other kinds of hospitalization, maternity patients are allowed to choose in which hospital to give birth, and the payment for the delivery is not transferred by HMOs, but rather by the National Insurance Institute, which is considered good, secure income for hospitals. Therefore, hospitals compete amongst themselves and act to increase the number of births in their wards. In addition to the array of services offered by hospitals, they also compete to offer the "best" birthing environment. One of the factors that impact the competition in this respect is the mixing of mothers from different populations. Mothers from what are considered "strong" populations wish to avoid being hospitalized with mothers from what they consider "weak" populations: Arabs next to Jews, asylum seekers next to Israelis.

PHRI addressed this issue in April 2013 after it entered public awareness through social networks. There were posts in which pregnant Jewish women asked for "recommendations" for hospitals that segregate between Jewish and non-Jewish mothers. Over the years, mainstream media outlets reported ethnic segregation in maternity wards in a considerable number of hospitals: as early as 2006, Haaretz reported segregation between mothers in the Rebekka Sieff and Western Galilee hospitals. In February 2012, Maariv reported segregation in the Meir and Soroka hospitals, and a few months later, in July 2012, Channel 2 ran a report about segregation between Arab and Jewish mothers in the HaEmek, Hillel Yaffe, Bikur Holim and Poriya hospitals.

In addition to reviewing past media reports,<sup>46</sup> and in an attempt to understand how widespread the phenomenon is, a PHRI staff member presented herself as a pregnant woman in phone calls she made to the maternity wards of the Soroka, Meir, Carmel, and Hillel Yaffe hospitals. The phone calls included the question of whether the hospital normally separated mothers at the mother's request. All the hospitals that were examined answered the question identically: the departments "try" to separate between mothers from different backgrounds. Furthermore, the impression from the conversations was that a request by a mother to share her room with those "like her" was not an unusual request and that it was considered reasonable and legitimate.

Therefore, the PHRI ethics committee and board wrote to the various hospitals in Israel (April 17, 2013) to stop segregating maternity patients, and later the ethics committee approached the Ministry of Health (July 9, 2013) asking it to stand firm on the principles of medical ethics. In these letters, the organization stressed that the only screening that should take place in hospitals should be based on medical need and medical indication, and that rooms must be populated regardless of the mothers' preferences, ethnicity or ability to pay.

**"In the last year about 700 babies were born to Eritrean and Sudanese mothers, and today there is an average of two births a day... The problem is that they closed the [border] fence but they didn't close natural migration, and the number of Eritreans born here rises every year,"<sup>47</sup> (Prof. Barabash, then Director of Ichilov Hospital).**

When the subject was raised, many women expressed misunderstanding and wondered why their wishes could not be taken into consideration. They stressed it was not a matter of racism but different cultural backgrounds and that, after all, the treatment is no different when the rooms are segregated. Therefore, it is important to stress that the doctrine of "separate but equal" is an illegitimate and discriminatory practice. Not

**"In the last year about 700 babies were born to Eritrean and Sudanese mothers... The problem is that they closed the border but they didn't close natural migration, and the number of Eritreans born here rises every year,"  
Prof. Barabash**

only has it never met the test of reality, but in medicine in particular it has no place and contradicts the essence of the profession, which is committed to the equal treatment of every person. In our opinion, approval of this illegitimate and discriminatory practice, even tacitly or by declarations that are not backed by actions, harms not only the excluded and separated women, but also society as a whole. Furthermore, we believe it is the duty of medical personnel to fight racism, and all the more so not to let it into hospitals. PHRI asked the Director General of the Ministry of Health to issue a memo on the subject to the different hospitals, and for the Israel Medical Association (IMA) and the National Association of Nurses to act to integrate the values of equality in hospitals and among their members.

The responses we received to our approaches were far from satisfactory. While in hospitals it appeared to be a practice whose purpose was to avoid conflict with women by treating them as customers that needed to be satisfied, it is harder to explain the disregard of the leadership of the medical community.

The IMA response (April 24, 2013) treads the thin line of "consideration of the mothers' preferences," while ignoring the fact that those result from racism, and it is not clear how section 1 of the response that talks about such a consideration can be consistent with the values of equality mentioned in the section 2.

