Not Just a Nurse: Nurses as Peaceworkers in Hadassah Ein Kerem

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My journey to Women’s and Gender Studies was a long one, but when I did arrive, I was welcome with warmth by Rosanna Hertz, who became my thesis advisor after one lively conversation. Rosanna challenged my thinking without leaving an impression of superiority, and her approach to advising students allowed me enough room to assert my independence as a thinker while having her guidance and insight to always rely upon.

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STARTING POINTS

JRH: Do you think Peace is possible?

Nurse: Isn’t everything? But we have to work towards it- whether we know it or not, we have to work towards it. We all have to do our part. And when we see it is working, we have to continue. When we see it’s causing harm, or doing nothing, we have to change our strategy.

JRH: And the nurses? Is what you are doing working?

Nurse: It’s unseen, unclaimed. It’s invisible to everyone- even ourselves. But then you see it in the small moments, in the smiles of the families when they walk in, in the way they tell you ‘good morning’ and ‘good evening.’ In how they cry and are vulnerable with you- that’s when you see it’s working. It’s working all the time.

My love for the work of nurses began when I was a patient in a Jerusalem hospital. After a near-fat al pedestrian-bus accident in July 2012, I spent three months confined to my bed in Hadassah Medical Center. During this time, I came to understand how a patient’s experience with her nurses is a factor in the hospital experience- including recovery time, mental wellbeing, and holistic health. Issues, including not sharing a common language, personal chemistry, and manner of showing care all impacted how I was able to trust my nurses- and based on this trust, how willing I was to comply with medical and non-medical treatment.

As a perpetual observer, the concept of nurses as peacebuilders came to me while I was watching how Israeli Jewish nurses cared for and developed trusting relationships with Palestinian patients. After a radical Jewish group threw a Molotov cocktail in their car, a family of East Jerusalemites (Palestinians) was cared for in the same burn unit as me. I watched as the relationship developed- the family, first timid, was shown compassion and care. After a few days in the department, I watched as two nurses and the physiotherapist, all Israeli Jews- helped the father, his legs as toothpicks even with layers of gauze, walk down the hall. Each step was met with cheers, and the man smiled and joked with the nurses.
My research and developing theory are driven by experience and desire to understand where peace building meets healthcare. While an undesirable experience, my accident was serendipitous in how the people I met have become a part of my life—both personally and academically. These relationships garnered my ability to conduct in-depth research at Hadassah, which I recognize is unusual for an undergraduate student.

In addition to my research, I derive my theory from a variety of disciplines, including history, sociology, political and social ethics, peace studies, and nursing and caring literature. At the unique intersections of these fields, I seek to answer—if not fully, than substantially—how nurses act as brokers for social change. The conversation of how nurses perform peacework leads to the question of why. In an attempt to answer, I posit that ethics of caring—from an institutional and individual perspective—are challenged and transformed at the crux of political action and moral resistance. The intertwining of motherhood and employment create a situation in which the kinds of expectations of “good” motherhood are extended to the workplace. In fact, the workplace itself requires nurses to provide a level of care as if nurses were members of the patients’ family. Most startlingly about this case study is that the nursing staff’s ability to stereotype categories often salient in the Israeli context is disrupted by their interactions in the hospital. I argue that, while not always possible, nurses are engaging in peacework through maternal caregiving.

In further locating my standpoint in relation to my research, I must assert the privileged position I had as a white-passing American. I remember one particular incident involving a Palestinian woman from the Old City. When I first met Marwa, she told me she didn’t speak Hebrew, but a little English. When her Jewish nurse left, she began to speak in Hebrew. Instead of answering questions I asked, she repeatedly told me that she was abused by the nurses, and
caused her to have pain, while the nurses were following protocol and doctors’ orders to sit after a surgery to fix a pelvic break rather than lying in bed. Approaching the situation with curiosity, I asked her how the nurses had abused her. Instead of cooperating with the question, she asked me if I was going to help her “escape from the bad nurses.” When I told her I didn’t have the authority to handle patients, she emphasized my American accent; I deduced that she thought my citizenship and whiteness granted me elevated privilege. This is similar to findings of Mignon Moore, who in a case study of black lesbians found that racial identity and citizenship/origin were often named as their primary status (Moore, 2011).

In speaking with the nurses after concluding my discussion with Marwa, I discovered that she was in pain- she was prescribed to sit in the chair for an hour every two hours after a pelvic fracture. She was given the prescribed pain medication before this treatment, and had additional “emergency” pain relief. Her nurse that day, a Jewish woman, said that the patient was hostile towards her and didn’t want to be touched. Their conflicting narratives warrant pause- which was true, or was the truth somewhere in the middle? How could this nurse communicate her good intentions if assumptions and political conflict got in the way?

For Marwa, my whiteness and citizenship mattered. Her nurse’s Jewishness and citizenship mattered. She falsely thought that I was in a position to help her because I am an American, just as she was uncooperative with her Jewish nurse, and later cooperative with a Muslim nurse. And just as it manifested in a cry for help from Marwa, I must too assume that other interview subjects ‘shifted’ their stories and experience to benefit my gaze.

Simultaneously, I acknowledge how my Jewish identity created immediate bonds with some collaborators. In cases where I was assumed or revealed my Jewishness, the language used
to describe Israelis/Jews and Palestinians/Arabs changed to include me in the “we” and “us” and exclude me from the “them”- Palestinians, Arabs, and European/American third parties.

In concluding this preface, I ask you to approach the following chapters with a “hermeneutic of generosity and suspicion.” My attempt to explain the beautiful potential for conflict transformation that nurses are bringing into reality every day is a piece of a larger picture. Here, I venture to retell the stories of nurses, patients, and families to direct attention and adjust our gaze.

In Chapter one, I direct attention to the unique history of Hadassah Hospital, which started as a nurses’ movement in Ottoman “Palestine.” Upon situating Hadassah as the “hospital on the hill,” I assess ethnic and citizenship divides, which are necessary for understanding Israeli society and Hadassah’s larger operation. Nurses, doctors, patients, and families almost all fall into these categories, which determine their access to care and their experience of Hadassah’s multiculturalism.

In Chapter two, I argue that Hadassah follows and diverges from Goffman’s (1961) total institution, in that Hadassah creates it’s own norms under which employees operate, which simultaneously free employees and patients from external norms of conflict. These new norms, that promote cross-cultural dialogue, are created and reproduced by the nursing staff, which is motivated by maternal thinking. Using Ruddick’s (1989) classic framework for maternal thinking, I assert that the socialization of Israeli and Palestinian women to become mothers in a conflict-driven pro-natal society translates to how nurses care for their patients and the goals they have for them. In doing so, nurses create the space to challenge how patients, families, and other nurses construct “Other.”
Chapter three documents my qualitative analysis of nurses’ peacebuilding potential through interviews and observations in three departments. In this analysis, I find that nurses, patients, and their families create bonds that cross ethnic lines, and often lead all to question how they relate to “Other” outside of the hospital.

Chapter four assesses the effectiveness of such relationships through how interactions inside the hospital exist beyond its walls. Such transcendence is measured on what Granovetter calls the “strength of weak ties” (1983). I argue that building a weak network across cultural and political boundaries holds the potential to transform the ways in which “otherness” is constructed in the long-term.

The stories I collected during the course of this research—both in interviews and observations—enrich understandings of the larger thematic elements of this text. In order to incorporate these voices, I have included them as sidebars peppered throughout the main text. These sidebars are methodologically essential to broadening perspectives and sharing voices that are often made voiceless.

Methodology

The data for my thesis was collected in stages starting in May 2014 and ending in August 2015, during which time I formally interviewed nurses, doctors, patients and their families through Hadassah Hospital in Jerusalem. The Hadassah Ein Kerem Board of Ethics gave Helsinki Approval for all formal research ventures. The original questions I asked between May 2014 through August 2014, grew out of earlier in-hospital observations, which I wrote up as daily field notes.

I collected interviews from doctors and nurses in which I asked the following questions: 1) why did you become a nurse? 2) how do you communicate with patients? Verbally? Non-
verbally? 3) Do you see your role as a peacebuilder within the hospital? Why/Why not?

Interviewees were found using the snowball method, and limited to those with English or Hebrew proficiency or the availability of a translator for Arabic speaking patients (Morgan 2008). Attention was given to the ethnic backgrounds of nurses interviewed, and efforts to interview nurses from marginalized, ethnic backgrounds were pursued, particularly Israeli Arab, Palestinian, Mizrachi, Druze, and Ethiopian nurses.

After qualitative review of transcripts, my interest evolved to focus on the intimate relationships between nurses, patients, and families, excluding doctors. I decided that including doctors reinforced power hierarchies I wanted to avoid, primarily that doctors are considered more legitimate voices in political and social structures because they are mostly men. However, Interviews with doctors, including women doctors, revealed distance from personal relationships with patients and their families, while nurses emphasized the relational aspect of care. In focusing on nurses, who are mostly women in Israel, the frame of my research changed to how nurses work towards peacebuilding. Between June and August of 2015, I collected interviews from two populations: Nurses working in non-ICU trauma units including General Surgery, Orthopedics, and Plastic Surgery, and patients and their families in the aforementioned units. I sought to interview nurses, patients, and family members from marginalized ethnic groups in Israel. Departments were selected because these units receive the most trauma cases, including terrorist attacks in which both victims and perpetrators require care. Many of these patients arrive to these departments after stays in the ICU. Nurses from the ICU were limitedly interviewed because patients are often sedated and less communicative during ICU care. Nurses in these departments frequently care for patients who have committed or witnessed atrocious acts, exposing them to uniquely compelling mindsets of what being “Israeli” or “Palestinian”
Interviews were conducted in English and Hebrew, and when an informal translator was available, interviews were conducted in Arabic. Questions for nurses included: 1) Why did you become a nurse? 2) How do you build a relationship with a patient from the time you receive him/her until the time they are released? 3) How do you touch the patient? 4) How do you communicate with a patient you don’t share a language with? 5) Are their political implications to the diversity of patients and staff found in Hadassah? If yes, how? If not, why not? 6) Do you see yourself as a peacebuilder in your role as a nurse? 7) Do you think the relationships you develop in Hadassah are carried outside Hadassah?

Questions for patients included: 1) Why are you hospitalized? 2) How would you describe your connection with the nurses? 3) What do nurses do to build good relationships with the patient? 4) How has the presence of multiple cultures impacted your hospital stay? 5) Do you think peace can be built in the hospital? How?

In total, during these two periods of time, I interviewed 22 nurses, 4 doctors, 23 patients, and 14 family members. 33 interviewees were Jewish, though they varied in intersectional identities including religiosity, Israeli citizenship, and ethnicity/origin. 25 interviewees were Palestinian, though they also varied in intersectional identities including religion/religiosity and Israeli citizenship. Five interviewees were of Russian origin, and were not forthcoming about their Jewish belonging or lack thereof. In order to guarantee anonymity all names have been changes. I have used names that are part of the ethic culture of an individual to preserve this for the reader.

Interview length ranged from ten minutes to one hour and thirty-eight minutes, and interviews were tape recorded and transcribed. I also wrote field notes during interviews in order to document the behavior and non-verbal communication of each collaborator present.
Interviews were analyzed qualitatively and validated by a second, non-interviewer, nursing researcher.

Between May-August 2014 and January-August 2015, I observed in the Plastic Surgery/Maxillofacial/Ear, Nose, and Throat/Hand Surgery Department for a minimum of eight hours per week. This department was chosen for observation because of its diverse patient load in terms of injury and/or illness and demographic diversity amongst nurses and patients. I took field notes, photographs, and videos as part of my fieldwork.

The latitude I enjoyed while researching and the close proximity to my subjects are rooted in my 2012 hospitalization in Hadassah. These established relationships with many of the nurses and doctors I interviewed eased my access into the hospital research system. However, when I decided to turn my experience into a research project, I attempted to retain appropriate distance with interviewees and maintain objectivity in my analysis. Still, as a constant presence in the department, I befriended many of the interview subjects- nurses, patients, and family members (Becker et al, 1976). Developping these relationships contributed to respondents feeling that I was a trusted member of the hospital (without a formal role). “Hanging around” which traditional ethnographers have used for decades allowed me to easily talk with staff, patients and family members. I was also able to gather more detailed answers during the interview process. Over time, I ran unofficial “triage” at the nurses station, which included finding nurses, providing beverages and utensils, and answering questions such as “when will I get my medication?” or “when is the doctor coming?”

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1 (Becker et al.) discusses how friendship developed but also how the participants have to go about their daily business. He also relied upon initial informants to give him access to others in the medical school setting.
As a former patient and current researcher with a long relationship with the plastic surgery department, I socialized extensively with members of the department, as well as attended department parties and staff members’ weddings and other life transition celebrations.
Chapter I: “Hospital on a Hill”-- An Examination of Hadassah’s Function Within Israeli Society

The larger of Hadassah’s two campuses sits alone on a hill overlooking the Ein Kerem valley on the outskirts of Jerusalem. A massive white building, the Jerusalem stone only interrupted by large windows, Hadassah is the new “city upon a hill.” In a physical and poetic way, Hadassah stands apart from perceived realities through the rest of the city.

In this chapter, I offer background on Hadassah’s historic involvement in Palestine/Israel and the current social and legal structures in which Hadassah carries out its daily operations. I argue that the legacy of Hadassah nurses’ universal care has extended to today- aligning with Hadassah president Henrietta Szold’s subversive gender empowerment mission. Despite the challenges of operating under conflict, Hadassah nurses have been uniquely situated at the cusp of history, serving as social brokers on the utopian “hospital on the hill.”

On Hadassah: Building a “Bridge to Peace” since 1912

The Second Zionist Congress in 1898 inspired American Jewish women to launch single-sex Zionist organizations in their communities. In 1912, Henrietta Szold was elected as the first president of Hadassah, which would become the largest women’s Zionist organization in the world. Their mission was “to promote Jewish institutions and enterprises in Palestine and [to foster] Zionist ideals in America.”

Horrified by the poor health conditions during her stay in Palestine, Szold recommended intervening to improve the existing social determinants of health and provide biomedical intervention to communities where Western medicine was either non-existent or inconsistent. The directorate composed a plan that included building and manning a daycare nursery, a lace-

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2 The “city upon a hill” is a reference to the Puritan utopic ideal that has been used by American politicians to relay the “Christian charity” model that the Puritans tried to exemplify in early colonial history. Hadassah, both in its physical geography and its unique social norms is comparable to the utopic elements of Puritan imagination.
making workshop for girls, a maternity hospital, a school for midwives, and operating a regional program for nurses’ training. In the coming decades, Hadassah added a nursing school, school of hygiene, mother and child health centers, and playground programs.

Hadassah became integral in building health systems in the early years of Zionist ambition. Despite the existence of Kupat Holim (1911)\(^3\) for workers and an Ottoman and then British government, high rates of typhoid, dysentery, cholera, and other diseases were rampant in all sectors of society. Poor infrastructure under the British mandate amplified disease likelihood by creating poor sanitary conditions; for example, in 1932, three of the four largest cities lacked a consistent long-term water supply; in 1948, central sewage facilities were only found in the three largest cities (Reiss, 1996).

The choice of Hadassah to tackle health issues in Eretz Israel (then a region called “Palestine” under the Ottoman Empire) was born out of necessity for health intervention and availability. Though the United States adopted nursing into the university system, persistent reluctance towards admitting women to other university programs considerably hindered the official positions women could retain in Western society (Bartal, 2005). Hadassah’s American women, primarily middle and upper class New England Jewish wives and mothers, had to contribute to Zionist practice within the limits of patriarchal society. In addition to mitigating the Zionist boys club, a health intervention of nurses contributed to the ideology that societies are built by “working hands.” Because women participating in ‘manual labor’ were less threatening than the idea of intellectual attainment, Hadassah’s efforts to contribute to health through nursing were not considered radical.

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\(^3\) Literally “Sick Funds.” Kupat Holim began as a health service for Jewish pioneers, and today serves as Israel’s national universal insurance. They also are networked physical clinics used daily for routine services.
During the First World War, Hadassah nurses (mostly American) had to evacuate Ottoman controlled lands, and left their public health projects behind. After the war ended and the Ottoman Empire fell, Hadassah nurses was able to resume their practice in Eretz Israel. The crown jewel of their practice was the 1918 establishment of the School of Nursing. Based on the popular “socialist feminism” ideology in the United States, the nursing school propagated the idea of health for all (Bartal, 2005). The nursing school worked to provide women with training to better the health of the existing population and new immigrants. The nursing school insured that there would always be a new class of nurses entering the growing health system (Bartal, 1999). The curriculum, similarly to the American model, was a mixture of didactic classes in the sciences paired with clinical practice (Landy, 1918). However, in departure from the American system, large numbers of immigrants and native communicable diseases paired with poor sanitation systems intensified the needs and expanded the services nursing practices provided.

The betterment of health conditions contributed to the Zionist ideal of a “civilized” land of Israel built by resilient “new Jews.” Similarly to republican motherhood, the primary role of the nurse was to train citizens to be active, hygienic members of society. Nursing school provided these women with medical and ideological training necessary for the indoctrination of the existing and immigrant populations.

Despite the early twentieth century feminist ideology of Hadassah’s governing body in the United States, the hierarchy of the medical system, particularly the power of doctors over

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9 “New Jews” is a term for the population of Jews that lived in early/pre-State Israel to settle the land. They are called “new Jews” because they were to counter the hegemonic imagination of what a Jew is- instead of weak and passive, new Jews were virile and active.
10 The term “republican motherhood” is used by historians of the United States to describe the mother’s increased influence over children (particularly male children) in the absence of their father due to war. Raising children to be educated, productive members of an enlightened society thus became the responsibility of the mother. In order to insure mothers could teach their children the way of the Republic, women’s colleges were founded so women could become refined, assimilated future “trainers” of the republic’s children. (1774-1865). Independence Hall Association, Philadelphia. ushistory.org. 2014.
nurses extended to Hadassah’s public health programs. As late as 1937, doctors’ interest in nursing school curriculum was to insure they knew what to do as “doctors’ helpers.”11 The distinction in duties followed traditional gender role tropes: the (male) doctor was responsible for medical research, diagnosis, prescribing treatment, and performing operations; the (female) nurse was responsible for educating the community on public health practice, perform prescribed treatment, care for the ill, and keep wounds clean. While some nurses specialized in various fields, they were not seen as equal to doctors, regardless of their authority within the communities in which they worked. For instance, community nurses with the School of Hygiene had monthly meetings with physicians to discuss problems they had in the schools where they were stationed. Physicians’ presence was not as equals, but as judges that offered rulings for the nurses’ issues. During a meeting in Tel Aviv on June 1929, the dysfunction of janitors within the school received a ruling from Dr. Berachiahu (the head physician of the School of Hygiene): “Janitors are required to dust with a damp rag half an hour before school starts.”12 The overreaching authority of doctors over both nurses and other community workers is illustrative of the pyramid power structure that dominated public health systems.

