Restoring Trust, Sustaining Care | Jewish-Arab Relations in Israel's Health System Since October 7

Watch the Recording

Following the conversation on February 12, 2026, we shared several unanswered questions with the panelists, Yana Neumann, Dr. Manal Hreib, and Dr. Abeer Suleiman. Here are their responses:

1) There is a great deal of trust that Jews and Arabs entrust to one another with their health and well-being, how can this trust be scaled upward?

There is indeed a great deal of trust that Jews and Arabs place in one another with respect to their health and well-being. However, in times of crisis, this trust and the generally good relations are often not sufficient to withstand the fear that emerges with the eruption of the Israeli–Palestinian conflict.

Many of our interviewees reported that Jewish patients avoided Arab medical staff or asked their HMO to be treated by a Jewish doctor. At the same time, many Arab patients refrained from coming to hospitals due to fear of hostility from Jewish patients or staff.

For trust to be viable and sustainable, it is essential that people feel safe regardless of who their doctor is, and that they know there is a clear professional and managerial address to turn to if tensions escalate. In times of crisis, clear and consistent communication across the healthcare system is critical—explicitly reaffirming the commitment to providing a safe environment and professional care by and for both Jews and Arabs.

Healthcare organizations must create a cohesive professional united front that emphasizes professional identity and shared responsibility, so that national or communal identities do not divide staff or position them as belonging to one side or another. When these principles are clearly articulated and implemented, the healthcare system can serve as a model that may be scaled to other fields in Israeli society.

2) Do you have programs that train professionals in advance to act as allies and support one another when someone is the target of offensive behavior?

Our approach is twofold.

First, we aim to establish **structural alliances** through the creation of a permanent Jewish–Arab senior team that reports directly to the CEO. This team will be responsible for preparedness, cohesion, safety, and coordinated organizational responses in times of tension and crisis.

Second, we seek to **train senior managers** so that they are equipped to ensure that these principles are implemented throughout the organization. Senior leadership plays a central role in shaping norms, modeling conduct, identifying risks, and ensuring that staff at all levels know there is a clear managerial process and a professional address to turn to when offensive behavior occurs.

The goal is not only to create a formal structure, but also to embed alliance-building, mutual responsibility, and support into everyday managerial practice across the organization.

3) How can healthcare systems balance respect for patient preferences with a firm commitment to non-discrimination: should patients be restricted from choosing providers based on identity, and are clear, human-rights–based standards of respectful conduct communicated and enforced as a condition of care?

We believe that the guiding standard should be professionalism. Healthcare employees are professionals regardless of their identity, and the responsibility of the system is to ensure respectful conduct and professional care irrespective of patient preferences. This should be the baseline guideline.

At the same time, it is important that guidelines and red lines are clearly communicated, and that managers have the discretion and capacity to engage with and decide upon rare value-based dilemmas.

During our interviews, we encountered a compelling example of this type of managerial judgment. In one hospital, a Haredi child was scheduled to be treated by an Arab Christian nurse who wore a necklace with a cross. The child's mother strongly objected, stating that she did not want her child exposed to Christian symbols. The manager understood the complexity of the situation and the tension between organizational principles and the specific needs of both the patient and the nurse.

Rather than imposing a unilateral decision, the manager asked the nurse how she would prefer to proceed—whether she would like another nurse to replace her, or whether she would prefer to cover or remove the necklace during treatment. This approach demonstrated respectful judgment, acknowledged the competing values at stake, and resulted in a solution that respected both the Haredi mother and the Christian nurse.

4) Do Israeli medical, nursing, pharmacy, and dental students intentionally train in communities outside of their own?

Approximately 60% of certified doctors in Israel study abroad due to a shortage of medical faculties in the country. Within Israel, medical and nursing schools are located primarily in major cities—Haifa, Tel Aviv, Jerusalem, and Be'er Sheva.

Importantly, there are **no government-run hospitals or medical faculties located within Arab society in Israel**. This reflects a structural inequality that limits opportunities for Arab students to train within their own communities and reduces exposure for Jewish students to professional environments embedded in Arab society. As a result, training across communities occurs largely by necessity rather than by intentional design.

5) Are there programs during professional training that prepare healthcare workers to respond to discrimination and support colleagues under stress?

There was **one dedicated committee** on the prevention of racism in the healthcare system that produced an excellent and comprehensive policy. Among its key recommendations were the appointment of a **designated officer for the prevention of racism** in every healthcare organization, alongside the development of **educational and training programs** on this issue.

However, despite the quality and clarity of the policy, training on racism prevention and respectful conduct is **not implemented in a sufficiently systematic or system-wide manner**. For example, in many educational institutions today, students are not necessarily exposed to these topics, nor are they consistently trained to identify, prevent, and respond to racism and discrimination in professional settings.

6) Should this training begin earlier to develop a dynamic culture of non-fragility and shared responsibility?

Yes. This training should begin as early as possible so that healthcare professionals enter the field with a shared understanding of what is expected of both employees and patients in a shared Jewish–Arab workplace. It should be defined as a core competency for every employee in the healthcare system.

7) How have past crises played out differently from today, and what impact did the First and Second Intifadas have on the Israeli healthcare system?

Past crises tended to be shorter and more cyclical—often described as "volatile cycles." The prevailing assumption was that Jews and Arabs would distance themselves temporarily, the situation would be unpleasant, and then life would return to normal once the crisis passed.

The events of October 7th and the subsequent two-year war were fundamentally different in their extremity, duration, and impact. The personal and collective trauma was far deeper, and the effects on shared workplaces, including healthcare, were far more severe and long-lasting.

8) How can anti-fragility principles be adapted to different organizational sizes or types of healthcare or other institutions?

The principles themselves are consistent across organizations, regardless of size or type. Each organization must adapt them to its specific characteristics—such as size, location, and mission.

Key principles include: managerial accountability; shared Jewish–Arab management; organizational learning from ruptures; identifying fragility and anti-fragility–promoting factors; and the design and implementation of mechanisms for preparedness, cohesion, and safety, including clear roles and responsibilities, processes, measures, monitoring, and reporting.

In times of crisis, this also requires managerial "skin in the game." The underlying assumption must be that the Israeli–Palestinian conflict will continue to affect shared workplaces. Therefore, organizations cannot assume a rapid return to a previous status quo. Instead, they must learn from each crisis, strengthen their

capacity to respond, and be better prepared for future disruptions that may arrive unexpectedly and take forms we cannot predict.