Wednesday, April 24, 2013 | Reference:

For the attention of  
**Mr. Itamar Inbari, Director of the Equality for the  
 Palestinian Population of Israel project  
 Physicians for Human Rights Israel**

Dear Sir,  
**Re: Ethnic segregation in hospital maternity wards  
 (Reference: your letter from April 17, 2013)**

Pursuant to your letter in reference and from an inquiry made with the board of the Association of Hospital Directors, I found there is no policy of ethnic segregation in the maternity wards in the hospitals in Israel. I was also told by that board that maternity patients are assigned to rooms according to their medical condition, with consideration of the patients' preferences as far as that is possible. I should add that the IMA believes it is very important to



יום רביעי 24 אפריל 2013  
 01:28:03 - 01:28:03

לכבוד  
 מר יטמר ענברי  
 מנהל המיניסט לווויין האוכלוסייה הפלסטינית בישראל  
 המשרד לבריאות הציבור - הארץ

מסדבי,

הודון  
 מנהל רח אגודת המיניסט לבריאות הציבור  
 11 במרץ 2013

1. במסגרת המיניסט לבריאות הציבור ישנו מערך של חלוקה, עלול כי לא קיימת מדיניות של הגדרה אגודת המיניסט לבריאות הציבור בישראל. עד נוסף כי מועד זה כי הגבט היחידות בחורים משתתפות במסגרת המיניסט לבריאות הציבור, ככל שאלה נחשבות לביטוח.
2. לא לפנות למיניסט לבריאות הציבור נדחלת בחולת עמי החיוון במשרד הבריאות העיבורית, ובכלל זה גם במיניסט לבריאות הציבור.

בברכה,  
 ד"ר ליאונרד אילסון, יו"ר  
 התאחדות הרופאים בישראל

המשרד  
 רח אגודת המיניסט לבריאות הציבור, ראש המשרד לבריאות הציבור, ת"י  
 ע"ד תל אביב, מרכזי המיניסט לבריאות הציבור  
 ע"ד תל אביב, ראש המשרד לבריאות הציבור ומיניסט לבריאות הציבור, ת"י  
 ע"ד תל אביב, תחום המיניסט לבריאות הציבור, ת"י



Original letter from the Chair of  
 the Israel Medical Association.  
 April 24th 2013.

apply the value of equality to the public health system, including the various hospital wards.

Sincerely,  
Dr. Leonid Edelman, Chair  
Israel Medical Association

The answer from Prof. Reches, then Chairman of the IMA Ethics Bureau, is a little different. While it does not mention consideration of the mothers' preferences, his answer ignores the facts brought before him and denies that numerous hospitals segregate mothers on an ethnic basis. It should be noted that at a meeting between PHRI and representatives of the IMA, a nurse and doctor testified about segregation in hospital maternity wards, and testimonies were brought from the media, and from PHRI's investigation. However, Prof. Reches was satisfied by a quick phone call with the head of one of the hospitals who denied there was such segregation in the hospital.

For the attention of  
Mr. Itamar Inbari, Director of the Equality for the  
Palestinian Population of Israel project  
Physicians for Human Rights Israel

Dear Mr. Inbari,  
Re: Ethnic segregation in hospital maternity wards  
In response to your letter in reference from April 17, 2013  
and pursuant to the letter from Dr. Edelman, Chairman of  
the IMA, from April 24, 2013, I would like to inform you as  
follows:

The ethics board discussed your inquiry on May 7, 2013.  
The alleged segregation on ethnic grounds is not familiar  
to the members of the ethics board as a whole or to me  
personally.

The members of the ethics board unanimously supported the  
position of Dr. Edelman that "the IMA believes it is very  
important to apply the value of equality to the public  
health system, including the various hospital wards."  
Needless to say the members of the ethics board object to  
any racist or discriminatory expression towards patients.

Sincerely,  
Prof. Avinoam Reches  
Chairman of the Ethics Board



Original letter from the Chair of the  
Ethics Board. May 8th 2013



Blood donation for the Magen David  
Adom blood bank, 2007.  
Avi Ochayon, Government Press Office.

Again, even in the face of an abundance of facts and proof, the medical system is unwilling to confront a reality that challenges its self-image, arguing that as long as there is a dispute over the facts, the professional association and its ethical leadership have no basis for action, although there is no doubt that raising awareness and formulating clear messages and guidelines for behavior should have been the obvious course of action at the very least. It seems like another case of the medical community turning its back on criticism and automatically backing its members.

## The Blood Donation Affair

The affair of throwing away Ethiopian blood donations was exposed on January 25, 1996. The affair involves a valid professional medical argument, and so, when it came to light and received great attention, the medical argument served as an effective way to reject claims of racism by the medical establishment and silence all criticism. The argument was that because of the high incidence of HIV among the Ethiopian community, it was decided for reasons of public health not to use blood donations collected from it. The fear was that at the time the donation was taken, the donor might be in the three-month "window" period in which a blood test would not show that the person was HIV-positive, because they had not yet developed antigens against the virus.