Hadassah Today

Hadassah is now the largest hospital in Jerusalem, and the only level-one trauma center in a 60-kilometer radius. The original hospital in the Har Hatzofim/Wadi Joz neighborhood straddles the line between East and West Jerusalem, and serves a largely Palestinian population. A second hospital was built in 1961, after access to the original Hadassah hospital was cut off for Jews living in West Jerusalem (Israel) because the 1948 borders cut through Jerusalem, and East Jerusalem and the West Bank became Jordanian territory. Hadassah Ein Kerem is the largest

11 Report by the Hadassah nursing school board, 29 October 1937, HSA. Dostrovsky, Arieh
12 Protocol of the annual meeting of doctors and nurses, 17.6.1929 Central Zionist Archives(CZA J113/343)
hospital building in Jerusalem, hosting the nursing and medical schools, and is the only level one trauma center in the city. They see the most severe cases of trauma for those coming from East or West Jerusalem, and accept major trauma cases from all over the region, whether Israel, the Palestinian Authority, or Hamas governs the patient.

**On Israeli and Palestinian Identity: Understanding Power**

When referring to “the Other,” I am often referring to differences in ethnic identity more so than citizenship. Despite nationalizing projects in Israel and Palestine, it is important to note that Israel and Palestine are not ethnically or culturally homogenous states. Contested territory—both in the forms of disputed boundaries and illegal settlements—adds nuance to constructions of “insider” and “outsider.” Within Israeli society—thus within Israeli hospitals—inequality and racism creates social hierarchies. In the next section, I explain the diverse cultures and how ethnic and racial belongings are stratified.

**Jews in the Jewish State: Understanding Yishuv**

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13 “Yishuv is the name for the Jewish community in Hebrew.

14 By technical definition, Moroccans, especially those from the Northern region of the country, are Sephardim. However, because of shared culture and language in Israel, most Moroccans self-identify and are identified as Mizrachim. There is an additional small population of Jews from India, called the Kochin Jews.
75.4% of the Israeli population is “Jewish.” However, in the Israeli context, being “Jewish” doesn’t imply total homogeneity. Instead, belonging is categorized into four “ethnicities” of Judaism based on diasporic origin: Ashkenazim, Sephardim, Mizrachim, and Beta Israel (Figure 1). As a relatively young country of refugees and their descendants, racial distinctions and inequalities echo those of imperial Europe.\(^{15}\) Ashkenazi Jews, most of who immigrated from

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\(^{15}\) In calling Israel a “young country of refugees and their descendants,” it is imperative to recognize the Jewish communities that remained in “Israel” even after the fall of the Second Temple in 70 CE to the Romans. Documented as less than 5% (25,000) of the population under Ottoman rule, Jews maintained geographical and spiritual ties to the land. For more information, see Government of Palestine, Report and General Abstracts of the
Central and Eastern Europe, consider themselves as the “pioneers” of Israel. Bringing with them the stereotypes and stigmas from colonial Europe, Ashkenazim established authority over Jews from the Orient.

Most Mizrachi Jews immigrated to Israel in the period known as the “Silent Exodus” between 1949-1967, after the British had left and the U.N. established a two-state divide. Rather than finding belonging and shared identity with fellow Jews from around the world, Mizrachim were met with discrimination based on shared traits with the Palestinian “enemy;” including appearance, language, cuisine, and regional identity. The legacy of prejudice in early statehood is perpetuated today- a 2014 study concluded that the average monthly income of urban salaried workers who were Ashkenazi was 42% higher than the average wage for all salaried workers, while Mizrachi urban salaried workers wages were only 9% above the national average (Gur, 2014).

The Sephardi Jews live in two worlds- both identifying with Euro-Mediterranean countries including Spain, Portugal, and Italy, and simultaneously forced to choose between “Ashkenazi” and “Mizrachi” identities. With the exception of the Moroccans, most identify as “Ashkenazi” and are white passing enough to do so.

The Beta Israel Jews17 are Ethiopians who came as refugees in the 1990s and 2015. Though the Rabbinate has ruled the Beta Israel Jews as legally and religiously Jewish, many Orthodox rabbis do not consider them Jewish.18 Their blackness becomes more of an identifier

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17 Beta Israel Jews are also called ‘Falasha Jews.’ Because of the usage of “Falasha” as a racial slur in Israeli society, I will exclusively use the term “Beta Israel’ to describe the Ethiopian Israeli community.

18 In Israel the body that determines Jewish law is comprised of Orthodox Rabbis. Ethiopians were a hotly contested group whose true ties to Judaism were challenged. This was not the case with India’s Jews who were welcomed in the 1950s even though they were settled in border communities.
than their Jewishness, and in the last decade, stigma against black Jews has grown as the African refugee and asylum-seeking population has grown.

A clearer perspective of how inter-Jewish racism presents itself is considering population growth. While the total fertility rate for Ashkenazi Jews has steadily increased since statehood, the rate for Mizrachi and other Jews of Color has steadily declined. This trend has resulted in “equalizing” the population: according to the 2013 census collected by the Israel Bureau of Statistics, 33% of the Israeli population is Ashkenazi, 26.2% is Mizrachi, 0.1% is Sephardi, and 0.02% is Beta Israel. A trend rising since the 1980s is intermarriage between these Jewish ethnic categories, which has created a new “Israeli” population that now measures 40.68%. Yet, this number is confounded by the definition of “intermarriage,” which includes Moroccan Jews, the largest national origin for Mizrachim, as “Sephardim.” I suspect that the number of “Israelis” (or those who intermarry) is then lower, and the number of “Mizrachim” is higher than the Central Bureau of Statistics suggests.

*People from Post-Soviet States (collectively called “Russim”)*

In the 1990s with the fall of the Soviet Union, thousands of Russians entered Israel under the premise of being “Jewish.” Under Israeli law, anyone with documentation that proves a grandparent was Jewish is eligible for Israeli citizenship, which includes free healthcare. Out of the approximate 250,000 immigrants from the former Soviet Union during the 1990s, an estimated 80,000 entered Israel with false papers. Because of assumed “whiteness” and thus “Ashkenazi” status, Russians enjoy privilege.
Arabs in Israel

Arab-Israelis v. Palestinian Israelis

Distinguishing between Arab-Israelis and Palestinian Israelis is a sensitive subject. The term “Arab Israelis” often refers to minority Arab populations who are integrated into Israeli society and may or may not serve in the military, including the Druze, Armenians, Bedouins, and more often than not Palestinian Christians residing in Israel. “Palestinian Israelis,” meanwhile, refer to Israeli citizens who maintain their belonging and support to an independent Palestine. A fuller discussion of how ethnicity intersects with citizenship is explored below.

Druze

In 2012, the Israeli government honored a request from the Druze community to be classified as an ethnic group. The Druze are an Arabic speaking ethnic group who live in Israel, Jordan, Lebanon, and Syria. They are differentiated from other Arab populations by religion, which is a combination of Islam, Gnosticism, and Neo-Platonism. In Israel, the Druze serve in the military, and enjoy a heightened status as part of the “covenant of blood” with the Jewish people.

Additional Communities

In addition to the larger Jewish and Arab ethnic groups, there are several smaller communities in Israel, including the Bedouins, Armenians, Baha’i, Copts, Ethiopian Christians, foreign workers, and refugees. Of these smaller communities, a majority are communities of color from North...
Africa, the Middle East, and Eastern Africa, and are discriminated against either as being too “Palestinian” or not “Jewish” enough.

**Ethnic Groups in Palestine**

Within the Palestinian Authority, “Palestinians” are divided into two major groups, Muslims and Christians, and host the transient Bedouins as they follow ancient nomadic routes.

*Palestinian Muslims*

Muslims make up 85% of the population in the Palestinian territories, most of whom are Sunni. The Palestinian Authority is structured around Islamic principles and practices.

*Palestinian Christians*

Within the Palestinian territories, only 2.5% of the population is Christian, and the number continues to decrease as more Palestinian Christians move to Israel and the Muslim population’s rate of growth increases within the Palestinian territories (CIA, 2015). Palestinian Christians are often ostracized by Muslim Palestinians, threatening individuals and property owned by Christians. While in Israel, Palestinian Christians enjoy increased religious tolerance, micro-level and structural discrimination against their Palestinian identity arises.

**Identity and Citizenship- Determining Hospital Access**

Despite stronger identity with ethnic belonging rather than national belonging, citizenship type determines access to the Israeli healthcare system and subsequently its hospitals. Israeli Arabs- including Druze, Bedouins, and Palestinians-are given a “blue card” indicating permanent residency/citizenship in Israel. They have full access to Israel’s health system. Regardless of desire to belong to the state of Israel, blue cardholders enjoy the privileges of citizenship while avoiding the responsibilities- such as military service (with the exception of the Druze).

<table>
<thead>
<tr>
<th>Card Type</th>
<th>Residency</th>
<th>Access to Israeli Hospitals</th>
</tr>
</thead>
</table>

19
<table>
<thead>
<tr>
<th>Blue (tehudat zeut)</th>
<th>Israel, Jerusalem (East and West), Israeli Settlements</th>
<th>Always with full benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange or Red</td>
<td>West Bank (Area A, B, &amp; C), Gaza Strip</td>
<td>With permission of Israel and Palestinian Authority; With permission of Israel and ability to pay privately</td>
</tr>
<tr>
<td>Green</td>
<td>West Bank (Area A, B, and C), Gaza Strip</td>
<td>Rarely; based on circumstance</td>
</tr>
<tr>
<td>VISAS</td>
<td>Within Israel</td>
<td></td>
</tr>
<tr>
<td>A/1</td>
<td>In process of making aliyah</td>
<td>Yes; Insured through Kupat Holim</td>
</tr>
<tr>
<td>A/2</td>
<td>Students</td>
<td>Yes; Insurance offered through academic institution</td>
</tr>
<tr>
<td>A/3</td>
<td>Clergy</td>
<td>Yes; Insurance offered through religious institution</td>
</tr>
<tr>
<td>B/1</td>
<td>Work Visa</td>
<td>Yes; Health Insurance offered through employer (non-work related) and through Kupat Holim for work related injuries</td>
</tr>
<tr>
<td>B/2</td>
<td>Tourist Visa</td>
<td>Yes; Billed to home country insurance/travel insurance or individual</td>
</tr>
</tbody>
</table>

Figure 2: Access to Israeli Hospitals
Access to healthcare for citizens of the Palestinian Authority with orange or red identification cards (indicating residency of the West Bank or Gaza) is based on ability to pay for private medicine or trauma too severe to sufficiently treat in Palestinian hospitals. The Palestinian Ministry of Health determines what is “too severe”, in a formula that includes the ability of the Palestinian Authority to pay for care.

Israel is able to deny entry- even for medical purposes- for citizens deemed a “threat to security.” Often, these include residents of the West Bank and Gaza Strip with green security cards, denoting that they are not allowed to enter Israel under any
circumstance. When severe trauma happens to these Palestinians—mostly men known to be involved with anti-Israel terrorist organizations—Israel considers the risk on an individual basis.

While Israel’s socialistic democracy supports a universal healthcare system for all citizens and those able to pay privately, health care in the Palestinian Authority (West Bank and Gaza) is controlled by a corrupt Ministry of Health. A report published by the Middle East Monitor conveys the results of a European Union investigation into the loss of two billion euros for aid between 2008-2012 in the West Bank and Gaza Strip. The report concluded that bribes and misuse of aid amounted to the large sum. (Ramahi, 2013) This included an investigation into the Ministry of Health, where medication smuggling, drug trafficking, and “illegal earnings” among the causes for poor execution of health services under the Palestinian Authority. As recently as 2014, Ma’an News Agency reported that ministry officials in the West Bank accused ministry officials in Gaza of stealing ‘large quantities’ of medicine and supplies, in turn creating a shortage in the West Bank.20 In the same article, the ministry denied responsibility for the hospital cleaners’ strike, who were not receiving payment, but claiming that private agencies, such as the Red Cross and UNRWA, not the ministry, were responsible for their pay. Though some human rights groups document these crimes, individuals affected by the misuse of funds, or those who have witnessed the misuse, are scared into silence.

After befriending one clinic head nurse in a major Palestinian city, she told me a story about, in her words, “the Ministry of Health creates our problems.” She described that a non-government organization in Germany donated 2000 doses of a certain vaccine to her clinic, to be given to the population free of charge. Before she could obtain the vials, they had to pass through the Ministry of Health for inspection. The Ministry sent expired vials of the vaccination, which she

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20 Ma’an News Agency is the principle news agency centered in the West Bank and Gaza Strip. They often publish reports without names for fear of repercussions.
didn’t discover until patients had already been vaccinated. Meanwhile, the Ministry of Health was charging to vaccinate people for the same disease. While she assures me there are reports by the German NGO about this incident, I have been unable to find anything online in English or Hebrew. Even to use this anecdote in this body of work, my source didn’t want to be named, nor her town identified. She was afraid of the consequences- either by the Palestinian Authority itself or her neighbors- if she spoke to a Jew about the corruption.

The distrust in the Palestinian Ministry of Health leads residents of East Jerusalem with liminal belonging to go to West Jerusalem or other Israeli institutions for care. For residents of West Bank and Gaza, those able to pay often travel to Israeli hospitals for treatment, especially political leaders and their families. Human rights, non-government and international governmental organizations’ clinics are often first sought for care, as it is believed better care will be given by these organizations than Ministry-run hospitals.

Conclusions: Hadassah’s Nurses as Witnesses and Actresses of History

As Israel’s premiere medical and nursing schools as well as the Jerusalem trauma center, Hadassah’s lasting mission to improve health conditions stand as evidence of the success of her inclusive model. Despite continuing to operate in difficult political, cultural, and social atmospheres, Hadassah maintains

Medical Supplies: Two Kilometers is from One End of the World to The Other

Corruption and poor international governance often affects what medical supplies are available in West Bank and Gazan hospitals. In the last two years, a nurse from an East Jerusalem hospital contacted nurses at a West Jerusalem hospital requesting pediatric heart surgery filters. In Israel, these filters are used during one surgery and discarded. Because of short and inconsistent supply, the same filters are used multiple times in Palestine. The Palestinian nurse asked the Israeli nurse if she could collect the filters after surgery, bring them to him, and his hospital would sterilize them and use them. Completely out, the hospital was desperate for the filters, without which lifesaving surgeries cannot be performed on children.
its “bridge to peace” mission. However, Hadassah has failed to value the caring labor of nurses that make such a claim realistic. The challenges of operating under such political tensions deserve critical examination— which voices are being amplified in constructing this narrative, and which ignored? If Hadassah succeeds in creating a truly integrated society within its walls, how can her methodology be translated beyond the hospital?

To answer these questions, I turned to nurses—the secret to Hadassah since her conception. Once only as witnesses to a different world, Hadassah nurses are now members of the society in which they work, and represent Israel’s diversity. Amplifying their voices reveals the theoretical and practical basis on which nurses act as prime conduits for creating “peace.”

Israel is a heterogeneous society with various intersections of religion, religiosity, and country of origin. As a community of immigrants and country in perpetual conflict, particular attention is paid to skin color gradient, in what Alice Walker terms colorism. White skin is considered normative— and anything else is approached with immediate othering. The issue of colorism intersects with state-mandated identity cards that determine privileges. In detailing levels of “citizenship” or its opposite, I have described who has access to medical care and by what means. While Israeli citizens have full access to a universal care system, those who live in West Bank or the Gaza Strip can only access the Israeli medical system through special permissions of the Palestinian Authority and the Israeli Ministries of Health and the Interior. However, once admitted to Hadassah, the institution expects “equality” in care. Whether or not this is normative or not is discussed in length in chapter four.

In the following chapter, I argue that Hadassah disrupts the norms outside its walls and replaces it with its own. These norms are directly counter to those of “outside” society, which seeks to divide the population rather than unite it. Nurses act as social brokers, responsible for
weaving their way through Hadassah’s expectation to treat all persons with a sense of equality. Understanding the extreme difficulty of “equal treatment” requires an understanding of the complexity of identity in Israeli and Palestinian society, both inherited and reproduced by the members of both societies. Hostilities on both sides are not only passed from generation to generation, but repeatedly experienced and perpetuated as the persistent war continues.
Chapter II- Peace Through Health: Nurses as Translators of Theory into Practice in Hadassah

As long as men have warred, healers have cared for casualties. Yet, medical practitioners and violent perpetrators are not necessarily enemies—, as too often in the past century, biomedicine has been used as a weapon of war. The intrinsic links between violence and healing are part of a dynamic process of understanding and explaining the practical and ethical implications of using (or not) health interventions in peace processes.

It’s important to note that the word “peace” is difficult to use after spending considerable time with Israelis and Palestinians. In fact, when in the company of either, the word “peace” doesn’t cross my lips. Popular usage of “peace” in media and international relations circles relies the absence of violence. Rather, this usage of “peace” in the minds of Israelis and Palestinians reminds us of what it is not—a solution for long-term security, respect for personhood, or the promise of an independent state. The word “peace” is charged with so many hopes and expectations, yet is little more than sound and fury; a lovely slogan for Western organizations.

Yet, the word “peace” appears often throughout this writing. Though I often find myself disliking the word “peace” because it doesn't have a widely accepted meaning, it doesn’t mean we should stop seeking it- and working to define it. In an effort to do just that, I offer a working (and evolving!) definition of peace based on feminist constructs of the word as it applies to health. Many of these aspects of “peace” are derived from conversations with Palestinian and Israeli nurses, while others follow the benchmarks of Joanna Santa Barbara’s peace through health.

