Safeguarding healthcare in conflict: SAMA's suspension of relations with the Israeli Medical Association

The South African Medical Association (SAMA)'s suspension of relations with the Israeli Medical Association (IMA) poses a practical question for wartime healthcare: what does neutrality require of medical associations? This editorial situates the decision in medical ethics and international humanitarian law, and proposes a clear, reviewable standard for conditional engagement. It does not adjudicate competing political claims. Rather, it asks why SAMA acted now, and what criteria medical associations might apply when assessing professional ties during conflict.

SAMA's decision in context: Neutrality and conditional engagement

On 3 October 2025, SAMA resolved to suspend professional and bilateral relations with the IMA, and to urge the IMA's suspension from the World Medical Association (WMA). The decision followed board deliberations, and sets specific, verifiable conditions for reinstatement of relations: condemnation of attacks on healthcare in Gaza; advocacy for the release of detained Palestinian medical personnel; condemnation of starvation and blockade policies that obstruct access to medical supplies; and measures to guarantee medical treatment for all persons under Israeli control, including detainees.[1] Soon after, an editorial in the *Lancet* echoed these concerns and urged medical societies to condemn attacks on healthcare, document harm and act against impunity.[2] Clinician accounts in the *New England Journal of Medicine* add operational details, describing a workforce and system that is under sustained assault.[3] Official reports of the World Health Organization and United Nations document at least 772 attacks on healthcare, 94% of hospitals damaged or destroyed and key capacities (including computed tomography, magnetic resonance imaging and dialysis) severely reduced. Hundreds of clinicians have been detained, large cohorts of patients left without essential care and >1 500 healthcare workers killed.[3] This is the highest toll ever recorded for healthcare workers during a conflict. A companion *Lancet* correspondence piece introduced 'healthocide' to describe the cumulative, system-level erasure of care, arguing that even if later proven, claims about misuse of hospitals cannot justify systematic attacks on health services.[4]

Professional standards: The WMA principles and medical neutrality

SAMA's rationale is rooted in medical ethics and international humanitarian law, not partisanship. The association links its stance to the WMA principles, and to the imperative to protect health services and personnel in conflict settings. The WMA's ethical instruments, the Declaration of Geneva and the International Code of Medical Ethics, set out physicians' universal obligations, with some of the core obligations including:

(*i*) place patient welfare first;
(*ii*) respect human dignity and autonomy;
(*iii*) provide care without discrimination; and
(*iv*) never use medical knowledge to violate human rights.

They also require physicians to protect colleagues and to safeguard the conditions necessary for impartial care.[5-7] In this context, SAMA's resolution reflects fidelity to the profession's highest standards that bind all physicians, even in war.

Evidence from the field: Health-system harm and operational constraints

The evidentiary question is not only what has been damaged, but how the system now functions. Peer-reviewed sources document severe disruption to services, and explain why indirect mortality is likely to rise as care and basic services deteriorate. They report consistent patterns: damaged hospitals, high healthcare worker deaths, and degraded water, sanitation and food systems.[8] Operational reports from humanitarian organisations provide on-the-ground evidence that complements the peer-reviewed literature. On 26 September 2025, Médecins Sans Frontières (MSF) announced that it had suspended activities in Gaza City.[9] Tanks had advanced to within <1 kilometre of MSF clinics, creating an unacceptable risk to staff and patients. In the week prior, MSF nevertheless delivered >3 640 consultations and treated 1 655 people for malnutrition, showing sustained demand for care under severe constraints.

These reports matter ethically and legally. Under international humanitarian law, medical personnel, facilities and transports enjoy explicit protection. The Geneva Conventions of 1949 and their Additional Protocols expressly prohibit attacks on hospitals, ambulances or health workers, and require the wounded and sick to be cared for without discrimination.[10-12] These protections apply to all parties to conflict, including non-state armed groups. Intentional or indiscriminate attacks on health services may constitute war crimes under the Rome Statute of the International Criminal Court, which criminalises an intentionally directed attack against buildings that are dedicated to hospitals and places where the sick and wounded are collected (provided they are not military objectives).[13] The duty to protect healthcare is reinforced by UN Security Council Resolution 2286 (2016), which condemns attacks on medical care, demands compliance with international humanitarian law and unimpeded access, and urges prevention, documentation and accountability.[14]

Neutrality is an ethical stance with operational content, and not a posture of silence. It begins with recognising all civilian suffering, but requires open condemnation of practices that undermine care, and active defence of access and the norms that protect care. The British Medical Association models this balance: it explicitly notes the 7 October 2023 attacks in Israel, the ongoing hostage-taking and the scale of harm in Gaza, yet keeps its advocacy centred on medical neutrality, humanitarian access and the protection of health services.[15,16] Recent literature moves from concern to implementation, mapping the operational duties that inform the benchmarks below.[17] Historically, professional associations have responded to crises through documentation, advocacy and norm-setting. Yet in a cross-sectional review of 53 US specialty societies, only 24.5% had issued public statements on the Gaza-Israel conflict, which indicates uneven engagement and a need for clearer guidance on institutional responses.[18] Against this backdrop, SAMA's resolution marks a stronger stance within the observed range of approaches.

Safeguarding care: Practical benchmarks for engagement

A practice-oriented standard for managing professional ties in conflict could ask whether a counterpart association: (*i*) affirms

medical neutrality and condemns attacks on health services and personnel; (*ii*) advocates for unhindered humanitarian access, patient evacuation and protection of facilities; (*iii*) opposes detention or mistreatment of healthcare workers and calls for due process and access to legal counsel; and (*iv*) supports care for all detainees and civilians within its control, in line with international humanitarian and human rights law. Each element reflects WMA principles and the conditions that SAMA sets for resuming relations. In South African professional practice, neutrality has long meant safeguarding the space for impartial care, which is an emphasis that the proposed criteria make operational.

For the profession, the question is why this matters now. Disruption to care has been prolonged and severe: near-universal acute food insecurity, ~500 000 at risk of starvation and daily energy intake reduced to about two-thirds of the minimum needed for survival during blockade periods. SAMA's suspension of relations with the IMA is appropriately understood as a professional, conditional measure grounded in the duty to protect healthcare. The association sets out concrete steps that, if met, would permit normalisation. This treats engagement as conditional on ethical safeguards rather than political alignment. This approach is anchored in the WMA's Declaration of Geneva and International Code of Medical Ethics. Ultimately, medical ethics and international humanitarian law are mutually reinforcing frameworks. The same principles that guide clinical ethics – beneficence, non-maleficence, respect for persons and justice – also underpin the legal duty to protect healthcare and those who provide it. For practitioners, this alignment matters not only in 'ordinary' clinical contexts but in the extraordinary settings of conflict and displacement, where vulnerability is greatest. Professional bodies also have a duty to protect the safety and dignity of clinicians at home, rejecting any form of discrimination, while defending impartial care in conflict. Together, law and ethics should make care possible rather than precarious, protecting patients' right to health and the professional integrity of those who deliver it.

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