Once the discussion was diverted to that public health risk, it was hard to maintain a straightforward discussion of alternatives that the medical community could choose in its conduct in relation to the Ethiopians who wished to donate blood. Only later was the public health issue separated from the question of concealment,<sup>48</sup> and the question was asked why the authorities continued drawing blood donations from Ethiopians and hiding from them that they were being thrown away.

**"The Ethiopian community expects the commission to draw personal conclusions against the director of the blood bank, Dr. Amnon Ben David, who attested to his responsibility for the blood bank's policy of lies and the policy of throwing away the Ethiopian community's blood donations. We will be satisfied with nothing less. I and the entire community expect the committee to bring to justice the person responsible for this affair, which caused irreversible damage to the community and its reputation."<sup>49</sup>**

Like in previous cases, the state agreed, after heated demonstrations, to appoint a commission of inquiry to handle the blood donations affair, headed by former president Yitzhak Navon. It was clear that the Ethiopian

**"We fight and die in the army... but that is not enough. It is unacceptable that a person goes to donate blood ... and is misled to believe that he is saving a life... the minute they turn their head they throw their blood into the garbage."  
Gadi Yeberkan, Rehovot**



community expected the committee to expose the misdemeanor, and that their expectations extended beyond the issue at hand to repairing the establishment's treatment of them in general.

**"We fight and die in the army, we go to the university, but that is not enough. It is unacceptable that a person goes to donate blood in order to help another person and is misled to believe that he is saving a life. They sit there, have a needle inserted into their body, a significant amount of blood comes out of their body, and the minute they turn their head they throw their blood into the garbage."<sup>50</sup>**

But like the Health Minister before it, the committee too emphasized the professional medical aspect and minimized the significance of the failure of hiding the information.

**"[Disqualifying the blood units] was undertaken for pure medical-professional reasons, according to the universal policy of the WHO and blood services in Western countries. All sub-Saharan countries in Africa are hyper-endemic for AIDS, and blood donations are not taken from those countries. Ethiopia is one of those countries."<sup>51</sup>**

If there was a defect, said the report, it was the attempt to hide that information from the public. The fact that, about 10 years later, it was discovered that the practice of throwing out blood donations was still going on<sup>52</sup> is proof positive that the system did not grasp its failure. And how could it, when the inquiry was motivated mainly by defensiveness and in the name of professionalism?

Yet today, another decade later, the change is evident, possibly as a result of the struggle by the Ethiopian community and its representatives. The information at Magen David Adom<sup>53</sup> is transparent and clear:

According to these procedures, you cannot use for infusion a blood unit donated by someone who was born or lived for more than one year since 1977 in a country with a high incidence of AIDS, including countries in Africa, Southeast Asia and the Caribbean islands. People who still want to donate blood can do so, knowing that the unit will not be used for an infusion.

The purpose of these procedures is to protect the health of recipients of blood units against units that might cause illnesses transmitted by infusion.

As for donors from the Ethiopian community, to whom this section applies, it is noteworthy that since some of them have rare subtypes of

blood which it is extremely important for them to know about for their health, and since it is important for there to be blood units from those subtypes, there is a special directive that blood units donated by them be examined, and if indeed they are from a rare subtype of blood, the units are frozen for future use.

The aforesaid procedure does not apply of course to members of the community who were born in Israel.

In general, the issue of blood donations by members of the community has been on the Ministry of Health's agenda for several months, and there have been a number of meetings between the health minister and MK Tamano-Shata and professionals from the ministry, experts on infectious diseases, and members of the board of specialists that advises the Ministry of Health on infusion medicine, which is trying to see if anything can be done to change the procedure without compromising public health."

Indeed, during her tenure as health minister, MK Yael German appointed a committee headed by Prof. Manfred Green to check whether there could be a change in the policy of using blood donations from members of the Ethiopian community. Due to the position that those units compromised public health, the recommendations remained in controversy and the policy remained unchanged:

"The minister's intention to contribute to social equality by changing the blood donation procedures was well-intentioned, but it is not practical," said a professional familiar with the committee's work, who elaborated: "There are very few immigrants whose risk of being carriers is low. To let the low-risk people donate blood, there would have to be a very clear separation between immigrants. You would have to tell one 'you can donate' and another 'you cannot.' Ultimately, it would cause a feeling of a split within the Ethiopian community and only deepen the rift."<sup>54</sup>

The dimension of hiding the handling of blood donations changed, but the institutional treatment of the blood affair did not lead to healing. The commission of inquiry headed by former president Navon did not discuss the broad social contexts of the issue and supposedly positioned medical rationalism and professionalism against cultural features of the Ethiopian community. The establishment's framing the conflict as one between public health and the community's dignity<sup>55</sup> actually prevented an effective discussion of the broader aspects of the affair. No wonder that when the Depo-Provera affair came to light, and throughout Ethiopian protests, the blood affair continued to reverberate.