1. Peace is the absence of violent conflict- including war, vigilante attacks, and terrorist attacks
2. Peace is assurance of shared resources— including food, clean water, and energy
3. Peace is the right to freely and safely travel— regardless of checkpoints and borders
4. Peace is guaranteed equality under the law
5. Peace is social equality for marginalized groups
6. Peace is equitable solutions for dealing with the past
7. Peace is equal access to health care and medical treatments

When using the term “peacebuilding” or “peace work,” I am referring to actions and conditions that make positive contributions towards these principles. This chapter examines nurses performing peacework in hospital settings. The theoretical basis is built on understanding the dynamic definition of peace through health, and how governments are seeking health solutions as conflict resolution paired with the unfortunate truth that societies in conflict often fail to preserve the health of civilians. Employing a critical feminist lens, I examine how nurses are excluded from articulations of conflict because of the concept that nursing work is women’s work (Reverby, 1987). Through this exclusion, I argue, nurses have developed their own methods of understanding and mitigating conflict through the maternal thinking modality employed in caring for patient and in caring for their children (Ruddick 1989). In each case, acts of preservation and training contribute to creating new citizens. The space for nurses to imprint such norms into the hospital system is dependent on the hospital as a total institution, or a place that disrupts reality and has a distinct set of norms (Goffman 1961). In the case of Hadassah, I argue that utilizing maternal thinking within the hospital not only acts as an equalizer for diverse populations, but also creates real opportunities for open dialogue and deconstructing concepts of “Other.” This space is held by a team of nurses, who act as social brokers between the institution’s norms and patient’s best interests.
**Understanding Peace Through Health**

Conversations linking human rights to the medical realm reached universal conversation beginning with the Nuremberg Trials at the conclusion of World War II. After prosecuting former Nazi leaders for “violations of human rights,” including many doctors, the Nuremberg Code became the first document protecting patient’s and research subject’s human rights. Effectively, the Nuremberg Code limited the use of medicine as a weapon of war (Annas, 1992).

In the 1970s, the conversation shifted to how health could be used to stabilize countries and improve the daily lives of citizens. The World Health Organization (WHO) passed the Ottawa Charter in 1986, naming fundamental conditions and resources for health as peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equity.

In addition to defining the fundamental resources that are beneficial to health, scholars Neil Arya and Joanna Santa Barbara name war/violence, environmental degradation, disintegration of community, poor governance, and poor human rights observance as factors universally detrimental to health. The health of the community is dependent on the State’s affairs. Violations against the wellbeing of society are measured in direct physical threats and structural violence. The intrinsic link between the violence and healing are in constant flux-while caregivers and perpetrators are often enemies, medicine can be used as violence. (Arya, 2008).

**The Social Detriments of Conflict: The Case of Israel-Palestine**

The conflict in Israel and the Palestinian Territories has contributed to factors that negatively impact health during its seventy-year duration. Israelis and Palestinians live in a constant state of uncertainty, despite constant military and militant presence. Security failures are
caused by military aggression, suicide bombings, stone throwing, Molotov cocktails, war, and more recently, “lone wolf” stabbings and car ramming. In addition to directly wounding people, the frequency, severity, and motivation of attacks disintegrate community-building efforts by government and non-governmental organizations.

However, falling into an Israel: Palestine dichotomy is one-dimensional. In order to understand the conflict, we must recognize the constant flux of representative actors, including the Israeli government, left wing non-government organizations, Jewish Settlers, the Palestinian Authority (PLO/Fateh), Hamas, Islamic Jihad, and other Palestinian liberation organizations. The dynamics between these organizations are multi-dimensional, yet their decisions directly affect citizen and non-citizen health and well-being, not limited to acts of traditional warfare. In addition to military/militant action, land disputes lead to field seizures and water shortages. Overlooked by the general public and healthcare systems, yet essential in processing how the conflict is detrimental to health, is the presence of constant warfare, security checks, and the quotidian stress of living in conflict place undue burden on mental health. Not only does this have individual consequences, but contributes to normalization of fear, and with fear, hatred. Poor mental health and healthcare deepen societal divides, which in turn adds to the difficulty of finding just and caring solutions (Murthy, 2006).

Constructions of Gender in Nursing and War

Scholarship considering nurses’ role in conflict and peace through health is often only tacked on to the end of doctors, or what I call the “and nurses” phenomenon. Despite the popular belief that nurses perform assistive, secondary roles to doctors, their purpose and function in the past half century has been distinguished from this stereotype. The roles nurses perform in conflict must be considered in the same light as the roles women perform in conflict are
examined—in a place between agency and oppression. Feminist security literature maintains that wartime obliges women to take on familial, agricultural, and industrial responsibilities, despite having little to no decision making power about going to war (Enloe, 2007). Primarily acting in non-combatant or “civilian” roles does not exempt women from the horror of war. While militaries consider the death, injury, and suffering of non-combatants as “unfortunate side effects of war.” In the last decade, the recognition by international organizations that women experience direct, gendered violence as part of a military strategy represents some progress.  

Yet, we as scholars have not determined what this means for other gendered professions, including those with intimate knowledge of violent conflict. Despite the innate connection between health, healing, and war, the trope of ‘wartime woman-nurse’ is a relatively new phenomenon. As a function of male-centric history, women as nurses and healers on the battlefield are not recorded until the mid-19th century. (Roberts, 1995)  

However, the production and reproduction of patriarchy through the expected role of nurses is clear. Positing women as caregivers further disenfranchises them from war. If women are disenfranchised from war, they are absent from violence, reinforcing the men: war women: peace dichotomy. This not only engenders conflict, but removes the possibility of peaceful solutions to conflict because of gendered power differentials. The goals of peacebuilding are healing, community reintegration, equitable distribution of resources, and renaming/reclaiming

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21 This is most evident in the UN Passage of Security Council Resolution 1325 (2000) and 1820, (2008) which posit bringing more women to the table in peace negotiations, and international interventions be particularly sensitive to the ways in which women experience conflict. Though only 22 of 192 member states have passed UNSCR 1325, it is the first time international government has recognized women’s roles in conflict resolution as agents in their own destiny.

22 A critical examination about the shift from male to female battle nurses is needed, though beyond the scope of this thesis.
norms. This is a severe departure from a war-model of conflict, in which the goal is to conquer and impose existing norms.

While some feminist scholars continue to argue for the integration of women into military structures and the end of violent conflict, I maintain that these two conceptions are not divorced from each other. Integrating women into existing structures is necessary for changing how we conduct conflict. Moreover, understanding how women contribute to peacebuilding or war making in existing social structures can shift conversations around their efficacy, finally recognizing the caring labor of nurses that helps heal social distrust.

Understanding Gendering in Israel and Palestine: Linking Conflict and Caring

Being female in Israel, regardless of ethnic or religious affiliation, implies you are a mother or potential mother (Izraeli, 1993). The cultural meaning of “woman” is one who will foster the growth of the nation (be that Israel or Palestine) and train her children to be “soldiers” for a cause. (Berkovitch, 1997). This hyper-pro-natalism translates into childbearing as an expectation, if not demand, by governments, social pressures, and stigma. Women must be mothers, or face the consequences of being considered “cursed,” “barren,” or a complete social outcast. Childrearing is a communal activity, as children represent the future of militaries, cultures, and civilizations, and “mothers” their nurturers and trainers (Izraeli, 1993).

The omnipresent conflict makes reproduction and child-rearing more pressing—Palestinian and Jewish governments encourage women to have as many children as possible, offering financial assistance and child-friendly societies. In Israel, this has led even scholars to call couples with less than three children “not a real family.” (Gooldin 2006)

Many women are willing participants in this nation-building project, and celebrate having children, both of their own, their relatives, and their friends. The wellbeing of their children, both

23 This has resulted in the “highest true fertility rate in the developed world—3.1 children per woman.”
in meeting their practical needs to the highest standard and their desires for/of their children, takes precedence.

The high percent of nurses in Israel who are women and mothers serves as a testament to the gendered nature of caring labor. Consider:

- 90% of nurses are women
- 80% are married
- 66% have children under the age of 18
- 34% have children over the age of 18

These statistics are representative of the demographic divide between Jewish Israelis and Arab Israelis- 87% of nurses in Israel are Jewish, 13% are Arab, which mirrors the societal divide in which Jews make up 83% of the population and 15% of the population is Arab. (Nirel, 2010).

While nursing aims to promote healing, nurses are primary witnesses to the extent of human suffering. They are not passive eyes to the suffering conflict causes, but rather take an active role to help “heroes,” “terrorists,” and “civilians” heal and empower them with the skills necessary to mitigate their lives with illness, injury, or disability when returning to their daily lives. This unique vantage point challenges national beliefs about conflict and “peace-building” activities, even for the nurses who maintain ardent expansionist Zionism or strict Palestinian nationalism.

**Re-Writing Florence Nightingale: The Reproduction of Patriarchy in Nursing**

Liberal feminism would critique the nursing heroine, Florence Nightingale, for believing in the strict separation of duties between men and women, in essence reproducing stereotypes that women should be in the personal and professional field of caring labor because of natural aptitude. Such attitudes emerge from Nightingale’s writings, where she pens:
“Instead of wishing to see more doctors made by women joining what there are, I wish to see as few doctors, either male or female, as possible. For, mark you, the women have made no improvement; they have only tried to be men and they have only succeeded in being third-rate men. “

And:

“Women should have a true nurse calling; the good of the sick first the second only the consideration of what is their place to do—and that women who want for a housemaid to do this or the chairwoman to do that, when the patient is suffering, have not the making of a nurse in them.”

This critique of Nightingale’s staunch beliefs is not lost on the daughter of a liberal feminist- yet I find a compelling advocacy within Nightingale’s framing of nursing, adjusted for changing times. The essence of Nightingale’s assessment of what a woman and a nurse should be is rooted in celebrating the concept of caring labor, which has been a woman’s domain from history to modernity. Caring labor is a part of female apprenticeship, as Reverby (1987) writes, and because nursing labor is caring labor, nurses tend to be female. Chambliss (1996) examines:

“Large numbers of women, in our society, choose to become nurses, while very few men so choose; and the job (as currently defined) calls for those behaviors and attitudes currently seen as “feminine.” The structure of the work reinforces and supports the going conceptions of femininity in the larger society, and this is not lost on people choosing (or not) a career in nursing. It may be theoretically plausible to suggest, as Kanter would, that the structure of the work is decisive; but jobs do not exist in the abstract, apart rom the capabilities and habits of the people who perform them. The caring nature of nursing, the undervaluing of that kind of work, and the assignment of such work to women tell us less
about a particular job or hospital than about the position of women in American society.

So nursing is a female occupation, not essentialistically but empirically.”

Distinguishing caring labor, particularly nursing labor, as empirically feminized and not essentially feminine is central to contextually understand the role of nursing in Israeli society. Socialization of women into caring roles in the Western world was introduced into Palestine-Israel by American Hadassah women, and continues in modern Israeli society.

Nurses as women, while empirically true in Israel, does not uphold in the Arab world. In Palestine, only 48% of nurses are women. Despite that women are socialized as care givers in Arab cultures, nursing breaks the taboos of women touching men’s bodies. Breaking gendered taboos has created the stigma of nursing work as “dirty” work for women, which is only taken up if in need of the money. While this stigma is slowly changing with the influence of Western society, caring labor remains undervalued in the Arab world.

Simultaneously, advocating for career advancement for women- that we too should climb the ladder of professionalism- endangers the bedside nurse. As nurses are trained to “climb the ranks” professionally and academically, they become distant from the bedside, the patients, the families, and the work of caring. Such motivations to be “successful” or to “fulfill” one’s potential” reinforce degradation of caring labor. In reclaiming the writings of Florence Nightingale, perhaps increasing the value of caring labor must pair with valuing women beyond their participation in competitive hierarchies.

On Maternal Thinking: The Mechanism for Caring in Conflict

Aspiring to explicate them mechanism of how nurses’ caring labor affects conflict, I turn to Sara Ruddick’s classic Maternal Thinking (1989). Ruddick offers how maternal care is used to rear
children in to adulthood, but an adulthood that the caregiver deems appropriate. She defines maternal labor in three parts:

1. Preservation love- the profound appreciation, respect, and caring that maternal thinkers employ to ‘preserve life’ at all costs to themselves;

2. Fostering growth- In addition to protecting physical wellbeing, maternal thinkers are responsible for the emotional, spiritual, and psychological growth;

3. Training- Because cultural and social understandings are not inherent, but learned behaviors, maternal thinkers are charged with teaching values, norms, customs, and taboos that are socially acceptable to the social groups they belong or aspire to belong to.

Ruddick emphasizes that maternal care is not comparable to caregivers; since professional caregivers are compensated for their labor and are often not constantly present in the patient’s life, Ruddick argues professional caregivers don’t have the same investment as mothers to their children. Ruddick, 1989; 57) However, Ruddick doesn’t account for the intersection between the roles, expectations, and perceptions of “woman,” “mother,” and “nurse” in the Israeli context, and I would argue, also in many other countries and regions around the world. “Nurses,” those trained in the nursing profession to provide medical care, share Ruddick’s first two goals actively. The act of preserving life and fostering growth are necessary elements of holistic healthcare.24 In most settings, nurses have limited ability to “train” patients, beyond working with them during the first stages of socially and culturally coping with a disability or illness. However, in a country where every action is political - in terms of motivations and ramifications- nurses assume additional roles. The time and intimacy nurses share with patients, patient’s loved

24 “Holistic Health” is defined by the American Holistic Nurses’ Association as “all nursing practice that has healing the whole person as its goal.” (1998.) Many holistic nurses cite the work of Florence Nightingale as the first holistic health model, because of her belief in “care that focused on unity, wellness, and the interrelationship of human beings and their environment.” Healthcare models in many Western countries are moving towards holistic models by offering the inclusion of mental health services, spiritual services, and social services.
ones, and other healthcare professionals creates opportunities to “train” towards understanding, loving-kindness, and caring, or its opposite. This process can affect nurses as much as her patients- changing the nurse’s own perspective of “Other.”

*From Theory to Practice: Exemplifying Maternal Thinking in Hadassah*

Amitit tightens the knot on her headscarf that began to slip, revealing her midnight black hair under the purple paisley pattern. As she hurriedly walked down the hall, responding to a patient’s call her knee-length white skirt—regulation uniform for religious Jewish and Muslim nurses—wrapped around her knees. She returned to the nursing station with a smile. Before she could sit down to be interviewed, a resident intercepted her, asking for her advice concerning a patient’s at-home care. “Don’t worry, I will call the social worker for you!” She said playfully. The resident smiled and thanked her before rushing out of the department.

When Amitit stopped for ten minutes to speak with me, she first offered me water. When I declined, but told her to drink, she said she was fine, and that any delay may mean I wouldn’t get my interview, on account of patient demand, half teasingly.

Throughout our time together, Amitit continued to reference one patient, a Palestinian man from Gaza. Though she couldn’t articulate why she connected with this patient, she attributed “the connection in his eyes! Something in his eyes is speaking with me” as the reason she felt compelled to take special care of him. In addition, she claims that his loneliness, his parents in Gaza and brother in prison, and no other visitors, influenced her response. Israeli-Arab and Palestinian nurses in the department claimed that she was spoiling him, and repeatedly yelled at him in Arabic “don’t be a child!” According to Amitit: “I treat my patients like family… They call him my son; even the doctors when they come will say “how is your son today?” I asked her to describe specifically how she communicated with this patient.
Verbal communication is limited— the patient only speaks Arabic, and Amitit is limited to Hebrew and English. When needed, she asks another nurse, a custodian, or a family member of another patient to translate for her. “Most of the time, we don’t need someone to translate” Amitit claims.

Facial expressions and miming are essential in communicating without a common verbal language. “Sometimes I understand his face, and sometimes he understands my face,” Amitit says, eyes widening, “we just sit and eat lunch together, sometimes not saying anything, just sit and eat.” With all of her patients, Amitit emphasizes the importance of making them laugh, whether through words or miming, and to learn what the problems are they are experiencing that she can help to relieve.

Despite her own religious restrictions as a Hassidic Jew, Amitit touches her male patients, reminding them that “you are a man” or “you are beautiful.” In the case of her Gazan patient, she feels he needs her touch, using her intuition and her knowledge of his family situation to determine his emotional needs. “Maybe they will amputate his leg, and he needs my encouragement—’try again,’ ‘don’t worry.’” For this patient, the relationship built primarily on non-verbal communication has positive medical consequences. “Sometimes he doesn’t want to take antibiotics, or speak with the doctor,” Amitit says, her shoulders raised, “but I give him a limit, no, you must do this. He trusts me, I think he trusts me, and he listens to me.

Amitit’s presence in the department illustrates how a nurses’ maternal thinking works in its most ideal form. While preservation is a commonality in hospitals, doing so out of love is not universal. Amitit’s dedication to the physical well being of all people— including her interviewer—demonstrates the type of caring that is intrinsically linked to “love.” The remaining attributes,
fostering growth and training, are demonstrated through her relationship with her Gazan patient. Amitit works towards his mental and psychological well being by encouraging him through an inhumanly difficult injury to “keep trying” while simultaneously bolstering his self-esteem with compliments. Even when he can’t understand the words, their connection through “the eyes” and body language conveys they message clearly. Amitit is clearly Jewish- the way her headscarf is tied distinguishes her from her Muslim coworkers. By befriending this patient, whose brother committed terrorist acts against Jewish Israelis, Amitit is training her patient away from radicalism. Particularly through sharing meals and spending time outside of treatment with the patient, Amitit is working to recalibrate the patient’s construction of “the enemy.”

While her interactions with patients are inspiring, observing Amitit also reveals potentially negative effects of maternal socialization. The ways Amitit was overloaded with work from patients, nurse administrators, and doctors demonstrates how socialization towards mothering, in which the mother is a skilled multi-tasker that can handle it all, is a disproportionate dispersal of benefits and burdens.

I am uncertain to what extent Amitit’s actions to befriend this patient were deliberate, though from the way she spoke about his radical brother, as though it were a secret to be guarded, I gleaned that there was some anti-radicalization intention. Yet, like most nurses I interviewed, when asked directly if she considered herself a peacebuilder, Amitit was reluctant to claim the title. “No, it’s not so political,” she explained, “I just take care of my patients, just like they all were family.”

Nurses undervaluing their work is nearly universal, both as it pertains to medicine and social healing. While not surprised that nurses don’t think of themselves as peacebuilders, patients and family members across social stratum answered adamantly that they are. Though
nurses see their roles in terms of their professions and expected social functions, their effect must be measured by the lives they have influenced—that of their patients and patients’ families.

The process by which nurses work for destigmatization is conscientious, though to what extent depends on the nurse. Muslim nurses are particularly aware of how their presence can affect patients. A young nurse asserts it most clearly:

“I want to show them that there are good Arabs and good Muslims- that I, Eman, am a good Arab, a good Muslim, and a good nurse. That I care for them and their wellbeing. And I hope that after I am their nurse, they care for me as well and wait before they think that we are all aravim melukhlakhim (dirty Arabs.)”

The desire to be seen as an equal person is mutual between nurses, patients, and family members. Implicit vulnerability in the hospital setting, or what C. Wright Mills (1959) calls “extraordinary circumstance” contributes to the creation of a space where shared vulnerability becomes a human commonality between involved parties—physical vulnerability for the patient, emotional vulnerability for the family and nurse (Mills, 1959). When a nurse exposes her kindness, empathy, and respect for humanness, vulnerability becomes an equalizer. Skilled nurses use this vulnerability to demonstrate the respect for all persons, and desire for reciprocation. With this power comes responsibility- unequal vulnerability can also be an avenue for exploitation. Using the extraordinary circumstances created in these settings to find shared humanity depends on nurses applying maternal thinking as though the patient were her child, and not her perceived enemy.

