

Safeguarding Cancer Care in Armed Conflict: Lessons from the 2025 Iran–Israel War

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ABSTRACT

Dear Editor,

The military hostilities between Iran and Israel in 2025 have laid bare the acute fragility of cancer care systems within conflict zones. In periods of armed confrontation, medical resources are typically diverted toward trauma management and emergency response [1]; however, for oncology patients, the interruption of precise, time-sensitive regimens can prove as lethal as the conflict itself. Iran navigated this 12-day crisis with a healthcare infrastructure already significantly burdened by long-standing international sanctions, which had historically restricted the flow of diagnostic technology and essential pharmacological agents. This conflict forced a rapid, often improvisational transition in how oncological care is delivered, revealing both the resilience of the local medical workforce and the systemic vulnerabilities that demand urgent reform.

During the height of the conflict, the perception of hospitals as potential targets—fueled by strikes on two medical facilities—created an environment of deep apprehension among both staff and patients. This fear, coupled with the withdrawal of several private sector oncology providers, placed an extraordinary burden on public institutions like the Cancer Institute of Iran. To sustain continuity, our facility underwent an immediate restructuring: radiotherapy shifts were condensed to mitigate risk, new patient admissions were paused to preserve capacity for those mid-cycle, and personnel were redeployed to ensure uninterrupted daily specialist coverage. Notably, the palliative care department successfully migrated to a remote consultative model, utilizing digital health platforms to maintain essential support services. While these measures were effective in the short term, they relied heavily on the personal sacrifices of staff who operated without formal crisis-management training, often requiring makeshift in-hospital accommodation to navigate the dangers of transit during air raids.

The broader regional experience suggests that such challenges are far from unique. A comparative review of conflict zones reveals that oncology services frequently suffer from a “cascade effect” of failure. In Syria, persistent instability and the targeting of healthcare infrastructure led to the mass migration of oncology specialists and the fragmentation of treatment pathways [2]. Similarly, the Iraqi oncology experience over several decades highlights how systemic collapse, exacerbated by environmental hazards, forces patients into dangerous and costly reliance on international medical



travel [3]. The Lebanese crisis, characterized by economic collapse and massive infrastructural damage, illustrates that a lack of financial liquidity can replicate the effects of open warfare, causing drug shortages and the breakdown of diagnostic capabilities. Furthermore, prolonged blockades in the occupied Palestinian territory demonstrate that oncology mortality is often defined by restricted access to borders and essential materials, even in the absence of kinetic warfare [4]. Similar total-collapse scenarios in recent conflicts in Sudan and the Tigray region of Ethiopia further underscore the precarious nature of highly centralized urban oncology facilities [5,6].

These regional precedents clarify that ad-hoc adaptations are insufficient to protect oncology patients. We advocate for a “Dual-Resilience” framework that shifts the paradigm from emergency reaction to institutionalized preparedness. This model requires, first, the physical hardening of oncology infrastructure—specifically the reinforcement of radiotherapy bunkers housing radioactive sources and the development of localized, redundant power and water supplies. Second, it necessitates the creation of a “digital shield,” where electronic health records and imaging archives are backed up on secure, off-site servers, enabling treatment to continue seamlessly if the primary facility is compromised. Third, we must prioritize the psychological and logistical support of the oncology workforce, providing them with safe, hospital-based accommodations and mental health resources to ensure operational sustainability. Finally, oncology must be elevated as a protected category in international humanitarian law, with the establishment of monitored corridors specifically for the transport of chemotherapy agents, radioisotopes, and specialized diagnostic supplies.

Ultimately, the 2025 Iran–Israel conflict serves as a sobering reminder that for the cancer patient, the “war” is constant. If we are to honor our ethical obligation to these vulnerable populations, the oncology community must integrate comprehensive disaster-preparedness protocols into the standard of care. By documenting these operational lessons and codifying them into international humanitarian standards, we can ensure that cancer care is prioritized—not as an afterthought, but as a critical component of civilian protection in the face of escalating global conflict.

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