**"Apparently our blood is  
only good enough  
for wars,"  
sign at a demonstration<sup>56</sup>**

## Summary and Looking Towards the Future

As illustrated throughout this paper, the medical community and various medical establishments tend to reject out of hand any charges of racism or discrimination. Their reactions help silence grave affairs from the past and present, and thereby actually prevent the necessary healing and restoration of impaired trust between injured communities and the medical system.

This conduct contradicts testimonies of discrimination against disempowered communities in Israel. From the cases described above, which are but a few among others, it is evident that such treatment is not unique historically or personally, but is rather a chronic failure of the Israeli healthcare system.

Therefore, expressions of racism in the healthcare system should be dealt with firmly and systematically. To that end, we must understand that such expressions recur not because of bad intentions or bad doctors in the system, but because the system contains structural features that prevent bold and thorough treatment of this issue.

The ethos of the medical community continues to rally around the principle of neutrality. Healthcare professionals often say they are "color blind" or view medicine as an "island of sanity" in a country beleaguered by severe political and social conflicts. This ethos prevents the medical community from seeing where that blindness acts to hinder and exclude disempowered groups. Grimmer yet, even when these communities indicate clearly that they were injured, the medical establishment rejects any recognition that the injury indeed arose because of that very blindness. As far as they are concerned, such acknowledgment would contradict their belief that they are acting rationally and scientifically. But the opposite can be argued. A critical, bold examination is one of the fundamentals of scientific and medical research, and these values must

guide the medical community when it examines its conduct and both its professional and moral failings.

The demographic composition of the health community, and especially its leadership, reflects the overrepresentation of men, Jews, and especially Ashkenazi Jews. The medical school admission exams do not help diversify the population that studies medicine, and even minority groups that have managed to get in have not yet succeeded to change their position in the hierarchy of the medical world. The question one needs to ask is how communities who do not see themselves represented among health policy and decision makers experience the lack of recognition and failure to take responsibility for the harm inflicted on them.

And finally, the Israeli healthcare system has not managed to move past the society-building stage that characterized its early years. The cases reviewed in this paper, many of which focused on women's uteruses and fertility, show that the focus on desirable childbirth and desirable pregnancy continues to occupy the healthcare system as part of a national demographic philosophy and belief in the supremacy of Western culture, from which the Israeli medical system drew its values. This philosophy recreates a hierarchy that defines what kind of demographic growth is desirable for the national effort. The conduct of the healthcare system cannot be separated from public discourse, which views the increase of certain populations as a risk to the national project, whereas the growth of others is perceived as contributing to national fortitude.

The inability to acknowledge past failures and or take responsibility for them leads to the continuation of silencing and concealing. The archives of the ringworm radiation patients as well as the archives of the abducted Yemenite children have remained closed by a state decision, but we can only imagine what the IMA or the National Association of Nurses could have done had they, as a first step, taken responsibility for the medical community's role in those incidents or joined the demand to open the archives.

In the absence of an apology and frank assumption of responsibility, and since the repetition of expressions of racism indicates that nothing has changed, it is only natural for the injured communities to continue to feel deep mistrust of the medical system. The avoidance of apology within the medical system can partly be attributed to the concern that the assumption of responsibility would lead to demands for compensation. However, there are many models of apology outside of the courtroom, and in any case in all of the conflicts described above, the demand for a symbolic but sincere apology and admission of responsibility has been stronger. However, since those demands have gone unanswered, it is