Recentering Ruddick’s Maternal Thinking

Ruddick’s work is criticized for excluding those who are deemed “unfit” mothers as capable of maternal thinking—primarily women of color, immigrants, lesbians and genderqueers, and the
mentally ill (Dietz, 1985) The gendering, racing, and classing the practice of maternal thinking were appropriate criticisms of Ruddick when *Maternal Thinking* was initially published. Yet, when examining how maternal thinking is employed in two societies in which every woman is expected to be a mother and motherhood is expected by the State, maternal thinking is attainable for all. By maintaining that the tenets of maternal care are open to interpretation rather than setting measurable, ethnocentric parameters, everyone can be or become a maternal thinker.

However, within my own research, I noticed a difference in the answers given by men and women in response to the question “why did you become a nurse?” While women mostly answered they became nurses because of a personal experience in the hospital as children, admiring a family member who was a nurse, or a desire to help people, men tended to answer that nursing insured they would have a job, could travel, or that they became a nurse in order to progress through the ranks into hospital management. This observation agrees with critiques of the “androgy nous carer,” or the idea that care can be separated from gender when we “add men and stir.” (Williams, 1992). Including men in caring labor does not make caring work valuable, but rather contributes to new patterns of male dominance (Fisher & Tronto, 1990). Whether this disparity is evidence of divergent socializations leading to different reasoning or fragile heteronormativity that maintains strict gendered roles in which men cannot be just caregivers, I cannot determine. I lean towards Fisher’s (1990) assertion that “caring, as women’s work cannot be abolished without a profound change in the construction of sexuality itself.” (p. 35)

*The Hospital as a Total Institution*

When nurses and patients alike told me that the world inside the hospital was separated from the world beyond its walls, I was reluctant to believe it. If such a separation existed, how could relationships built “inside” the hospital exist outside? Moreover, how could the workers
who occupied the hospital halls forty-plus hours a week draw such a harsh difference between the two realms?

Erving Goffman (1961) defined a total institution as “a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.” Working exclusively in asylums during the 1950s, Goffman’s definition represents the “ideal type” of total institution, explained by five categorical types:

1. Institutions responsible for the care for persons felt to be both incapable and harmless.
2. Institutions responsible for the care for persons felt to be both incapable of looking after themselves and a threat to the community.
3. Organization established to protect the community against what are felt to be intentional dangers to it.
4. Institutions (purportedly) established the better to pursue some work-like task and justifying themselves only on these instrumental grounds.
5. Establishments designed as retreats from the world and training stations for the religious.

Hospitals, particularly in departments with limited lengths of stay, can be defined as a quasi-total institution. Hospitals disrupt how personal norms can be expressed and practiced, and the hospital’s norms are either temporarily adopted or ineffectually defied. In either case, realities of the outside world are suspended. Yet, hospitals cannot exclude the competing or incompatible world of family life. In the ideal type, Goffman asserts:

“Total institutions are also incompatible with another crucial element of our society, the family. Family life is sometimes contrasted with solitary living, but in fact the more pertinent contrast is with batch living, for those who eat and sleep at work, with a group
of fellow workers, can hardly sustain a meaningful domestic existence. Conversely, maintaining family off the grounds often permits staff members to remain integrated with the outside community and escape the encompassing tendency of the total institution…the formation of households provides a structural guarantee that the total institutions will not be without resistance. The incompatibility of these two forms of social organizations should tell us something about the wider social functions of them both.” (p. 12)

Goffman argues that family and the hospital setting are competing structures- that may have been the case at the time of his writing. Since the 1960s, nurse researchers have reframed what Goffman considers “competing” structures to be promoting, supportive structures. While families can be hostile towards “the institution,” especially nurses responsible for daily care, families can also be essential to the caring process. The nurse, rather than excluding the family, is responsible for designing a custom practice for mitigating the anxieties and needs of the family with the care of the patient—essentially, an Israeli nurse never has a singular patient, but a network of patients in need of human care. Additionally, the nurses’ own families have a degree of compliance, even when hostile, towards the organization that splits their parents’ time between home and work.

While Goffman asserts a strict “basic split” between “the largely managed group” (patients) and a small supervisory staff (healthcare workers, security personnel), reproduced gender hierarchies complicate this dichotomy. While nurses are considered to have “power” by most patients,

26 Worth mentioning is the time period during which Goffman wrote Asylums was a bleak period in the US’ treatment of the “feeble minded” and mentally ill. Many were institutionalized not to better their lives, but to remove the “burden” of care from the family. These wards of the state were most often considered “untouchable” or incapable of functioning as “normal” citizens. (for more on this, see Brenzel’s Daughters of the State, 1985) While Goffman’s total institutions exist as an ideal types, context for Goffman’s study explains his harsh judgment of the institution’s actors.
nurses often feel disempowered within the hospital professional hierarchy, by restrictive laws and requirements, and by overbearing patients, their families. As several nurses from Hadassah quipped, “the H is for Hilton, not Hadassah,” implying they are not maids and wait staff, but medical professionals.

Redefining the Total Institution

Despite Goffman’s focus on only certain players and their roles in the hospital system, Goffman’s total institution offers the proper frame to understand how perceived enemies could develop positive relationships within a unique set of norms created and maintained in the hospital. While other institutions and public spaces can enforce policies of inequality and exclusion, the hospital exists as a place of perceived “equality” in available treatment.Outside of the politicization of payment described in the previous chapter, Hadassah holds equal treatment as a cornerstone of their organization. In fact, Hadassah so much believes in their equality model that they adopted “a bridge to peace” as their slogan.

Within the hospital, nurses keep a foot in each world- the first as an actor of the institution and its wellbeing, and the second as a “translator” and advocate for the patient. The dual belonging can result for internal and interpersonal conflict for the nurse, as she operates as a soldier and a rebel, depending on the world in which you sit. Mitigating both worlds, nurses are responsible for creating, enforcing, and reproducing social norms while giving medical care. Because nurses are socialized as mothers and professional caregivers, and operate in a system that frees itself from existing external prejudices, nurses integrate maternal thinking into the

27 Similarly, in the US, hospitals are compelled to treat criminals and their victims regardless of how horrific the crime is. This issue became most visible during the 2013 Boston Marathon Bombing, in which nurses and doctors at Beth Israel Deaconess had to care for one of the terrorists, and dozens of his victims. (Kowalczyk, Boston Globe May 19 2013.) It’s interesting to know that Hadassah’s trauma team was brought to Boston after the bombings to coach nurses in reacting to a terrorist attack with victims, and in treating the terrorist. (Haaretz, “What Boston Hospitals Learned from Israel’s Experience of Terrorism” 29 April 2013)
hospital culture. Nurses, especially from minority groups within Israel, actively work to preserve life, foster growth, and train other occupants of the hospital. Clearer examples of this are provided in the following chapters.

The power of the nurse is checked by the belief that she is ‘powerless.’ By only believing in micro-level power structures in which personal relationships are more effective than official hospital procedure, nurses are able to advocate for patients without threatening the fragile empowerment of doctors and high-level administrators, who are mostly men. The “comfort” of employing a maternal structure as understood by Israelis and Palestinians is non-threatening, yet assertive enough to lead to measurable ideological progress.

**Conclusions: Nurses as Social Brokers within the Total Institution**

While Goffman gives limited agency to nurses, feminist models of thinking about caregiving construct nurses as independent actors, not only agents of the institutional norms.²⁸ As discussed in Chapter I, Hadassah has a history of empowering nurses to be independent actors in building health and health infrastructure in the pre-state period, an organizational act continued until today. Despite little recognition within their institutions and, too often, scholarship, nurses operate with tremendous influence. Responsible for the holistic health of patients and their families, nurses preserve lives while preparing people whose realities are limited to the hospital walls for an undetermined amount of time for reintegration into their own societies.

Israeli motherhood is intimately entwined with the idea that your child may never come home—as much as your child belongs to you, so too do they belong to the state. Raising children

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²⁸ This is not to imply that feminist models promote neo-liberal values of autonomy, but rather nurses are considered to be professionals that can assert their own will (to an extent) outside of the institution’s expectations. In the institutional model, nurse A can be replaced by nurse B without a difference, as nurses are only enacting the will of the institution. A feminist understanding of women’s roles within institutions departs from women only following orders.
in the abnormal conditions of coinciding war and peace requires a particular attentiveness to the safety of the child— not just for the day, but for the future war one’s child may fight in. The desire to raise children outside of the war/peace dynamic is salient. Simultaneously, Israeli women must work, and have answered this demand since the pre-state period. Consider that recent statistics tout that 79.5% of secular Jewish women work, while 66.2% of religious Jewish women work. These numbers are important based on two comparisons: First, compared to Arab Israeli women, of whom only 28 percent are employed. Second, to the statistics of men: while 86% of secular Jewish men work, 76% of Arab Israeli men work and only 48% of religious Jewish men work (Arlosoroff, 2016). Particularly for all women, it is important to note these statistics only include labor taxed by the state- not unofficial labor many women participate in—including cleaning houses and caring for children, the elderly- and the disabled, is excluded. The expectation for women to work originated in the need to cultivate the land, and is perpetuated by Israel’s high cost of living and

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Figure 3, Percentage in Work Force by Gender/Ethnicity
ardent pro-natalism. Because women are expected to work and be mothers, the type and manner of labor are blurred. The flexibility demonstrated by society, the workplace, and the family represents the ways that raising children is woven into the fabric of life in ways that work becomes more invisible.

Hadassah acts as an un-ideal total institution, where the invisibility of this weaving is essential to the institution setting expectations and norms that differ from greater society. Within this structure, maternal thinking shapes the norms of the institution because nurses maintain the liminal space between patient and institution and have the most direct contact with both. Beyond caregiving, nurses in Israel are social brokers- creating opportunities for cross and inter-cultural dialogue where there is not.
Chapter III: Building Relationships: A Case Study at Hadassah Ein Kerem

In this chapter, I analyze the interviews of nurses, patients, and their family members at Hadassah Ein Kerem.29 Building on the meaning of maternal-nursing practice in the last chapter, concrete examples and methodologies of nursing care serve as evidence of the peacebuilding capacity of nurses. First, I analyze the practical steps nurses take to build relationships with their patients. I analyze these steps as acts of maternal nursing described in the previous chapters. After, I offer four thematic elements of the nurse/patient relationship based on nurse, patient, and family member interviews that answer the question “how is the nurse/patient relationship important?” Finally, I use a feminist lens to consider the elements of race, culture, gender, and conflict to characterize the role of nurse as one of “peacebuilder.”

Nursing Methods for Building Relationships with Patients and Family Members

In order to understand how nurses’ conceptualize building relationships with patients, I asked them to describe their process. Through their answers and an extensive literature review, I compiled the following list as a “best practice” guideline:

- Read available information about the patient
- Introduce self to patient at each shift
- Assess what the patient has around him/her (i.e. family, friends, photographs, entertainment)
- Tell the patient what you are doing during the treatment
- Ask questions/Listen with the whole body
- Take time to speak (for example, when taking blood pressure) about pain level, family life, interests

29 Hadassah Ein Kerem Ethics Committee issued Helsinki approval valid from May 2014-April 2015, and July 2015-June 2016. All interviews were collected within the range of time that they were ethically validated.
• Respond to questions/requests timely
• Be sensitive to needs—give “permission” to be emotional
• Instruct medical care post-hospitalization

These steps are taught through nursing schools in Israel, which rely on several major nursing models to create best-practice methods. These steps can be separated into two categories: education and communication. Steps such as “read available information about the patient,” “be sensitive to needs/give “permission” to be emotional,” and “assess what the patient has around him/her” are ways to investigate the patient’s potential problems and address risks before harm is caused. In the case of Hadassah nurses, this includes consideration for the patients origin, and the particular difficulties inherent in crossing borders—including absence of family members unable to obtain passes, difficulties in follow-up care, and potential feelings of isolation. Methods to opening communication, including “tell the patient what you are doing during the treatment,” “take time to speak,” and “respond to questions/requests timely” are steps taken to reaffirm to patients that nurses are invested in the holistic health of the patient.

It is the contention of this author that, when performed with care-centered intentions, methods for opening communication are introductory to more dynamic peace processes between nurse and patient. Whenever communication is productive—meaning nurses and patients can speak openly and respectfully—it encourages trust between nurse and patient. Once productive communication and trusting relationships are founded, factors of sociopolitical conflict and identity politics are complicated by new personal experiences with “the Other.”

The gendering of nursing as “women’s work” is then made a strategic tool for nurse-as-peacebuilder: the expectations for nurses to be women, and in Israeli/Palestinian society, women as mothers, encourages native patients to place trust in nurses because nurses are “motherly.”
Aspects of the Caring Process that Contribute to Peacebuilding

In the course of interviewing, four distinct themes emerged concerning how nurses conceptualize the caring process. These themes are intrinsically related to maternal thinking in their goals and processes. For example, “building trusting networks” is necessary for fostering growth and training patients, though necessary to a lesser extent to perform preservation love. Each aspect of the caring process has been distinguished for individual interpretation—but it should be noted that all aspects of the caring process is deeply interconnected and sometimes interdependent.

Relationship Building: Trust as Nursing Work

While the aim of this study was to investigate relationship building between nurse and patient, special attention was given to the concept of trust. In the context of peace scholarship, trusting relationships must be built/restored in order to attain just, dialogic solutions (Galtung, 1996). For fear of prompting interviewees, the word “trust” was omitted from the research questions. If and when the subject of trust arose organically, follow-up questions attempted to tune in to its importance in medical care and peacebuilding work. Nurses conceptualized trust on two frameworks: first, that trust in nurses is innate because they trust the uniform, not the person; second, that nurses’ processes to develop trust is continually developed through communication. Nurses who actively pursue the trust of their patients often cited communication as key to building trust. Ilana, a young Israeli nurse whose parents emigrated from Russia, reports: “I [speak] five languages. Sometimes when there is no Arabic staff, they [call] me to translate. I am not going into politics. I am looking the patient in the eye, like trying to find the common between us, to tell, even if I am bringing examples from my life, just to get closer, to get his confidence.”
Other nurses echo Ilana’s search for commonality to build trust, and make “small talk” to discuss family, hobbies, and interests. Additionally, taking the time to meet with patients and family members is highlighted; nurse Rotem, an Ashkenazi Israeli, claims, “when you set aside a few minutes to listen, to sit, not stand, with them the relationship changes. You gain trust, and after it is easier and the treatment has a better result because the patient has less anxiety.” Dissecting this claim and ones similar to it, nurses assert that trust betters the physical outcome of medical treatment, as well as mental and emotional ones. They characterize this trust as personal. Nurse Esther continues: “I adapt myself to differences, but my treatment will always be the same. I am a nurse, I am Esther, and I am also different. I am not the same nurse that you had before- I try to always show the patient I am open to everything.”

However, a few nurses expressed that the trust isn’t personal, but inherent in the uniform system of the hospital. According to Bruchi, a nurse who is departmental middle management, links patient trust to the expected/intended relationship between the patient and any nurse, claiming, “they have trust, they see the white (uniforms.)” In interviews with this minority of nurses, less emphasis was placed on speaking to patients and family members, often dismissed by claims of being “too busy” to speak with patients.

Gabi,\(^\text{30}\) an experienced nurse in plastic surgery and burns, responded by combining the two trust modalities:

“\(\text{I think they have a sort of level of confidence in the person looking after them. Because I was thinking about this just the other day, if someone just suddenly came to me and}\)"

\(^{30}\) Gabi converted to Judaism when she married her first husband, who was British and Israeli. While she keeps her conversion a secret from most, she “passes” as a Mizrachi Jew, and her children are Mizrachi. Her ability to speak openly is limited by her conversion secret, this is not outside the norms in Jewish communities across the globe. Because of an extensive history of anti-Semitism, Jews become suspicious of anyone who isn’t Jewish by birth wanting to join the Yishuv. This shouldn’t then be read as a limitation to speaking openly as an element of productive communication, but normalized by Jewish culture.
gave me medication, would I take it? Would I trust them enough to give me something IV or I have to swallow it? I mean, I don’t think I would, maybe because I am a nurse, or maybe because I am a suspicious person. But, if I feel confident with someone and they know what they are doing and have a lot of experience, I would feel a bit easier with that person…“I think the patient also gives you, not respect but sort of, if you feel they are sort of believing in you and they trust you, than it is easier to do your job. If someone is suspicious of you all the time you kind of start doubting yourself and I think the nurse tends to stay away more. You know it’s a process, you can’t just expect someone to believe in you and trust you without any sort of introduction before.”

By asserting that there is a trust in experience, Gabi agrees with the immediate trust given to nurses as knowledgeable medical professionals. However, her assertion that patient’s constant suspicion leads nurses to “stay away more” relates to the communication model of trust building— if trust is not built through nurse’s efforts, or mutual vulnerability is absent, the nurse is less willing to be mentally and emotionally exposed to the patient.

I developed a close relationship with a patient recovering from severe burns in the course of my research. During one of our conversations, the patient emphasized the difference between building a relationship and trust, claiming:

There was a nurse [who said] ‘I am thirteen years in the department, I know better.’ It doesn’t make me trust her. When they say that, because they don’t know me. I think when the nurse, when I feel that she knows me, and she stays with me a long time, and then I trust her. I know they are professional and I know that, and they saw thousands of people with burns, but they never saw me with burns, and I think, so I can listen to them, but I don’t need them to be hard. This is my feeling. When they suggest something, it’s
okay. But when they tell you ‘do it like this I am forty years in the department’ (laughs) I don’t like it, and it makes me ‘no thanks, I don’t need your help.”

This patient’s assertion that experience with burns doesn’t matter to her trusting the nurse because it is not personal knowledge attests to the need for communication between patient and nurse to establish trusting relationships. If this patient would have felt heard, or had her fears validated by a professional voice, perhaps she would have had more trust in her nurses’ professional opinions.

This expectation for personal “insider” knowledge is a gendered expectation. When finding a good doctor, potential patients put their trust in online reviews or specializations that emphasize the doctor’s credentials and effectiveness of the treatment method. However, trust in nurses, regardless of their experience, comes with the caveat of personal knowledge of the patient to improve the overall treatment. While predominantly male doctors are valued on their credentials, nurses are valued on their character and communication with the patient.

Navigating Illness: Nursing Knowledge

In interviews, some nurses directly addressed that the manner in which nurses can communicate with patients changes from the time the patient arrives to the time the patient leaves their care.