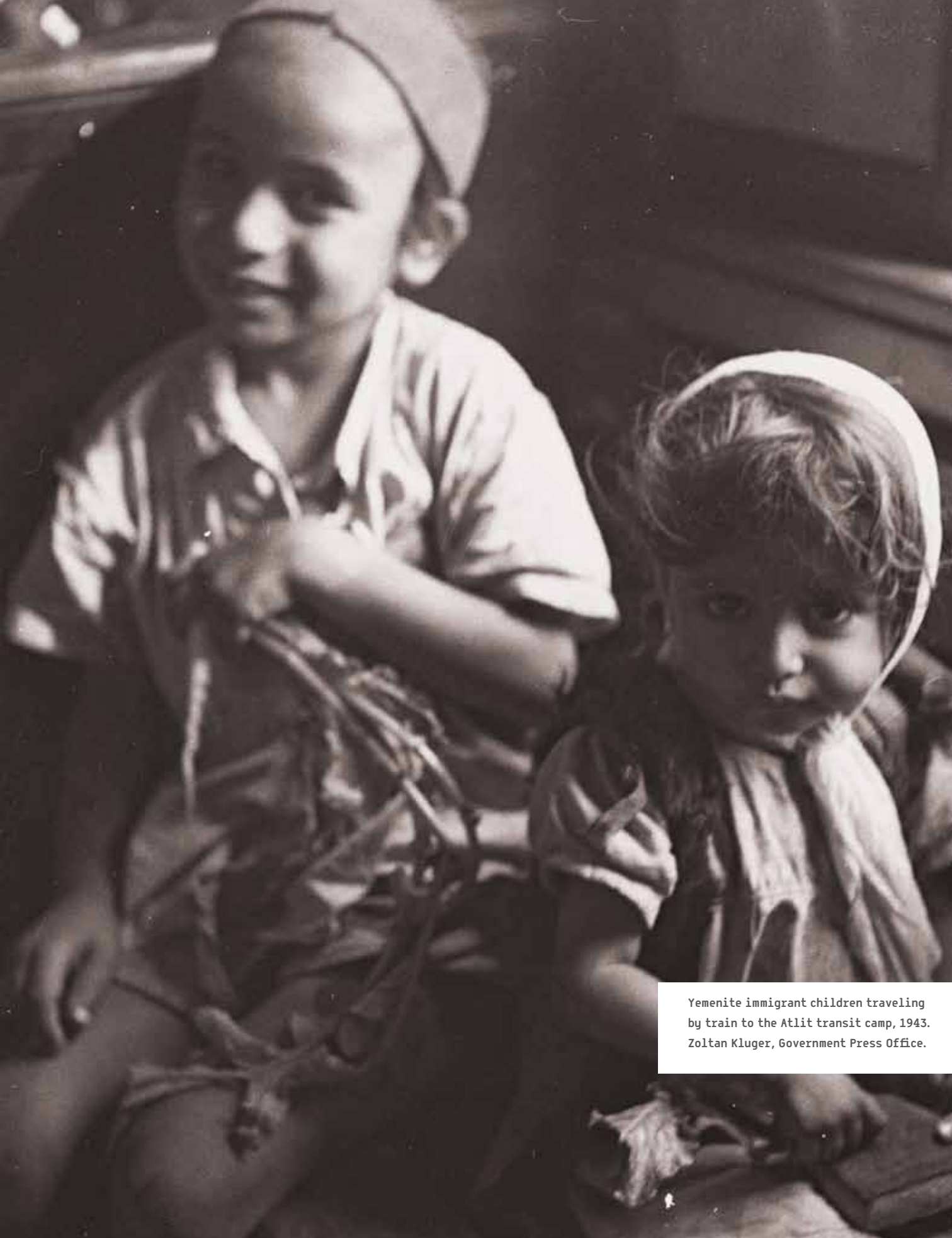
possible that these cases will indeed end up in court.<sup>57</sup> In the absence of the taking of responsibility and the absence of an apology, it is impossible to restore trust in the medical system in communities that suffered traumas such as the ones described in this paper. Acts by the medical system can create collective as well as individual trauma. Members of injured communities whose trust in the medical system was compromised might minimize their contact with the system and avoid preventive medicine vital to their health and to public health. Thus, on the collective level as well, the trauma can be a mental wound that spreads to the entire community and affects the constitution of its identity and the self-worth of individuals within the group.<sup>58</sup>

Such events indicate that the problems do not pertain to a particular individual but rather are systemic, and reflect a culture and social array that maintain discrimination in the environmental, social, and political factors that define health. These taint the delicate human relations between physician and patient and blemish the medical establishment, including its professional and educational institutions. It is true that a less riven society, which promoted social solidarity, would help and have an impact on the medical community and system. But as long as that does not change, the medical system must deal firmly with the racism and paternalism in its midst. In order to create change and lead the system towards promoting equality and respect of the diverse communities in society, a number of measures must be taken:

Ensure adequate representation of diverse communities and social classes in the study of medicine by investing in programs that improve their admissions and promotion in the medical hierarchy.

Change medical education to include issues of social justice and collective trauma and emphasize the importance of tools from the fields of human rights and distributive justice.

Develop a model of recognizing deficiencies, taking responsibility, and apology, while including the injured community in a way that enables healing and restoring trust. As Davidovitch and Alberstein note, in order for the apology to lead to healing and reparation, it must include recognition of the wrong, a taking of responsibility by the injuring institution, measures to heal social wounds, reparation of the wrong, and the granting of compensation, to make forgiveness possible.<sup>59</sup>



Yemenite immigrant children traveling by train to the Atlit transit camp, 1943. Zoltan Kluger, Government Press Office.

## Endnotes

1

<sup>2</sup> Baldwin-Ragaven, Laurel; de Gruchy, Jeanelle & London, Leslie (editors), *An Ambulance of the Wrong Colour - Health professionals, Human Rights and Ethics in South Africa*, University of Cape Town Press, 1999.

<sup>3</sup> In this paper we will refer only to access to health services, even though it is clear that the right to health includes equitable access to all of society's resources.

<sup>4</sup> Ibid.

<sup>5</sup> The members of the ethics committee during these periods included Prof. Bella Kaufman, Dr. Bettina Birmanns, Dr. Noa Barhaim, Dr. Ze'ev Weiner, Dr. Kobi Arad, and Dr. Mithal Nassar.

<sup>6</sup> The section that discusses this affair is based on a paper written by Naama Katiee of the Amram Association and Hadas Ziv of PHRI, to mark the Day of Awareness of the Abduction of Yemenite, Mizrahi, and Balkan Children.

<sup>7</sup> Boaz Sangero, *Where There is No Suspicion There is No Real Investigation*, p. 48, *Teoria Uvikoret* 21, Fall 2012.

<sup>8</sup> Even though the deliberations were open, the raw material is no longer accessible to the public.

<sup>9</sup> Shlomi Hatuka, *The Yemenite Children's Affair: a Journey in the Footsteps of the Tragedy of the Adopted*, Haokets, 4.10.2013

<sup>10</sup> Ibid.

<sup>11</sup> Shoshi Zayed, "The Child is Gone: the Yemenite Children Affair," Jerusalem: Gefen, 2001.

<sup>12</sup> Hatuka

<sup>13</sup> Lori Shem Tov, *Haokets*, October 7, 2013, Retrieved February 22, 2016.

<sup>14</sup> Following public pressure, it was decided in 1967 to set up a parliamentary commission of inquiry (Bahlul Minkovsky), followed by the Shalgi committee (1988-1994). Both were severely criticized regarding their functioning. In 1995, after the self-barricading of the late Rabbi Uzi Meshulam and his followers put the issue on the public agenda, an official commission of inquiry was established, whose conclusions were published in 2001.

<sup>15</sup> Sangero pp. 48-49

<sup>16</sup> In Canada, Australia, and Switzerland, children were taken away from families that belonged to "backward" ethnic groups and given up for adoption or placed in institutions as part of a policy of "integration," intended to reeducate those groups and eliminate their cultural and spiritual existence. In Ireland, young women who gave birth out of wedlock were forced to give up their children for adoption by Catholic Church institutions under the auspices of the state. In France, 1500 children and infants were taken away from their families in the colony of Reunion and sent to France, with the authorities creating the false pretense that they were going to be given education and welfare. In fact, the children served as cheap labor, suffered from physical, emotional, and sexual abuse, and were completely cut off from their families. In Argentina, hundreds of babies of dissident parents were abducted and given to families that were "more desirable" in the eyes of the regime. In Spain, thousands of babies were abducted shortly after birth and given up for adoption after their parents were told that their children had died. Nurses, doctors, private hospitals, and nuns were involved in the abductions, which were motivated by greed.

<sup>17</sup> See also Ruthie Amir, for the information of reader Yaron London, *Ha'aretz* 11.7.2013, retrieved on June 10, 2015.

<sup>18</sup> Shoshi Zayd, Wait until 2066, Haokets 24.7.2013

<sup>19</sup> Tzipi Talmor, the film "On a One-way Road."

<sup>20</sup> See p. 6: Filc et. All , Is socioeconomic status associated with utilization of health care services in a single-payer universal health care system? In: International Journal for Equity in Health 2014, 13:115

<sup>21</sup> The consumers leaflet even said that the contraceptive is for use "when there is a medical indication for contraception and other contraceptives cannot be used for that purpose." Retrieved February 20, 2016, in: [http://www.old.health.gov.il/units/pharmacy/trufot/alonim/Depo-Provera.sus.for.inj.PL\\_Heb\\_1439973347725.pdf](http://www.old.health.gov.il/units/pharmacy/trufot/alonim/Depo-Provera.sus.for.inj.PL_Heb_1439973347725.pdf)

<sup>22</sup> Danny Adino Ababe, "Neighborhoods without Babies," Yedioth Ahronoth, January 6, 2008.