The notion of “guiding” the patient through their illness or injury reoccurred among nurses from various departments. A nurse in general surgery uses the notion of guiding the patient to make an agreement for honesty. She states:

“What’s important from my eyes is to guide the patient all the time, to speak with them, to understand what disturbs them the most, and to go deeper. From my opinion, it’s very important to understand what bothers them, and when I see the patient the first time, I ask
from him to tell me really what disturbs him, what isn’t comfortable for him, and always to tell me everything, if he is content or not.”

Nurses’ knowledge of the patient, and her ability to achieve the best results for the patient, are dependent on the patient’s honesty. Though it can be requested in the beginning, patients must feel safe with verbalizing their pain and perception of care.

Gabi explains her process as introducing herself to the patient or “saying hello” at the beginning of each shift, providing any medication, and explaining the day’s schedule. She asserts, “knowledge always helps with anything, it prevents fear, we create rapport between each other before, and they know what is going to happen during the day.”

Observing patients over several months in the same department, I noticed that the dynamic process could work towards increased or decreased trust. While the vulnerability of patients and families many lend to a “baseline trust” in nurses based on their profession, the experience with individual nurses changes the trust dynamic. Whenever patients or family members lack confidence in the medical staff, compliance decreases (Benbenishty, 2015).

Overcoming Ethnic Boundaries and Citizenship Differences

Building from the changing nature of the caring process, nurses add that the abilities to connect, communicate, and care for patients and family members are sometimes a matter of personality or chemistry. One nurse describes the connection as the patient “gives you a very good vibe.”

Another adds:

“I think if you have chemistry with someone, if you have some sort of connection with them, I think you want to be more involved with them, obviously it helps, if you have chemistry with someone and they aren’t in your room the next day, you will think about them at home as well, if
you have established a relationship with that person, then you will go and see or say hi to them or see how they are doing, because they have made an impression on you.”

Caution must be taken when evaluating the “chemistry” connection between nurse and patient. Sometimes, it is a guise to discuss race relations in socially acceptable ways. Sociologists have defined this phenomenon of grouping based on physical, social, and ethnic characteristics as “homophily.” (Lazarsfeld, 1954) The strongest ties, or those we “discuss serious matters with,” tend to be our partners and close friends, who tend to mirror our own characteristics. Other relationships, such as work acquaintances, neighbors, and people one routinely encounters are less likely to share these characteristics.

During a collective year of observation, I noticed that a particular Russian nurse, Lydia, often had hostile relationships with Arab patients and families. The most blatant example of her prejudiced behavior occurred during an evening weekday shift. I heard raised voices from the central nurses’ station, and went to see what was happening. I saw a middle-aged Arab man raising his voice, explaining that he had “already been through hospitalization” and “didn’t want to return downstairs.” (to hospital admissions) in Hebrew. Lydia aggressively told him that “he needed to calm down” and she was calling the Emergency Room about his daughter. I looked in the family room and saw a young woman holding her jaw and rocking back and forth. “They said you had a room, why do you have to call them!” the father yelled. Another nurse asked an Arab doctor to speak with him. Before the doctor can arrive, Lydia says into the phone “there is an Arab man here that wants to attack her.” The father begins yelling again, claiming that he was not in any way trying to hurt her, that he just wanted care for his daughter. The doctor arrived, and asked him to sit in the family room while the nurses found a room for his daughter. He complied.
I went to speak with the father about what happened. He told me that he knew it wasn’t right to yell, but they had been at Hadassah for two hours and his daughter was in pain.

However, “that nurse” (Lydia) couldn’t say that he was going to attack her—she had no right or basis—what if they sent security to take him away? Who would take care of his daughter then?

In a later interview with Lydia that didn’t mention this specific incident, she states:

“But somehow we have to make him understand, that this isn’t the place for him to bring out all his color—it doesn’t matter what kind of person. I don’t care where he comes from, but there are some specific people who allow themselves to explode… I am from a place where I didn’t know many foreigners. I came from St. Petersburg, specific people with a specific culture (smiles) and it’s difficult, despite I am here more than 20 years, it’s still difficult to get used to things.”

(Emphasis added)

Despite coded language, Lydia revealed her racial bias. She characterized Arab people as “allow[ing] themselves to explode” is both conversational and political, language that reflects decades of suicide bombings. The characterization of nurses as violent is not exclusive to nurse Lydia. Her friend in the department, nurse Tatiana, spoke about the violence of “Mizrachi culture:”

…there is a type of culture that I cannot, like, I cannot… for example, people that don’t speak Hebrew, I don’t have a connection with them. How much I can is to bring someone who translates, I show how much I am worrying, how much I take care to help. It matters to me and it’s not a game, I try to find the common way. And if they are patients more “Mizrachim” their manner of speaking, they are yelling, they are demanding, the way they do this, it disgusts me. I don’t like this. But, I have no choice. I don’t have to educate them and I cannot teach them… We have another role, we have another role, even one
spit at the police officer, and he did not have good behavior. But you have to take care of him. So I do it. This is how I see it. Not that I like him, or I justify him, I don’t think he is right, I am not from the left, the opposite, my role is to give treatment, and it doesn’t matter to whom. I am really like this. I don’t do less if it’s an enemy or not. Maybe I am lying a little here, but generally yes.”

Contrary to popular usage of “Mizrachim” in Israeli usage, Nurse Tatiana use it to refer to both Palestinian Arabs and Jews of North African and Middle Eastern descent. Nurse Tatiana’s wording of the inability to tolerate or teach the Mizrachim how to speak and behave reflects inter-Jewish racism and otherizing of “Oriental” Jews, who are historically grouped with the native Palestinian population because of shared cultural and hygienic habits. (Hirsch, 2009)

More than racism, Tatiana and Lydia’s treatment of Arab patients resulted from “uninterrogated coloredness.” Emilie Townes uses this phrase to reflect the ways in which race is “collapsed” into a black-white dichotomy, which ignores the ways that people color across the spectrum face particular injustice. Towne writes:

“Exploring yet another track, Hurtado points out that ignoring race allows Whites to assume that they are just like other colored people—they share profession, gender, geographic residence, family structure, artistic difference. These may all be true and there may be other points of commonality as well. However, we must still reckon with the relational dynamics of race, the active transformation found in process-historicity-politics, and those attendant social interactions that maintain a racialized social order that includes other processes such as social class and gender to maintain and aid its sustenance.”
When we consider the particulars of “color,” including the various degrees of “vanilla” implicit in whiteness, the relationships of some nurses and patients can be interrogated to reveal specific fractions in Israeli and Palestinian identities.

Though she knows she must say she provides equal treatment to patients, she also admits to lying. This should raise concern and gives reason to pause.

While Lydia and Tatiana, who enjoy structural privilege because of their whiteness, have the luxury of “collapsing” all people of color into “Orientals,” Palestinians and Mizrachi Jews experience their assumed superiority differently. For a Palestinian, hostilities from a Russian Israeli (Jewish or not) perpetuate norms of the white oppressor. For a Mizrachi Jew, hostilities from white Israelis (Jewish and not) represents a tentative belonging to Israeliness and Jewishness. Whiteness dominates the narrative of Jewishness and Israeliness. Despite majority status, Mizrachim are viewed as equivocal to Arabs, Arabs to Palestinians, and Palestinians as enemies (Omer, 2013).

In the hospital, the few nurses that actively perpetuate direct violence against people of color are few—in my year of observing the hospital, I only saw three such incidents in hundreds of interactions. But, that it exists has the potential to disrupt, if not destroy, the peacebuilding efforts of other nurses. Disturbed by these incidents, I asked these nurses, with suspicion and generosity, why they became nurses. I learned that in the 1990s, there was an accelerated program for Russian immigrants to go to nursing school. Since many of the degrees and certificates from the former Soviet Union weren’t accepted by Israeli institutions, many Russians took on new professions with such programs. Tatiana was a biology teacher in Russia, and didn’t consider nursing as a profession until she was faced without other options. Tatiana continued in nursing education, holding a Master’s degree. While she thrives in teaching new nurses technical
details, she remains distant from her patients. “I don’t like when people ask me about my life or my family without knowing me,” she states precisely, “so I am not that nurse who asks her patients that either.”

Similar to Tatiana, Lydia didn’t consider nursing until arriving to Israel, and had a career as a chemical engineer before emigrating.

From literature and interviews, I gleaned that nursing is a career one actively chooses, rather than falls into. The caring labor required of nurses in addition to technical skill and knowledge, demands a moral choice to care. Without purposefully making such a choice, nursing becomes a job rather than a career, a patient a customer, and a nurse a procurer of treatment.

Despite enjoying structural privilege because of their whiteness, such as career track programs not offered to Beta Israel Jews who immigrated at the same time, Russian Israelis are not synonymous with Ashkenazi Israelis. This fracture receives little attention in sociological literature, but pervades “white” Israeli society, particularly in Jewish circles. One of my collaborators revealed that intermarriage

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**The Writer’s Reflection**

After leaving the ICU, I was moved to the general surgery floor. Most of the nurses on this floor were Arab Israelis/Palestinians at the time of my hospitalization. Because of the complexities of my case, I was assigned the same nurses repeatedly who learned how to take care of me, despite being outside of the realm of their expertise. In the mornings, I consistently had two Palestinian men from Betlehem as my nurses. They changed my dressings, bathed me, answered my calls, and learned to understand how I expressed my pain. In exchange, I taught them how to wash a woman’s hair. They took to calling me “hamalkah:” the queen. After leaving the general surgery, they continued to visit me once a week or more. When I could finally sit in a wheelchair, they were among the first I wanted to visit - the queen had a new throne.

Growing up in a post-9/11 world, I was cultured to fear Arab men. As a Jew, this was particularly true for Palestinian men. My interactions with Michel and Ihab transformed how I construct and interact with Palestinian men - approaching each with the same suspicion and compassion as all others. My relationship with Michel and Ihab were limited to my hospitalization. When I returned to Hadassah a year later, I was informed that Michel had opened a restaurant in Betlehem, and Ihab was working in a West Bank hospital. Yet, each time I remember them, I smile. Moreover, each time I hear tropes of “Palestinian violence,” I reflect on these two young men. This serves as an example of how extraordinary circumstance creates meeting points that change perspectives on Otherness.
between Ashkenazim and Russian religious Jews is “scandalous” because of vast cultural differences.

_The Body as a Site of Connection_

Communication was discussed at length in many interviews of nurses, patients, and family members, who classified communication in verbal and non-verbal categories.

“It means to listen to him, and you know how they say you don’t listen just with your ears, you listen with all your body, and just show him that I am here when he needs me, even with small things.” “You don’t touch the body without permission, of course. Usually you get to touch the body or see bodies, especially when someone has a shower or something. It is a very intimate place-shower or toilet, when you are with a patient in a place like this, he opens up. He is already without covers, so he lets all the covers go. When I was in the old building used to buy a dictionary in Cyprus, a lot of… and it was easier for me. You could see the patient who doesn’t speak English or Hebrew and they speak only German or Dutch or whatever and you are telling them a few words, and you see them happy, and you feel they are more comfortable <I give them to feel secure,> you know? So it’s important for me. If I know that we have a doctor or someone who speaks their (the patient’s) language, I ask them “how do I say this” and it’s important for me that it will be good with him, and he will feel good and the treatment he will get from me will be more than 100%.”

While nurses acknowledge the importance of communication, the experience of patients and family members is changed based on the communication they have with their nurses. Patient Elyad, a twenty-three year old Israeli man injured while racing a motorcycle, differentiates between “good” and “bad” nurses based on the manner in which he felt the nurse’s
touch and the way she spoke with him. “It’s a difference in how she touches you, how she speaks with you, if she treats you with respect and more delicately. If they speak with you rudely, you feel this, and it’s not nice. But mostly, they are good b’not (girls).

How do you say that in your language? Nursing in Multiple Languages

Due to the extent of Hadassah’s multi-culturalism, issues of lingual understanding and cultural competency play key roles in how nurses are able to provide practical and peace-oriented care.

Nurse Esther introduces her technique of nursing across languages:

“Language could be seen as a problem in communicating care—BUT, even if you don’t speak the language, you have body language that can help you understand and develop a relationship with the patient and his family. I don’t know Russian, for example, but I communicate by body language and a few words to help make myself clear. I have fewer problems in Arabic, though it’s Palestinian Arabic. But I look, I ask, what he shows me, I ask for him to show me. I can understand. I can do something to help him. And if I don’t understand really, I ask for someone to help me. But I never say that I don’t understand him and then just send someone else. I am his nurse, I want him to know I am invested.”

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**Esther (Tunisia→Paris→Jerusalem)**

Esther knew she wanted to become a nurse after being hospitalized as a child. “I had a nurse that called me her “petit lune,” and made me feel important. This was in France, so my parents couldn’t visit often. (there were set visiting hours, and the hospital was far away) The nurse is who healed me, and I wanted to make others feel as she made me feel.”

Esther has been a nurse for thirty-six years, first as a home health nurse in France, then as an emergency room and plastic surgery nurse in Jerusalem. She is a department and hospital favorite, and her patients will often come to her, even when she isn’t their assigned nurse. In fact, she is the doctors’ favorite nurse, which allows her to advocate for patients without fear of repercussions. She is a leader in the nursing community, representing Hadassah in various committees and the chairwoman of the Israel Plastic Surgery Nurses Association.

Watching her work has inspired mine—she is a passionate advocate of peace work within hospitals, and brings that mentality with her to every shift, meeting, and patient. “[Nursing] here is political,” she once told me, “but to call it that is so limiting.”
In the course of interviews, I found that many of Hadassah’s nurses are multi-lingual—with Hebrew and English as the most common combination. Depending on a nurse’s family origin, Arabic, French, Russian, and Spanish were also spoken fluently or with enough proficiency to communicate with patients.

In addition to speaking multiple languages, nurses also tended to pick up key words from other languages they heard frequently in the hospital. One nurse, Hadar, showed me her locker filled with tourist phrase books. “I buy them each time I have a patient that speaks a language I don’t, and I keep them here just in case! Even if I can’t pronounce it, I can show them what I am trying to say in the book. Normally, they smile.”

As important as verbal communication is to nursing, all nurses interviewed identified non-verbal communication as core to their nursing practice. “You can communicate with all your body,” Rotem told me, “and so does your patient.”

While interviewing a patient, Yael, her husband jumped from his seat and compelled his wife’s roommate to stop trying to stand. “She doesn’t speak Hebrew, not even English. Only Russian—it’s very difficult for the nurses,” Yael told me, explaining her husband’s bizarre behavior. I asked her how they communicate with her, as Yael’s husband ran out of the room to call a nurse. “They have learned a word here and there, and they have found someone who speaks Russian to explain to her not to stand up by herself- they are very worried that she will fall. Most of the time, it’s with a lot of patience- more than I have watching them! (laughs) They smile at her a lot, and listen to her speak even if they don’t understand the words, they understand what she needs.”

As Yael finishes explaining to me how nurses communicated with this patient, I witnessed it firsthand. A nurse entered the room, smiling towards the patient still trying to stand
on her own. “Madame, what can I get you now?” she quips in Hebrew. The patient lights up-smiling and stopping her activities- it’s evident that she likes this particular nurse. She starts speaking in Russian, and the nurse patiently listens. When she finishes her tale, the nurse takes the patient’s hand and holds it against her own chest. Eyes wide and eyebrows raised, the nurse points in the direction of the bathroom, and after to the bed. The Russian patient shakes her head, agreeing to the nurse’s plan. The patient points to a water bottle across the room, and the nurse nods. The nurse puts her hands on the walker in front of the patient, and then reaches out her hands. The patient puts one hand on the walker, and grabs the nurse’s arm with the other.

Working together, the patient stood up.

_How Hospital Multi-Culturalism Works Towards Peace_

I was leaving the department when Amar, a patient from Hebron who had undergone many surgeries to save and reconstruct his hand after a machinery accident, entered with his parents. Upon arriving to the central station, Amar’s mother saw Esther. Immediately, she smiled, spread her arms and said in Arabic, “My dear, how I love you! I have missed you!” The two embraced. In her limited Arabic, Esther asked the mother how she was, and told her she was happy to see her. Amar and his father followed the sentiments of the mother, though not as liberally—gender taboos, even between nurse and patient- limit physical contact. Later, Esther told me that during a conversation with Ihab’s mother, she said, “I didn’t know Jews could be so nice to us.”

I stayed to interview the family. Amar’s father spoke English, and was a reliable translator for his wife and son, though he mostly answered from his own experience. Amar’s father differentiated the personal experiences with the doctors and nurses from the experience with the administration. When describing the obstacles his family faced when trying
to navigate the bureaucratic systems of Israel, the Palestinian Authority, and Hadassah herself, Amar’s father states:

“We are suffering. Today, today we are suffering from oppression, like the cult, with permission like this (shows the two slips of paper that allow him and his wife to stay in Israel overnight) we have to take permission until we are in all the files… From two o’clock, I am at Hadassah since 10 o’clock. I go from this office to this office. My feet feel very hot. Some of them in the office he said to me, go home, and come back tomorrow. What is this? Go, at the end of the process? I said, I am from a village, next to Hebron, it’s called Shuch, it has maybe 1200 [people]. I decided, I will never go home until after, to recovery, it’s related to the money, the recovery, the operation, and the stay here. It takes 100,000 [shekels] to cover the operation. You understand? And 102—it’s too high, the price. So I related to some friends outside and the company he worked at to cover it. He said to me, you’re private, just private, Feldman. She said to me, you need it to be high, the cost of it, the operations. At the end, they called it hospitalization instead of private. 10 hours, more than 10 hours, this office to this office. That’s our life, it’s difficult… This is our fact.”

However, while Amar’s father is critical of the administrative system, his words about nurses stand in strict contrast.

AF: A nurse is like a pigeon. Each pigeon- there are different colors of pigeons. But nurses are like a white pigeon. She goes everywhere and spread peace. And when her feet or his feet come and lands, there is peace in the area, every area of the world.

J: How?
AF: He is working, to work, work impacts the society or the country where he or she comes. The nurse is very important profession in the world. Why because, it joins the humanities. For example, you can forget where you come, or where you are from for example America or Israel or Palestine or Jordan, you are a nurse you can see something when you walk in the world. For example, you can help him (points to son) and he is Palestinian, and she is Israeli or Palestinian or whatever. Because nursing takes the heart of people, touch is a feeling from the heart… The nurses all the time [help] us and [give] us a better chance, and [give] us the strength and [give] him all the time to change himself, something like this. The nurses- it’s okay here, with all of them, truly.

Though Amar’s family finds solace with their nurses, my observations of a doctor’s interaction with Ihab and his parents asks for another level of analysis. A second year resident, Dr. Y, entered the room with the patient consent form, which was provided in Hebrew and English. Without smiling or saying hello, he said in English “I am Dr. Y, I will be assisting with your surgery tomorrow, you need to sign this,” handing the papers to Ihab.