<sup>23</sup> See: Hedva Eyal, Depo-Provera, a contraceptive administered by injection: on the policy of use among members of the Ethiopian community in Israel, Isha L'Isha and Kvinna till Kvinna

<sup>24</sup> December 8, 2012, investigative report on Gal Gabbay's program Vacuum.

<sup>25</sup> See: Hedva Eyal, Depo-Provera, a contraceptive administered by injection: On the policy of use among members of the Ethiopian community in Israel, Isha L'Isha and Kvinna till Kvinna. In a letter from Ms. Dina Hemo, head of The clinical pharmacology and pharmaceutical information unit, she says that in January 1996 "... the preparation called DEPO-PROVERA 150MG/ML was indicated as a contraceptive when there was medical indication and when no other contraceptive could be used." The author of the report adds that Clalit Health Services said that the criteria for receiving the injection are women who do not have counterindications for progesterone treatment, when there is a failure of other contraceptives, and when there is no possibility or desire to install an IUD, Mirena. It appears that the declared general policy does not consider Depo-Provera to be a recommended contraceptive but only one that should be used if others are inappropriate.

<sup>26</sup> December 8, 2012, investigative report on Gal Gabbay's program Vacuum.

<sup>27</sup> Hedva Eyal, Depo-Provera, a contraceptive administered by injection: on the policy of use among members of the Ethiopian community in Israel, Isha L'Isha and Kvinna till Kvinna  
<http://www.isha.org.il/upload/File/%D7%93%D7%A4%D7%95%20%D7%A2%D7%91%D7%A8%D7%99%D7%AA.pdf>

<sup>28</sup> After the publication of the Isha L'Isha report (mid-2009), MK Hanin Zoabi (January 6, 2010) submitted a parliamentary question to Deputy Health Minister Yaakov Litzman. According to his reply, there never was a policy to reduce the birth rate among the Ethiopian community, no instruction was ever given to prefer treatment by Depo-Provera for women from Ethiopia, and the injection was given by the accepted indications and according to the patient's condition, including consideration of possible side effects.

<sup>29</sup> From the letter by the organizations, the Association for Civil Rights in Israel

<sup>30</sup> December 8, 2012, investigative report on Gal Gabbay's program Vacuum.

<sup>31</sup> <https://www.youtube.com/watch?v=ps001TmYpc>

<sup>32</sup> While the Jewish Agency pointed a finger at the medical institutions, the JDC, which operated the clinic in the camp in Ethiopia and the HMOs in Israel, replied that family planning workshops were given in Ethiopia, including on the use of contraception, but it did not have exact details about the recommendations given in Ethiopia, and suggested asking the Health and Immigration Ministries for information on the subject. The Ministry of Immigration suggested asking the Jewish Agency and the Ministry of Health for information on the subject.

<sup>33</sup> The medication is not recommended for women suffering from or at risk of osteoporosis because it can lead to a drop in bone density.

<sup>34</sup> Some women were given the impression that receiving the injections was a condition for their migration to Israel.

<sup>35</sup> On ACRI website: <http://www.acri.org.il/he/wp-content/uploads/2013/01/depo-provera100113.pdf>

<sup>36</sup> A session of the Labor, Welfare and Health Committee on July 10, 2013 about administering Depo-Provera to Ethiopian women.

<sup>37</sup> <http://doctorsonly.co.il/2013/07/61418/>

<sup>38</sup> For example, a film about the ringworm affair became an instrument for criticizing Israel, to the point that its producers, although exposing a very grave policy by the state against them, warned others not to use it. A report that revealed deficiencies in the case of an experiment on soldiers (anthrax) was censored on grounds of harming Israel's foreign relations.

<sup>39</sup> Pnina Tamano-Shata, A session of the Labor, Welfare and Health Committee on July 10, 2013 about administering Depo-Provera to Ethiopian women.



<sup>40</sup> Mk Orli Levy Avaksis, A session of the Labor, Welfare and Health Committee on July 10, 2013 about administering Depo-Provera to Ethiopian women.

<sup>41</sup> Boaz Sangero, Where there is no suspicion there is no real investigation: Report of the state commission of inquiry on the disappearance of children from Yemen, Teoria Uvikoret 21, Fall 2012.