Confused, Amar signed the paper. Dr. Y took the consent form, and then explained key changes to the operation, including a change of where the donor skin was to be taken (from the shoulder to the abdomen). Ihab looked at his father, who translated in Arabic. Immediately, Ihab and his mother began protesting, grabbing their abdomens and shaking their heads “no” while articulating their dismay in Arabic. Dr. Y said it was better to take skin from the abdomen, but didn’t provide an explanation. Dr. Y began to leave. Amar’s father hurriedly asked if they were taking the large toe and implanting it to the hand to make a “thumb.” Dr. Y coldly said “not this operation.”
After the doctor left, Amar’s father asked me if I understood him, and if I could explain what the doctor said. Placed in an ethical dilemma of my own, I called for the nurse, told her what the doctor said, and asked if I should explain this to the patient and family. With her present, I explained what Dr. Y had said. Again, the family protested skin being taken from the abdomen. I told them I would ask the nurse to contact the lead surgeon to come and discuss the donor site with them.

Amar’s experience stands in an interesting paradox: while praising nurses, the doctor’s poor communication and lack of respect confounds the excitement of Ihab’s mother when seeing her favorite (Jewish) nurse. While proud to say he felt equal to the nurses, Amar’s father’s experience with border crossing and Hadassah’s bureaucracy tells a different story.

After I conducted the formal interview, I continued to speak with Amar’s father, particularly, looking at pictures of his children and telling him how beautiful they were. We sat in Ihab’s hospital room, with the capacity for two patients, with an Ashkenazi Haredi family. In Hebrew, they were complaining about sharing a room with “mululakim aravim,” which directly translates to “dirty Arabs.” I tried to ignore their comments and focus on Amar’s father. Despite not understanding Hebrew, Amar’s father kept glancing at his son’s roommates, noticing the sly looks they continually flashed towards the other side of the room. Not to mention, “aravim” is audibly detectable as “Arabs.” Noticing their discomfort, Amar’s father speaks to his wife in Arabic. She takes out one of many large sacks to retrieve apples and peaches. She takes the fruit to the Haredi family, smiling and speaking to them in Arabic, much to their surprise.

Amar’s father explains that extending “one’s hand” is better than extending “one’s foot,” “If Jews can take care of my son, I can be friendly to Jews.”
The acknowledgement by Ihab’s father that it is a responsibility to actively pursue peaceful relations in the hospital illustrates the work element of peace. This responsibility is not limited to nurses, but must be reciprocated by patients, family members, and doctors. An agreement to actively develop a relationship with a perceived “Other” is exemplary of agreements found in feminist peace theory – in which the individual, personal relationship is judged as separate from group identity (Porter, 2007).

Reflexivity: Healthpeace Work Healing Nurses

So far, peacebuilding potential has been directed from nurse to patient. In the interviews collected from nurses, one example stands as proof for nurses, who also suffer from the conflict, to be healed by patients. Dafna has been a nurse for more than forty years working in various departments. Halfway through our interview, she asked if she could tell me a story that she thought may help me. Before agreeing, she began:

“My nephew was killed during his military service. He was a good boy, he wanted to help everyone. The women that were watching thought the vehicle looked suspicious – that something bad was going to happen if the soldiers walked over to it. But that’s not what my nephew thought. He thought the person inside the car was in trouble, so he went with another soldier on duty to make sure everything was okay. He didn’t even draw his weapon. And when they arrived to the car, a Palestinian shot him; he shot my nephew and killed him before the bomb went off. The other soldier and the terrorist were the only other two killed. I took several weeks off work, and I didn’t think I could go back. Why? Because I didn’t think I could go back and save the lives of the people that killed my nephew. He was such a good boy, sweet, he wouldn’t hurt anyone. But I decided to try. The first day I walked into the department, an Arab family who had been there several
months hugged me and cried with me. We cried together. That’s when I knew that I could go back to work- that I had to go back to work.”

After the attack, Dafna relied on the stereotypes external to the hospital that contributed to the death of her beloved nephew- namely, that all Arabs are violent towards Jews. Her experience returning to her department and being greeted by an Arab family that mourned her loss with Dafna complicated these stereotypes, and Dafna’s perception of Other conformed to hospital norms- allowing her to continue to nurse “all people.” While this helped Dafna to heal on a personal level, it has political implications. The vulnerability of caring and being cared for, a common factor for most in hospitals, allows for ideologies of hatred, bigotry, and racism- even when they are rooted in the death or injury of a loved one or colored by personal experience- to be complicated, altered, or even completely changed. That Dafna, who felt “justified” in not wanting to care for Arab patients continues to care for them stands against retribution politics and towards a politics of restoration.

Respecting Cultural Difference—The “Line Between Cultural Sensitivity and Playing into Racism and Sexism

While a majority of nurses interviewed discussed not allowing ethnic difference to affect the quality of their treatment, many made allowances for cultural differences, particularly around issues of communicating with patients. Esther explains:

An orthodox man, for example, won’t look at you while your speaking. For me it is disturbing, but I know, and I try not to be upset. There was one woman, for example, that told me “why does an Arab man have to take care of me?” And I said, “he is a nurse, and if there is something for the toilet, for example, we will take care of this.” I try to answer to this- but just because he is Arab, this is not a reason to not be her nurse. We had a
Haredi man, and they said, “we don’t want women to take care of him.” Ok- if we have a man, it will be, but if not… However, this is not that we give in to all the patients’ demands. There is a line between cultural sensitivity and playing into racism and sexism. During the course of my observations, I had casual conversations with nurses that claim that some head nurses will concede to patients who insist on not being roomed with culturally different patients. In one case that was discussed, a Jewish patient’s mother claimed that the patient’s sister was raped by an Arab man, and that she could not be kept in the same room as an Arab woman whose male family members accompanied her. The head nurse put the Jewish patient in a private room. In another case, an Ashkenazi Jewish patient complained that he could not be in the same room as an Arab patient because “all the patient’s visitors disturbed him.” The patient did not want to be roomed with another Arab because ‘to have large family visits is part of their culture.’ The same head nurse denied his request.

*Family Matters: The Inhibiting and Promoting Families*

A holistic analysis of how nurses operate as agents of peace requires interrogating the role of the family in the nurse-patient dynamic. As established in previous chapters, Israeli and Palestinian cultures are both family oriented. Often, when a family member is hospitalized, the entire nuclear family and much of the extended family spend all the day in the hospital, visiting with the patient and with each other. Hadassah, in non-ICU departments, allows one (or two) overnight guests to stay with the patient. Because of the proximity of the family, the relationship that the patient develops (or not) with the family members can either inhibit or promote holistic caring practices between the nurse and patient. Additionally, the nurse becomes a central figure in assisting and “healing” family member’s response to illness and injury, family feuds, and the social impact of hospitalization.
“If you don’t have it, it is very hard for the patient, for the family, because you always, they take the family as a nudnik. But you are not a nudnik. It’s my son, It’s my son. I am sorry (laughs). My feelings are very… it is very difficult for me to see him like this because I know him. I know his personality. So when I see him like this, it is very hard for me. If I say something to the nurse and she is not sensitive, she will say ‘I know, I know what I am doing.’ Okay, she knows, but I also know.”

As we were finishing the interview, Eyal nurse entered his room: “She’s an angel!” his mother exclaimed, her eyes lighter than before. The nurse smiled and spoke with Eyal, asking about his pain and how long his port had been in his arm. Shoshana answered for her son, and proceeded to ask the nurse about the x-ray that was scheduled for later that day. The nurse answered her questions patiently, explaining what would happen in the next few hours. Shoshana listened intently, and seemed relieved. She sat back down on the bed and listened as the nurse explained which medications she was giving to Eyal.

Despite no longer being a patient, doctors and nurses continue to ask me about my own mother, who has become their model example of the “promoting” family. “She is the reason you are doing so well” one nurse told me. I whole-heartedly agree.

_The Terrorist Victim and the Family from Nablus: The Hospital as a “Safe Space” for Social Integration_

On August 2, 2015, a Jewish religious, young mother, Anna, was admitted to Hadassah’s burn unit after a group of Palestinian youth threw a Molotov cocktail into her and her husband’s car in Beit Hanina.

Two rooms over, Zuella has been in a serious vehicle accident in Nablus, and suffered from a crushed hand.
In any other circumstances, the two would never meet, nor would their families. But, as
the families waited together in the family room while their loved ones underwent treatment, they
started speaking. Then they started eating. Then they started joking and laughing together, and
repeated this tradition each day. They asked about each other’s loved ones, and began to visit
each other’s rooms to “check in.”

I followed both cases closely during my final month in the hospital, and befriended both
families. In my first conversations with Anna after a week of hospitalization, I asked her if she
believed the hospital was a place to build peace. After saying no, she continued:

Anna: “I think that when a person meets a person, I don’t know, we are all humanity.”

Naomi (Anna’s mother): That’s what she is getting at

Anna: Wait a minute- but the questions between us and the Palestinians are so big. There
is a <big gap> like, I don’t know how we can bridge between our wishes, we all want this
land, and no one can give up. It doesn’t mean that if I meet a girl in the street I can’t love
her, but we can’t agree about everything. So the peace won’t come between you and me
and the other one and the other one. It’s so sad, but it won’t bring peace, I think. Maybe it
will relax the war.

Naomi: My son sits all the time in the family room. And he speaks Arabic. So he speaks
with all of the Arabic families from Hebron, Bethlehem, and we speak and we share the
food and we have a very good time together. And I am sure those families will come
back- I don’t know how it can be another way that they will understand the Israeli people
are people… I see them again and again and I am saying to myself “you’re going back to
Nablus. What are you going to tell your neighbors? What are you going to tell them? You
got the best treatment all around because you have ben to the hospital in <the Palestinian
Authority> and they sent you here because they know the treatment here is the best.

Everybody treats you just as if you are a human being. Nobody is treated another way than they treat Anna. So how can it be? Because it’s not one, it’s not two, it’s not ten, it’s thousands of them and they are here.”

While Anna and Naomi both acknowledge the ability of the hospital to allow for a “safe space” to complicate “Otherness,” Anna is not convinced that it is enough to change feelings and norms outside the hospital. Hannah, holds hope, though is not optimistic that the friendship her son has developed (at the time) with Zuella’s family will change their attitudes outside the hospital.

My direct conversations with Zuella were limited because of gender norms in some sects of Islamic Palestinian culture. However, her husband, Jabir, reported on his family’s behalf “we can be friends with the Jews. Our friends next door (Anna’s family) proves this. How we love all the nurses, Jew and Palestinian, proves this.”

When I asked him if he would tell his neighbors in Nablus that his wife had been treated in an Israeli hospital, he laughed and said, “they don’t need to know all the details. Just that, Praise Allah, she is alive and has her arm.”

Following up on this case, Esther told me she had a conversation with Zuella’s brother, who traveled from Nablus to see his sister. She reported:

“He said that, for him, before he came to Hadassah to see Jews meant to see settlers. He would be afraid of them and they would be afraid of him. When he came to Hadassah, especially to speak with Anna’s family, whose brother speaks Arabic and translated between everyone, he was surprised that he could speak and eat with Jews like friends-unafraid…He spoke about how the doctors and nurses were fair, and that Zuella loves the nurses. For him this was the most important—she told him that she felt safe. But, he also
said it was only possible inside Hadassah, because he doesn’t know if he could feel the same “outside.”  

Observations of and interviews with Anna’s family and Zuella’s family serve as evidence for the capacity for peacebuilding in hospital settings. Because of the atmosphere created by nurses in the department, including equality in care, positive communication, and inclusivity, patients and families feel “secure” to be vulnerable with each other. However, it also speaks to the idea of the hospital as a “safe space,” where people who do not necessarily share same citizenships or identities to feel they will be treated as equal patients.

**Departmental Culture: Who’s Working this Shift?**

Though the nurse-patient-family relationship is uniquely compelling, nurses operate as a team. In this team, there are nurses,  

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-Zuella (Nablus)

“It was a very bad accident, G-d blessed us that our sons (one of them severely disabled) and I weren’t injured, just my wife.” Jabir told me. He spoke for his wife, Zuella, for two reasons- the first practical, in that he spoke English more fluently. Second, as traditional Palestinian Muslims, the patriarch answers questions asked by non-family members. Zuella was hospitalized in the plastic surgery department after a car accident in Nablus. The car rolled on top of her arm, ripping the skin from her arm. She required many skin grafting surgeries, and was transferred from a West Bank hospital. Jabir, a wealthier businessman, privately paid for the transfer and hospitalization. Zuella watched her husband speak, smiling whenever her husband would speak of her merits as a wife and mother. Palestinians living under Palestinian authority can only have up to one visitor at a time, and permissions are controlled by the ministry of Health and Interior. Jabir returned to Nablus, and Zuella’s mother, Rajah, came to stay with her daughter. Each time I went to the plastic surgery department, Rajah and Zuella made a point to come and see me. In my limited Arabic and with heavy reliance on non-verbal communication, we became friends. When I came to say goodbye before returning to the US, we had a celebratory meal together. Zuella stayed a few more weeks in the hospital before being discharged. She returns to Hadassah every three months, security willing, to ensure her skin graft is healing correctly.

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31 A month after being discharged, I received a report from Anna’s brother, Avihad. He said he received an email from Zuella’s brother, asking about Anna’s condition and speaking of his sister’s recovery. Despite his reservations, Zuella’s brother and his relationship with Aviyad stand as evidence that relationships developed inside the hospital can survive, though with modifications, in the outside world. The intervention of technology, which makes communication possible across borders, is essential to the ease of follow-up conversations.
nursing assistants, secretaries, doctors and residents all responsible for patient care.

In Hadassah, head nurses are directly responsible for nurses and nursing assistants, determining their schedules, mitigating problems, and communicating most directly with hospital administrators. In the three departments I followed most closely, the head nurse also largely determined how nurses worked as a team, what kind of nurse was represented, and how to handle conflict. All three head nurses did so differently.

*Orthopedics*

“I try to make sure not to put everyone from the same religion or group together during the shifts, I want my staff to work well with everyone, and I want them all to trust one another.” Orit told me. Orit is the head nurse in Orthopedics, which has a reputation for a well-integrated staff. Throughout our talk, she repeatedly emphasized diversity and diversifying. While her goals are mainly practical- to insure the nurses are all comfortable working together, asking for help, and knowing one another’s style, Orit’s scheduling has social and political implications. The nurses interviewed in Orthopedics felt comfortable with all the nurses “even if they are Muslim” or “even if they are Jewish” as two informants emphasized.

But just as encouraging as it is to see diversity at work, it is more telling when it doesn’t. Patients noticed solidarity between Arab (Muslim) patients and nurses. One patient said:

I am jealous of the Arab patients. You know, when they, the nurse, the majority of the nurse are Arab, they do all the best, they do good work and everything. But with us, no smile or anything… I am jealous of the Arabs here, because they got a good empathy from everyone, and real sympathy and <charity, Arabic> and they even kiss them. Every time they meet, a new person outside, they don’t do it in the room, but outside. And I say
“Oh my G-d, I am jealous of this Arab guy.” See how he gets, you have a good feeling to have someone sympathetic to you.”

A patient in a different room held similar feelings, stating:

M: They are very, it’s like a family, or even the nurse which are men, most of them are Arabic, only one was Jew, they take care- they are very nice. Just you have to behave. You know when you ask somebody, when you have the time, if it’s urgent you say “I am sorry, I need it immediately.” Or maybe because my problem is a minor problem in comparison to other ones. It’s very nice. I needed a few times after the surgery-because I couldn’t go to the bathroom by myself-and they put so many liquids that I needed every minute- and it was okay. It was okay.

J: And is there a cultural difference if a nurse is Arab or if a nurse is Jewish, does it change how you feel you are taken care of?

M: Look, this is a matter of the political situation. You feel they are trying to make their best professionally, even more. But sometimes you feel we are a country in war. They, they are Arabs, you cannot deny it.

J: How do you feel it?

M: Maybe it’s because I am a journalist that I can feel it, ok? I feel it, I feel it, but they’re nice. They are trying to make their job. Even though they spend more time with Arab patients like here (references other bed in room) a very friendly patient, but you can, you can feel it. It’s not- it’s only not- it’s almost utopical to put together, especially after the events we had recently. So it’s Jews together with Arabs, and the crew, which is mostly Jew and Arab, where the Arabs are mainly men and the Jews are many women.

J: Do you see it even from a gendered perspective? Do you feel it is different being cared for by a woman than a man?
M: There are the differences, but no. Not very, no, it’s okay. But you feel it. And once they are with you they want to show you that it’s good, that everything is okay. But it’s not like with the Arabs when they stay with them and speak with them. They are there a long time. The Jewish women are more focused on their job and wouldn’t spend so much time, and I understand that. It’s like when you are a Jewish nurse in Italy and you have a Jewish patient in the hospital, I guess it would be the same, she would do the same. But you can feel.

The jealousy patients feel when they perceive they don’t receive the same degree of attention and/or unequal time exemplifies the acute sense of how patients expect equality, particularly based on ethnic belonging.

*General Surgery*

The general surgery department has a high turnover rate, and tends to have a high rate of head coverings on nurses—hijabs and headscarves. Why religious nurses are attracted to this department is a puzzle, though proves sociologically interesting. Though external efforts to build camaraderie are mostly non-existent, the head nurse makes an effort within the department to de-escalate political tensions. The head nurse explains: “We don’t talk about politics in the department. Never. Maybe two by themselves in the corner, but it is not tolerated publicly. Too many nurses have too many friends and family members outside, and the emotions when someone feels insulted affect the team for the whole shift, and sometimes longer.” Purposefully excluding political conversation creates the space for Hadassah’s norms to take full effect without conflict. Inside the hospital, nurses live in an alternative reality—one where the conflict outside is external to self, patients, and fellow nurses.
Plastic Surgery

Plastic surgery is completely different from Orthopedics and General Surgery. The head nurse, a Russian Jew who immigrated to Israel when she was five years old, had a gentrified (Russian) department until the new hospital building was ready, at which time she became the head nurse of plastic surgery, ear nose and throat, maxillofacial, and hand surgery departments. While her team diversified, it is still majority “white.” As she nears retirement this year, two Muslim male nurses were hired, a first in the department’s history.