<sup>42</sup> Eyal, Hedva, And only the woman's voices were not heard, the Hottest Place in Hell, February 1, 2016, retrieved February 28, 2016. <http://www.ha-makom.co.il/post/doar-edva-eyal>

<sup>43</sup> See for example the description by Davidovitch and Schwartz of the actions and feelings among those who were involved in the healthcare of the immigrants: "For those who were involved it was an activity that went well beyond the realm of health. 'We are building a culture here,' that was the feeling of the public health professionals in the yishuv." Nadav Davidovitch and Shifra Schwartz, Health and the Israeli melting pot , <http://in.bgu.ac.il/bgi/ijunim/13/9.pdf>, retrieved March 15, 2016.

<sup>44</sup> The study of the factors that inform the shaping of a race with the goal of leading to its improvement received very negative connotations due to its centrality in shaping racist policies.

<sup>45</sup> Traubman Tamara, To maintain the purity of our race, degenerate Jews must avoid having children, Ha'aretz June 10 2004, retrieved February 28, 2016.

<sup>46</sup> See for instance in 2012: <http://www.nrg.co.il/online/1/ART2/341/000.html>, and <http://www.mako.co.il/news-israel/health/Article-af2604b4e135831017.htm>

<sup>47</sup> Bender, Arik, There are currently 80 thousand African infiltrators living in Tel Aviv, Ha'aretz April 24, 2013, retrieved March 1, 2016 <http://www.nrg.co.il/online/1/ART2/463/462.html>

<sup>48</sup> See for example the report by Dana Spiegelman, The D point: Why Ethiopian blood is worth less, Walla, December 2, 2006, retrieved March 1, 2016.

<sup>49</sup> HCJ 1356/96 Dr. Amnon Ben David v. Shimon Peres The Prime Minister of Israel et al, from the judgment given on April 8, 1996, retrieved on March 1, 2016

<sup>50</sup> <http://www.ynet.co.il/articles/0,7340,L-3322120.00.html> Quote from Gadi Yabrakan, resident of Rehovot.

<sup>51</sup> <http://www.haaretz.co.il/news/education/1.1158711>

<sup>52</sup> A report on Channel 2 found that even in 2006, blood donations were drawn from members of the Ethiopian community and thrown away. Different sources claimed that the donations were frozen and preserved for research and that the donors knew they would not be used for infusions. The lack of clarity led to further serious injury to the Ethiopians' trust of the healthcare system. <http://www.ynet.co.il/articles/0,7340,L-3322120,00.html>

<sup>53</sup> Magen David Adom (emergency medical services) website, "Who can and cannot donate blood," retrieved on March 15, 2016.

<sup>54</sup> Tokrab Ron, can members of the Ethiopian community donate blood? Available online, retrieved March 15, 2016.


<sup>55</sup> See: Seeman, D, "One People, One Blood": Public Health, Political Violence, & HIV in an Ethiopian-Israeli Setting" in: Culture, Medicine and Psychiatry 23: 159-195 1999.

<sup>56</sup> Screenshot Channel 2, retrieved from <http://www.ice.co.il/media/news/article/407281>

<sup>57</sup> Thus for instance, soldiers injured by the anthrax experiment went to court only after military authorities ignored all of their approaches.

<sup>58</sup> See: Alberstein, M. & Davidovitch N., "Apologies in the Healthcare System: From Clinical Medicine to Public Health 74 Law and Contemporary Problems 151-175 (Summer 2011)

<sup>59</sup> For more on the concept of apology see: Alberstein M & Davidovitch N., "Apologies in the Healthcare System: From Clinical Medicine to Public Health 74 Law and Contemporary Problems 151-175 (Summer 2011)



How did gynecologists administer Depo-Provera as a default option to Ethiopian women and not think they had the right to choose just like any other women? Why is the Ethiopian community's blood donation affair still an open wound among members of the community? Why is the medical establishment afraid to reveal the testimonies of nurses and doctors on the abduction of Yemenite children? Why are the files of the ringworm radiation patients maintained as a military secret at the Sheba Medical Center to this day? Why did doctors approve the anthrax experiment specifically on soldiers when it was clear that the military hierarchy made it difficult for them to refuse? Is the medical establishment capable of admitting its wrongs, taking responsibility, and acting for healing? And if not, why?

The ethos of the medical community in Israel rallies around the principle of "neutrality." Healthcare professionals often say they are "color blind" or view medicine as an "island of sanity" in a country beleaguered by severe political and social conflicts. This ethos prevents the medical community from seeing where that blindness acts to hinder and exclude disempowered groups. Therefore, there are inevitable repeat expressions of paternalistic and racist attitudes by the medical establishment towards certain minority communities. Even worse, the history of the Israeli healthcare system shows that when a community receives such ill treatment, as soon as it begins to suspect or protest, the medical establishment and its supporters resort to tactics of concealment or aggression and refuse to take responsibility or work restore the trust of the violated community.