In January 2016, a collaborator contacted me to tell me of what was happening in the plastic surgery department. Staff changes had altered the department demographic, adding Arab Muslim nurses where there were once Russian and Ashkenazim. The head nurse, herself Russian, had been scheduling the Arabs to work together exclusively some shifts. When a Jewish nurse was scheduled for the same shift as the Arab shift, she found it difficult to have effective communication. This was caused by two variables: first, all of the Arab nurses were speaking to each other in Arabic. “What if they were talking about a patient? And what if something happened to this patient, and I didn’t have any idea about what was going on with him because they spoke in Arabic? It’s dangerous! I don’t mind if they talk in Arabic themselves, but if they are in front of me at the same nursing station as me, I need them to speak in a language I understand.” Kehina told me, her words sticking together as she became more and more upset. Second, the Arab nurses avoided her. Whereas the staff normally sat together for meals, sharing salads and bread, the Arab nurses were all “busy” when Kehina asked them to dinner, only to sit together for a meal after she was finished. “It’s not that I care, but I feel they are doing it on purpose,” Kehina asserted, though it was visible that it bothered her more than she said.
I called a friend and collaborator, Esther, in the same department to see if she had noticed similar problems. She replied with the following:

“Yes, of course this is a problem. Yesterday, I worked a shift after them (the all-Arab shift), and I had a patient who was dirty and abandoned. The chart said he had been bathed, but I couldn’t believe it. The man was non-compliant, so I called Marwa (the nurse in charge of the previous shift) and asked if the man had been cleaned or not. She said: ‘You know Muhammad cleaned him, so why do you ask? Because we are Arabs?’

I told Marwa that to say this was really not okay, because it’s not true, the patient is non-compliant and stinks, so I have to ask. Then I told her that she needed to check herself because she had never said anything like this. It hurt me! I thought we were friends, and I have supported her as a leader even though she is so young.”

The experiences of Orit, Orthopedics nurses, Kehina, Esther, and the “Arab shift” expose the magnitude that composition of the nursing staff can have in either building bridges or reinforcing stereotypes. Head nurses, who determine the nurses’ schedules, bolster tremendous responsibility in staff integration. Without carefully mixing nurses...
from different cultures and subcultures, she risks creating clusters of nurses who are distant from the others. If these clusters are one day broken, nurses may not work as a cohesive unit, and conflict may arise.

**Conclusions**

In this chapter, I have attempted to interrogate the details of multi-ethnic relationships formed in Hadassah.

I have specified nurses’ processes in relationship building, which is both medically and socially therapeutic for the patient and their family members. Guided by Hadassah’s norms, nurses, patients, and family members experience a high level of exposure to Other in a safe place. Extraordinary circumstance and the hospital unite people, whether they are employees who guide patients and families through vulnerable times, or the patients and families themselves. In the following chapter, I will expand on how these connections transcend the walls of the hospital.

I have shown that not all nurses practice the same model of “cultural care,” while some neglect it completely. By interrogating coloredness, I examined the fractures that nuance times when nurses fail to give cultural care. I suggest the reader walks away with these examples as an afterthought—as they were exceedingly rare. However, it is essential to document failure in order to address it. The effectiveness of nurses as peacemakers is still dependent, in part, on the departments’ atmosphere, which is primarily orchestrated by the head nurse. While the nurse-patient relationship is vital to nursing to peace, so too are the relationships formed between nurses in the department. Their repeated exposure to each other over years of work occupies a unique place in this research—as nurses’ intimate exposure to the lives of Others are largely
shaped by these repeat exposures. They can either help a nurse with her patient, or continue to harm it.

Hadassah, as a permeable physical location, can act as a site for inducing positive co-existence. But as I conducted this research, I was always curious that nurses didn’t think it could exist beyond the hospital walls. In asking why, I understood that it does. The next chapter details that process.
Chapter VI: Beyond the Walls: Transcending the Institution

The transformative process that occurs within Hadassah would only serve as a model for positive co-existence without examining how relationships and memory shapes patients’ and nurses’ lives long-term. Nurse and patients rarely become “friends,” but many maintain casual or professional relationships. These connections resemble Granovetter’s weak ties, which he asserts have the power to transform network relations. He explains:

“Ego will have a collection of close friends, most of whom are in touch with one another—a densely knit clump of social structure. Moreover, Ego will have a collection of acquaintances, few of whom know one another. Each of these acquaintances, however, is likely to have close friends in his own right and therefore to be enmeshed in a closely knit clump of social structure, but one different from Ego’s. The weak tie between Ego and his acquaintance, therefore, becomes not merely a trivial acquaintance tie but rather a crucial bridge between the two densely knit clumps of close friends.” (emphasis added).32

Subsequent use of Granovetter’s “strength of weak ties” have confirmed that the ability to use weak ties is classed—people of lower socioeconomic status tended to rely on strong ties because either 1) believed it was their only option 2) their weak ties were the strong ties of their relatives and close friends, limiting the “bridging” of weak networks. In his book Unanticipated Gains, Mario Luis Small confronts this phenomenon in daycare settings, but ones where mothers were ethnically diverse. According to Small, the “weak ties” created by repeated exposure and infrequent cooperative activities expand mothers’ networks more than strong ties because they

work against homophily, He adds that “actors may form ties either purposely or non-purposely; that forming ties either purposely or non-purposely depends on the context of social interaction; and that the context of the interaction can be shaped significantly by institutions.” (Small, 2009)

Similarly, in the context of my research the relationships that are maintained once a patient is discharged are considered “weak.” While you won’t often see a nurse and former patient getting coffee together, patients frequently will email nurses with questions or updates, and similarly nurses request this kind of report from patients. Moreover, memory serves as a conduit for political and social nuance by defying the collective memory. These “weak” ties, established in a particular time and space, complicate the strong tie to collective memory.

Extraordinary circumstance of hospitalization—particularly in an institution that attempts norms of multi-culturalism- creates the possibility for acquaintance making far outside ethnic belonging, geographical location, socio-economic status, or religion/religiosity.

This chapter contains how nurses’ relationships with patients and other nurses transcend hospital walls, first examining the role of the Internet, memory, and nurses organizing outside the hospital. I ultimately argue that the series of one-on-one connections formed in the hospital contribute to a mounting movement towards social change.

The Internet as a Site of Connection: Potential Burdens and Benefits

“You’ll love him,” my research advisor said as we were gliding through the long hallways of the new building, “he is a reporter with the AP in Gaza. He was injured last summer [during the 2014 war] and was sent here by the AP. He is back for a secondary surgery.”

I have stopped asking Sarah how she keeps up with patients to know when they are returning. In our time working together, I have witnessed the floods of emails that come from former patients
and their families. Some have her telephone number, and call her when they need medical advice, are returning to Hadassah, or just want to give an update.

While citizenship and borders can hinder opportunities to “befriend” outside of the hospital’s context, the Internet creates a virtual space for nurses and patients to maintain relationships.

Upon entering Azzam’s room, the man sprawled out on the bed expressed his excitement with a prolonged “SARAH!!!!” opening his arms wide. She smiled, spread her arms just as wide, and returned an “AZZAM!” Their excitement to reunite was contagious, and soon Azzam’s wife joined in the fervent chatter. They talked about Azzam’s injury, his colostomy, children, housing situation, and the ways that the omnipresent conflict was affecting nurse and patient’s life.

Other nurses I casually asked outside of interview context also admitted having former-patients as Facebook friends or as email contacts. While emails frequently contained follow-up questions to care, Facebook was a platform in which pictures of self and family, achievements, and burdens could be shared and acknowledged.

Anna, Esther, and Zuella: Six Months Later
(Settlements, Jerusalem, and Nablus)
On 7 October 2015, Esther received a message from Nadir:

Dear Esther,

How are you? Is everything OK? I am Nadir, Zuella’s brother from Nablus. Do you remember us? As you know… the situation in West Bank & Jerusalem is really hard these days. So is it possible to delay the appointment for Zuella or not? Please, write back soon.

A few hours later, Esther answered Nadir’s email, and in addition to logistical questions, added:

“I pray for better days where all this craziness will end and that we can live in peace for everybody. I remember our conversation and my heart cries. I saw Avidad and Anna and her mother a few days ago and we spoke about you and we keep a very good [memory] of all of you. I wait for the day where I can see Zuella and your mother and you in the best conditions.”

Esther, Nadir, and Anna continue to stay in touch via email at the time of this writing, and reunite whenever Zuella has follow-up appointments at Hadassah. The level of intimacy shared after discharge is variable, but typically compartmentalized to follow-up questions, appointments, and check-ins. These conversations do not disclose intimate knowledge about the nurse, which includes discussion of relationships, family, and spirituality, but can include intimate information about the patient because of the insider knowledge the nurse may possess.
A month after leaving Hadassah, Amar posted pictures and a story about Dr. Feldman, his surgeon, on Facebook. In the post, he praised Dr. Feldman as “the sun that shines… energy to perform a 16 hour surgery to save my arm.” The public acknowledgement of his Jewish surgeon in an Israeli hospital- despite being from a small village outside of Hebron, speaks to the power of positive relationships with healthcare workers in the peace process. In the post, he tagged several of the nurses that cared for him, who he remains Facebook friends with and in contact until today.

After our interview, Amar added me on Facebook. As fellow trauma survivors, we occasionally message each other with health and wellbeing updates. Amar knows that I am becoming Israeli. At the conclusion of each of our messaging sessions, he will write a message of hope for peace. Below is the most recent example:

“I send a message of love for all Palestinians and Israelis live with love and respect and the relationship of brothers”

For many, the Internet is a space where physical borders and sociopolitical boundaries are relaxed, allowing for vulnerability to be expressed through private messages to people “far away.”

Despite many positive relationships that have continued and “grown” offline, Palestinians are particularly at risk for facing backlash. While Palestinians will take pictures of themselves with their Jewish nurses, they ask for such photos not to be shared on Facebook. If a Palestinian nurse comes to a conference in Israel with Jewish Israelis, she will either avoid the camera or asked for photographs not to be shared. If the Palestinian Authority’s security forces see such images, they may flag the person’s record for corruption.
Memory as Transformation

Individual and collective memories are responsible for how conflict, and subsequently peacework, takes form. According to Cairns and Roe (2003):

“While memory may play an important role in creating and recreating conflict, in reactivating it from the form in which it may have lain dormant, perhaps for several generations, this is not what we see as the most important role of memory in conflict. Instead, we believe that it is important to study the relationship between memories and conflict for their potential role in helping resolve conflicts. This is related to the fact that such groups are often left with a sense of ‘victimhood’ that stems from unacknowledged and unreconciled historic losses. These in turn present a powerful barrier to traditional methods of peacemaking and diplomacy and create new senses of wrong and injustice thus creating the potential for future conflict.”

Israelis and Palestinians share a sense of victimhood that has complicated traditional diplomacy efforts, and further thwarted co-existence by constant violent retaliations stemming from mutual ‘vulnerability.’ Interactions within the hospital complicate individual memories, where soldiers and nurses share space in constituting “Israeliness” and terrorists and their Palestinian victims constitute “Palestinianess.” This section explores how otherness is reconstituted by memory during and after hospital stays.

The Soldier and the Nurse: Complicating Israeliness

For Palestinians holding a red, orange, or green identity card, their first exposure to an Israeli is as a soldier. Combined with the collective memory of acts of war, Israeliness is constituted as militant soldiers. Amar’s father spoke about how the only Israelis they were exposed to before coming to Hadassah were soldiers, and three other Palestinians with red, orange, or green
identity cards specifically recalled the same. In other interviews with Palestinians, they either held blue cards, and were exposed to Israeli society more regularly, or didn’t specifically mention their exposure to soldiers as dichotomous to their exposure to Hadassah nurses. Examples that permeate this text show how nurses- Jewish or not- nurses comprise a different “Israeliness.”

Azzam had returned to Hadassah for yet another surgery. While he described his relationship with the nurses as a healing one, his wife’s response was more telling as to how one reconstitutes Israeliness:

“After the explosion, he was here sleeping [comatose] for two and a half months. MONTHS. And every day, the nurses came in and washed him, they spoke to him even though he was asleep, and they took care of his wounds. They would shower him in the bed, *(husband interjects): I couldn’t move, and they would move me!* In the hospital I see that everybody doesn’t say he is from Gaza or there or there, he is a sick man, and that’s all. He is a sick man and they want to help him. It’s not about Israel or Palestine, it’s that Azzam could have died and he didn’t. They cared for him and they didn’t have to.”

Azzam’s wife, pragmatic in her approach, notes that Israelis “didn’t have to” care for her husband, which resulted in saving his life. This defies the typical collective memory Gazans in particular hold for Israelis—soldiers who harm rather than help. Nurses offer a stark alternative to soldiers, which complicates how one constructs the enemy. While continuing to harbor the cumulative and individual experiences of Israeli military presence, patients and families treated
by Israeli nurses must simultaneously hold a new memory that directly defies established Otherness.

_The Terrorist and the Victim: Complicated Palestinianess_

Just as Palestinians’ experience of Israelis can result in reconstituting Other, so too are Israelis changed by having Palestinian co-workers and patients. Outside of the hospital, Israelis are only exposed to Palestinians through military service and collective memory, which reinforces the terrorist stereotype. Many nurses that were interviewed admitted a change of heart in their nursing career, explaining that the longer they are nurses, they see people as people, not as enemies, but as “human beings.” When I asked one nurse if it was just a body to care for, she corrected me,

“No, I don’t distinguish between them, and they will receive the same treatment, but they are unique, all human beings are, and have to be treated like their own person. I am not here to change his mind as my one purpose— I take care of him, because he is a human being. Maybe he doesn’t love me. Maybe he hates me…but that’s not important. He shows me something else,
Question: Does Nursing Have a Political Impact?

TR20 I would really love to have an impact and a positive impact on all the patients who come, and give them hope that everything is possible if we just try to understand each other- the language of the heart. Because I don’t think that language is a barrier- the barrier is if you are blinded by your own fears. And when you discover that the person in front of you is the same human being as you- the same needs, the same hopes, so this is how I think we could- and should- begin to live together.

TR26: Social. Not politics. I don’t believe in politics. I am even getting mad when they talk about politics, because we are not here to treat by politics.

TR28. I can tell you it’s my dream to progress the peace here, we are in a society very complicated. There so many people here, there are the Jew, the Arab, the Muslim, the Christian, so many cultures. For me, this is my dream to progress peace. It’s a part of my profession, to help everybody, to show them that we can, like, be together, we can have peace among us, and I show this to my patients. For example if a Muslim is in the bed and beside him is a Jew, I can even make them meet. I can make a good atmosphere between them in the hospital. But outside, it’s difficult to control this because you don’t know what happens afterward. It’s a difficult situation now in Israel and in the State. In my position here in Hadassah, I try to assemble between the patients, to make a good atmosphere between everybody. But outside, it’s difficult. Very Difficult.

“No. I don’t believe it. I believe that everybody can be together, I don’t think like this (that everybody is separated into stereotypes) I am okay with everybody, usually… No I don’t think so, unfortunately. Because everybody they come with their culture, their education, with their thoughts, and I don’t believe that because he is a patient I can change him.”

“It could be. Listen, you can’t make a “bill” (you can’t tally up). We had several times who were arrested and brought to here, and they were very aggressive with the police. We have another role, we have another role, even one spit at the police officer, and he did not have good behavior. But you have to take care of him. So I do it. This is how I see it. Not that I like him, or I justify him, I don’t think he is right, I am not from the left, the opposite, my role is to give treatment, and it doesn’t matter to whom. I am really like this. I don’t do less if it’s an enemy or not. Maybe I am lying a little here, but generally yes

“Here, we will tell it like this. Right now in room four, there is someone Arab. But he’s a prisoner. He attacked an Israeli soldier. It’s a mess. Because he’s a prisoner I will not take care of him? Or because he attacked another Jewish soldier I would not take care of him? I am here for him, for everything he needs, for his well being. But a part of the nurses won’t. He’s an Arab man who attacked a Jew, so no. They won’t give him treatment. So part of the nurses will give treatment and a part won’t.”
Nurses describe the process of getting to know Palestinian patients as “lehetyaches” (라도ח), which is translated to “to treat, to refer, to relate, to hold true, and to regard.” The root of the word, yachas, (יחס), means “relationship, connection, and treatment.” In order to build this relationship, nurses learn to listen, even if the truth of their patient runs counter to the truths they themselves hold. The term “yachas” is personal- a connection between two people established on trust. While it is the nurses’ professional interest to build trust with her patient, this trust has personal implications. Building relationships with Palestinians—terrorists, terror victims, trauma victims, and the uniquely ill diversify Palestinianess for Israeli Jewish nurses. While this may or may not change their political views (both were noted in interviews), nurses acknowledged that getting to know patients and holding them as paramount memories has nuanced their political beliefs. “It’s complicated,” one student nurse told me, “I served in the military. I know what is possible from them, but in the hospital, they can be just people. I am not afraid of them here. It’s a different experience, and it makes me think of all the things in the military I wish we didn’t do.”

*The Pervasiveness of Memory: A Syrian Story*

During my time at Hadassah, I networked with dozens of nurses at other hospitals in various hospitals across Israel and the Palestinian territories. At three of these hospitals, they were treating Syrian non-combatant victims, primarily women, children, and the elderly. Syria and Israel have not had contact in the existence of the State of Israel, and animosities towards each other are socialized early, particularly around the borders. The border region sometimes experience quasi-battles. Collective memory, rather than personal experience of Other, shape how Other is constituted.
One nurse described to me the interactions between the two over time:

“At first we didn’t know how to speak to them, or if we were supposed to (if the military had reason for us not to), if they would speak with us. Many of us speak a little Arabic, so if we wanted to, we could. They seemed scared of us too, and were very closed, their arms like this (brings shoulders and arms inward). We didn’t know what to do- these weren’t Palestinians like we were used to—we didn’t know what to expect. So we treated them, and when we learned they would stay a while, and we knew we could speak with them, we tried.

Just little things at first- ‘how are you?’ ‘what kind of music do you like?’ (and we would play it!) ‘do you like this food or that?’ It seems silly, but we didn’t know how they

The Internet as Communicating Gratitude

While writing this chapter, I heard of a website created by a Syrian refugee (Turkey) who was treated in an Israeli hospital to thank his caregivers. Called “Thank you Am Israel,” the website serves as a platform for Syrian refugees who were treated in Israel to thank their caregivers anonymously. Because danger still exists for Syrians that have had contact with Israelis, anonymity is required. One post reads:

“I remember my own astonishment when the first news reports began to circulate of the assistance being provided to wounded Syrians by the IDF’s medical teams on the Golan.... I will never forget the phone conversations I had with elderly Syrians being treated at a northern Israeli hospital, of the stories I heard of the world-class limb replacement and cancer treatment that Israeli medical staff were providing.

A people who I had been told all my life I was at war with, were proving themselves more humane and more compassionate than the Arab countries I, as a Syrian, was no longer welcome in. Dark days may bring out the worst in people, but they also serve to illuminate the truly enlightened societies. Every humanitarian catastrophe is also an opportunity for individuals to display the best of humanity, and as a Syrian refugee myself I can truly attest to the fact that this generation of Jews have done their people proud.

And as a Syrian, I am morally obligated to ensure that the goodwill that Israelis and Jews have displayed towards my people will not be overlooked nor forgotten. The day will come when the conflict in Syria will come to an end, as all things come to an end. **On that day, it is imperative that Syrians reciprocate the enormous goodwill shown towards us by Israelis and the Jewish people.** Whatever supposed reasons we may have had to be adversaries is dwarfed by the compassion shown to us during our darkest days, a time when we have nothing to give back except our gratitude.”

( emphasis original)
would react. But they started smiling, and slowly slowly, their shoulders weren’t in their ears. Then we could ask things like “what happened?” or “how can we help you?” Many wanted to find their families. We did the best we can, and with the military, found many of them who were in refugee camps in Jordan. When they learned that once they healed, they would also go to Jordan, they didn’t want to leave. They didn’t want to leave the comfort of the hospital to go to a refugee camp, and we didn’t want them to go. It was a big dilemma for the nurses—to treat them, to heal them, to love them, and then watch them leave to a refugee camp where they won’t get the same care. *They weren’t our enemies, they were our patients.* And I think something changed for them too— if not, wouldn’t they want to be reunited with their families, even in refugee camps?“ (emphasis added)

The transformation from enemy to patient described by the nurse instantaneously occurred when each was admitted to the hospital. By becoming a part of the hospital institution, the political implications of his identity became unimportant, but his identity as a Syrian—who spoke only Arabic—was continually recognized. Rather than an erasure of who the patient was as a human being, becoming a patient diffused the political tensions. That the first Israelis he ever knew were his nurses, imaginably, diffused the same political tensions, allowing for a care-centered relationship to develop.

While unable to speak directly with Syrian patients, the nurses I have heard from all recount that, after time, bonds are formed. While they know they likely won’t keep in touch, the memory of their Syrian patients has transformed how they constitute “the enemy.”

The author of this post, Aboud Danachi, emphasizes the shared humanness of Syrians and Israelis, particularly Israeli Jews. Perhaps, in situations of extraordinary circumstance, our shared
humanity is more evident, and nurses act as conduits of human kindness to spread and receive this message.

In all three of these examples, a series of one-on-one encounters have complicated the collective memory and reproduced stereotypes of what “Other” means. As memory persists beyond time and space, memory can nuance perceptions of Other. (Cairns and Roe, 2003)\textsuperscript{33}

\textit{Nurse-to-Nurse Transcendence}

In addition to influencing patients and their families, nurses have a significant impact on each other. The need to work as a cohesive team sets the tone for the hospital—where one is to put differences aside for the good of the patient. Each department has a unique way of tackling team cohesiveness, particularly across cultural, ethnic, and political boundaries. For instance, in plastic surgery, doctors, nurses, and nursing assistants will join together a few times a year for a party at one staff member’s home. In other departments, including internal surgery, team meetings are a time to address potential conflicts and build trust.

As has been discussed in previous chapters, relationship building takes time. In this way, nurses are simultaneously social brokers and the recipients of such brokerage.

\textit{Nurses in the Middle East}

“We have to meet in secret,” Julie told me from the chair near my hospital bed, “it’s dangerous for the nurses from Palestine to meet with us.”

My introduction to Nurses in the Middle East seemed like a morphine-induced hallucination, yet the reality of the organization hit me in follow-up conversations with Sarah, the group’s fearless leader and the trauma coordinator at Hadassah. After a year’s recovery, I began working for the organization from a distance, and during the course of my research, became the administrator for

the organization. My proximity to NME 
denotes not only my belief in its mission and 
efficacy, but my access to its members, 
conflicts, and successes.

Nurses in the Middle East began meeting in 
2011, and became an official non-profit 
organization in Israel in 2014. The mission 
statement reads:

“We seek to encourage nurses to be 
ambassadors of caring and through 
patient care, create communities of 
compassion & understanding. While 
our political systems have built 
borders and checkpoints, we insure 
that care has no boundaries and 
carries no identification card. 
Through outreach, nursing exchange, 
education, and research, we build 
lines of communication throughout 
our region and the world. This 
network supports community and 
individual holistic health. “

**Nazzar (Hebron)**

During the First Intifada, I was part of Fateh,” he said. We were outside a hotel that borders East Jerusalem from West Jerusalem, the summer sun still shining as Nazzar lit another cigarette, “and not a little person in Fateh, I was an officer. I have been in fights with Israelis- hurting them and being hurt. That’s how I got this scar” he continued, pointing to his forehead where a distinct scar ran a few centimeters. “I went to 

The Palestinian Nurses Association, upon 
receiving the news that he would be investigated, 
decided that he could no longer hold membership. He 
ends his belonging to the union at the end of the 
month, which means a los of benefits for him and his 
family.

While he came to the conference, he was 
honest about his need to physically step away from the 
group for the next few months. While he was 
investigated, he would use a different email address to 
maintain communication, and would receive updates 
from other group members.
The fourteen-member board of directors has representation of major stakeholders—Israeli Jews, Israeli Arabs, and Palestinians from hospitals and health organizations in the Jerusalem area. The group is careful to balance the number from each group, abstaining from over and under representation.

Despite friendly insistence that the actions of this group of nurses are inherently political, the nurses insist that they don’t “enter” politics, but instead focus on well being. Yet, efforts to navigate licensure laws for Palestinian nurses, influence patient-transfer policy, and create a network of nurses that will insure continuity of care across borders make political statements. Moreover, the group’s existence is political, as it urges Israeli-Palestinian cooperation.

These statements can come at a high price to some. Joining the organization can be a risky move for Palestinians. In 2013, after a too-revealing Facebook post by a new member, the dean of a nursing school in Palestine was told to stop her communication with Israelis or be removed from her position. Students boycotted her classes. She ultimately ended her affiliation with the organization.

Current Palestinian members, particularly the women, refuse to allow their pictures to be publicized on the organization’s website. They fear the repercussions of their hospitals, communities, and even their own families. In the course of writing this chapter, I learned that a pivotal member is under investigation by the Palestinian Authority for “normalization” activities.34

34 Normalization refers to actions, systems, organizations, or relationships that make the “Israeli Occupation” ‘normal.’ These charges are often used to discourage Palestinians from forming ties with Israelis.

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*Crossing the Border with Stoma Bags*

A patient living near Bethlehem was treated at Hadassah before being sent home with a stoma. However, he soon learned that the matching bags were not available in the West Bank. He called a nurse he knew at Hadassah, asking if she could help. She bought the bags he needed and gave them to a nurse she knew from the group to give her patient in Bethlehem.
Despite the political risks, leaders in the Palestinian nursing community make an effort to be involved in various capacities; for instance, the president of the Palestinian Nurses Association participates in conferences, and is instrumental in recruiting new nurses to the organization. This past year, the Chief Nurse of the Palestinian Ministry of Health attended the annual Middle Eastern Nurses conference. Participation of such nursing administrators is demonstrative of the maternal care nurses give to their community. Their political activities tend to reflect the defense of health for all, even if that means cooperating with the “enemy.”

**Conclusions**

In this section, I have followed how the bonds formed inside the hospital transcend it. Bonds, such as keeping in touch over the Internet and nurse advocacy organizations, are weak. Like Mario Small, I assert that these weak ties expand individual’s networks, and thus opportunities. These weak ties work as “expansion” because it works against homophily— the clustering of people based on similarity to self.

The second element I introduced in this chapter is the idea that the persistence of memory transcends the hospital. Memory does not require people to stay in touch for them to remain connected. Memory is both individual and collective—and while collective memory is often responsible for the socialization against a certain feature of a person, individual memories can hold negative and positive experiences in tandem. Michael Ignatieff writes: “We tend to vest our nations with conscience, identities, and memories as if they were individuals. It is problematic enough to vest an individual with a single identity: our inner lives are like battlegrounds over which uneasy truces reign; the identify of a nation is additionally fissured by region, ethnicity, class, and education.” (1998)
By interrupting the so-called “national memory” in individuals, a shared humanity is revealed. This shared humanity reveals the possibility of new, innovative peacework taking root. While experiences of “Other” beyond the stereotype create nuance, they do not replace alternative experiences of Other. This sweet, interrogated Otherness is what creates honest dialogue and open minds to listening to different sectors of society.
A New Starting Point

1. Peace is the absence of violent conflict—including war, vigilante attacks, and terrorist attacks
2. Peace is assurance of shared resources—including food, clean water, and energy
3. Peace is the right to freely and safely travel—regardless of checkpoints and borders
4. Peace is guaranteed equality under the law
5. Peace is social equality for marginalized groups
6. Peace is equitable solutions for dealing with the past
7. Peace is equal access to health care and medical treatments

In Israel, the efficacy of acting as a peacemaker is grounded in gendered norms. Since women are trained to be maternal, these qualities extend into their workplace (Izraeli, 1993). The collected interviews, shared in this text through quotations and sidebar narratives, serve as empirical evidence of how nurses at Hadassah disrupt categories that typically compartmentalize people. Nursing is a profession where actors encounter people in heightened vulnerability, and this vulnerability facilitates nurses’ ability to preserve, foster growth, and train is facilitated by diminished barriers against Other. Replacing the hostilities of war, nurses are permitted access that leads to deep and profound connections that are therapeutic within the hospital’s walls and beyond them.

Additionally, by choosing their profession in a zone of conflict-in-flux, they become the creators and reproducers of Hadassah’s “bridge to peace” model. Without realizing their roles as social brokers and—to the more liberal mind—peaceworkers, nurses assume the responsibility of nuancing Otherness. This effect stretches Ruddick’s original Maternal Thinking, which wasn’t written for a zone where war, terrorism, and violence were the norm. In taking Maternal Thinking into the realm of nursing in Israel, the relevance of Ruddick’s goals of maternalism heightens for others in the field of peace studies, conflict resolution, and diplomacy.
Throughout this text, I have referred to nurses as peaceworkers. Reflecting on the seven components of what “peace” means (above) and this body of work, why I name them as such becomes apparent. In their interactions with patients, family members, and colleagues, nurses are the foot soldiers of these goals. Creating connections with patients and families is an act against violent conflict, and the radicalization that leads to them. Listening to the pains and joys of people’s lives, particularly when created by extraordinary circumstance, is a step towards equitably dealing with the past. Equality in care works against inequalities for marginalized groups, inaccessibility in care, and unjust distributions of resources. Demonstrating such equality paired with a nurse’s genuine investment in her patients’ wellbeing stands as proof that coexistence is possible without overbearing security presence.

More than being the “hospital on the hill,” the weak ties nurses, patients and families keep expands the influence of Hadassah’s norms while increasing individuals’ networks. The pervasiveness of memory in the quotidian further shapes how nurse and patient constitute Other, which can transform how people from different ethnic groups approach each other in the future. Nurses who use their profession as a form of activism—such as Nurses in the Middle East—extend their professional values to advocate against policies that perpetuate inequitable access to resources and rights that constitute a good quality of life.

In concluding, I want to address how we, citizens of the world, can facilitate nurses caring in conflict zones. I propose that governments, societies, and individuals are all responsible for easing the burdens of caregivers in order to facilitate their ability to heal persons and societies.
Caring as a Political Strategy

Philosophical arguments often juxtapose ethics of care with neo-Kantian morality to oppose moral universality. In doing so, care has become a moral modality in and of itself, and by some scholars, the ethereal modus operandi. This is to ignore other forms of virtue and life that also deserve consideration in social and political pursuits for rightful living. In this study, even the nurses themselves—our caring actors—have compounding ethical interests—that of traditional justice, loyalty to one’s “family,” utilitarian ethics, and an extended ethics of care. To prioritize the caring voice would be to impose the same form of ethical imperialism that kept care out of mainstream ethical conversations for centuries. Each of these forms of justice deserves consideration in order to achieve political and social justice, particularly when violent histories create tension in daily life.

Care transects other principles, posing the challenge to make human societies more moral. Tronto writes that care’s potential to increase morality is true on two planes: first, care’s centrality to human survival makes it a critical standard. Second, focusing on care is to focus on the process through which life is sustained. In order to perpetuate human (and group) survival, care holds the potential to put moral ideas into action.

In the context of nursing as peacework, care as a critical standard and care as a transforming standard deserve attention. Mainstream media and nationalist politicians on both sides present the conflict between Israelis and Palestinians is one with an innate introversion; as the concept of nation-state is tied to physical location, Israeli Jews and Palestinians very existence is one that can only continue if the other is eliminated or expelled. As both groups have endured this reality for centuries, fighting in the name of “existence” has become the standard.
I propose that care offers an alternative. As demonstrated by Hadassah nurses, caring for and about each Other allows Israelis and Palestinians to act against the nation-state standard of violence in favor of mutual benefice.

In her book *Moral Boundaries*, Tronto explains that her recommended “paradigm shift” is not to “overthrow” current moral premises, but to highlight they are incomplete. (1993). Incorporating caring practice into our private lives and our collective political life takes attention to the particular. Nurses live in these particularities, which grants them unique access into the cross-sections of hegemony and counter-narrative. Situated in the nuances, nurses are healers and political actors all at once. Listening to their voices is to collect the wisdom of how all sectors of Israeli and Palestinian society can live together.
Afterward

In the spring of 2016, I attended the fourth Annual Nursing in the Middle East Conference and gave a presentation titled “Nurse Healer, Peace Builder: Implications of Therapeutic Relationships between Nurses and Patients.” The conference was hosted by the Nurses in the Middle East whose organization was discussed in the previous chapter. The conference was co-hosted by Watson Caring Science Institute, whose name partnership drew many participants from all over the world. We met in Jordan because it is the closest “safe” space in which Israelis and Palestinians can gather without the Palestinian Authority seizing nurses’ licenses. American co-sponsorship through the Watson Institute decreased suspicion from the Palestinian Authority, who would consider Nurses in the Middle East as a normalizing organization. This year, the Chief Nurse of the Palestinian Ministry of Health was able to attend because of international sponsorship. While this threat was most stringently faced by Palestinians in the West Bank, Jordanian nurses who are members of the national nursing union faced expulsion if they attended the conference.

My participation in this conference was made possible by Wellesley College’s Schiff Fellowship, which granted me the time and funds to present my research while collecting new data from conference participants from all over the world. In addition to Israel and Palestine, nurses from Iran, Jordan, and Pakistan were in attendance.

Mary Jordan US (California)

“I told you I would tell you some stories.” Mary had stopped me on my way back to the conference room in Jordan. More jetlagged than I was, she was sitting outside the hotel, overlooking the Dead Sea, a beer and pistachios sitting on the table.

“Yes,” I answered, “I would love to hear them.” I sat down beside her, declining the bowl of pistachios she lifted towards me.

“I was a little girl during the war (1967), and my parents and other adults would talk about what was happening. They don’t always think about what that can do to a child. So I had the image in my mind that Israelis, that Jews, were monsters. A few years later, I was a young adult, and I needed to cross the border for the first time. Whenever I arrived to the checkpoint, I remembered the monsters I had imagined as a child, and I was horrified. I am a fairly rational person, so I couldn’t understand why I was thinking this way- it wasn’t okay to think this way. A few years later, and I crossed the border again, and I had the same thoughts. I was going to speak at the University (Kfar Saba, Tel Aviv) and before I started my lecture, I told the audience, I said ‘look, I am a little frozen here today, so please cooperate with me, I want to tell you why’ and I told them. They were very understanding and supportive. Why do I tell you this? Because it’s so easy to demonize the other, we can’t help it when that is what we are told. But we have to overcome it. And I didn’t overcome it, not really, until years later.”

“What happened years later? Did you go to therapy or—”

“No! When we moved to California, my son went to a school where the parents were very involved, and the kids were multicultural, and they would have culture days. So on one of these days, I made tabuleh, and I heard a mother telling her son in Hebrew that this was the authentic thing! And we began speaking, and our sons were friends, so we set up play dates, and while they played, we spoke. We were the same age and remembered the same things, but from opposite sides. But we grew up thinking there was this other…”
Thematic presentations and conversations were the connections between motherhood, family life, nursing, and direct and structural violence against women. The interrelatedness of these subjects is so intrinsic, particularly across borders, that it deserves more careful attention than I can give it here. Yet, the focus on these subjects and the relations between them among Middle Eastern nurses speaks to the larger culture of maternal nursing care in the region.

An explicit secondary goal of the conference is conflict mitigation, especially through exposure and trust building. Though not as pronounced as maternal nursing, presenters and participants discussed the implications of borders and differences in medical supplies and healthcare accessibility. Mary, a Jordanian-American, gave the keynote address concerning women’s healthcare in Jordan, and how healthcare has the potential to increase human dignity or dehumanize. She explicitly discussed the needed partnership between men and women to better health for all, despite everything patriarchy was responsible for. “We cannot just blame our men, we have to teach them and partner with them,” she asserted as the crowd applauded.

I include this example for its particularity - though my research was in an Israeli hospital where nurses were nearly exclusively female; this is not the case in much of the Middle East. While my theory rests on the maternal care nurses give as they are socialized to be mothers, a different modality must be used to access nurses’ peacework capabilities in neighboring Palestine.

Curious, I asked the male nurses at the conference, mostly nursing administrators, why they pursued caring labor. After waiting—listening—to receive an answer greater than “job security” (accompanied by laughs), I learned that three out of the five men present rooted their nursing practice in their religious practice. One even said, “Allah orders us to care for the People of the Book” (meaning Muslims, Christians, and Jews.) Operating within their own institutions, Islam guided many institutional principles, particularly in who could care for which bodies.

While nursing in Israel can be read as a feminist counter to violence and war because they are socialized as mothers is not universally applicable- it’s not even applicable in the hospital twenty kilometers away. Yet, I maintain that the socialization of certain people towards caring professions shapes
institutional norms, and that in some zones of conflict, the difference in an institution’s principles of caring and the outside world can be transformative. Partnering with these institutions allows us to expand and explore our own capacities for caring.

As I return from this conference, I am struck by how individual encounters can be totally transformative. In Hadassah, the individual encounter never only affects two people—but extends to the families of patients, the nursing team and the families of nurses. By training the children and youth in these groups towards an ethic of caring—or minimally, that we are not each other’s enemies—holds the capacity to transform entire generations. Singular encounters, when facilitated by care, are what make the children of former Fateh members and generals in the Israel Defense Forces exchange medical supplies instead of gun shots.

Perhaps it’s the innocence of my youth, or the compilation of experiences that speak against violent nationalism, but I return to Wellesley believing more than ever in the power of nurses as peaceworkers. My greatest hope is, that in reading this, you will be added to the network of people influenced by my experience- perhaps even walking away believing that--one by one--we will have an answer to violence.

In Peace,

Jordan

Tel Aviv, 5 March 2016
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